

# New Patient Intake Form

(Please fill out this entire form)



Dr. Benjamin Ho | Irene Ho, PA-C

Patient Name:		DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:		City:	State / Zip Code
Mobile Phone #:	Home Phone #:	Social Security Number::	Race:
Email Address		Pharmacy(Name & Street)	

## Responsible Party and Emergency Contact:

Responsible Party (Name):	Relationship to Patient:	Social Security Number:
Address (if different from patient's):	City	State / Zip Code
Email Address:	Mobile #:	Home #:

Emergency Contact (Name):	Relationship to Patient:	Social Security Number
Address:	City	State / Zip Code
Mobile #:	Home #:	Work #:

## PRIMARY INSURANCE:

Name of Insurance Company:	Insurance ID:	Group ID:
Policy Holder's Name & Relationship to Patient	Policy Holder's Date of Birth::	Policy Holder's Social Security Number::

## SECONDARY INSURANCE (IF APPLICABLE):

Name of Insurance Company:	Insurance ID:	Group ID:
Policy Holder's Name & Relationship to Patient	Policy Holder's Date of Birth::	Policy Holder's Social Security Number::

## ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned hereby authorizes my physician or his agent to release any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as through the undersigned had personally signed the particular claim as described on the attached form:

I \_\_\_\_\_ hereby authorize the insurers listed above to pay all insurance benefits to Dr. Ho for his professional services. I understand I am financially responsible for all charges incurred.

X \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

## MEDICAL HISTORY

Current Medical Conditions:
Current Medications:
Other doctors/therapists that patient currently sees:
Previous PCP or Regular Doctor:
Birth History (if you remember): <input type="checkbox"/> Full Term <input type="checkbox"/> Vaginal      Birth Weight: ___lb___oz      Length: _____in <input type="checkbox"/> Premature <input type="checkbox"/> C-section      Complications?
Past Surgeries (with dates):
Past Hospitalizations (with dates):
Allergies:      Vaccines up to date?

## FAMILY HISTORY

### Diseases/conditions that run in the family:

Condition:	Who has it?
Condition:	Who has it?
Condition:	Who has it?
Condition:	Who has it?
Others:	

## SOCIAL HISTORY

Who all does patient live with?
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Substance: <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> Smoke Exposure (if patient is non-smoker) <input type="checkbox"/> None

## PRIVACY PRACTICES ACKNOWLEDGEMENT

The revised Notice of Privacy Practice (eff 8.31.2018) was provided for my review. I hereby acknowledge that Family Care of Middle Georgia will share my or my child's medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

# Consent Form



Dr. Benjamin Ho | Irene Ho, PA-C

## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Family Care of Middle Georgia (FCMG) to use and/or disclose certain protected health information (PHI) about me or my child to the following Person or Entity to receive the information:

Please list other medical providers, family, friends, etc. who may receive your child's medical information.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

\_\_\_\_ (Initial) **PATIENT HEALTH INFORMATION.** I understand that this authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV-related information unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

\_\_\_\_ (Initial) **INSURANCE PAYMENT.** I hereby authorize direct payment of medical benefits to FCMG for services rendered. I consent to the use or disclosure of my child's protected health information by FCMG and if needed information from other providers, for the purpose of obtaining payment for my health care bills or to conduct the healthcare operations. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by my contract with my insurance plan. Due to the vast amount of insurance plans, our staff is unable to know your plan's specific benefits allowed by your insurer. When in doubt, you are encouraged to review your policy and contact your insurance company. I understand that I am financially responsible for paying any balance not covered by my insurance at the time of service or upon receipt of a billing statement from FCMG. Failure to pay for the services will be sent to a collection agency. All payments are due at time of visit. If you are uninsured, you are required to pay for the cost of the office visit before being seen.

\_\_\_\_ (Initial) **CANCELLATION POLICY** I understand that if I am unable to make my appointment, I must notify FCMG one day (24 hours) prior to the appointment or I will be charged a no show fee. If I miss an appointment, I'm aware I will be charged **\$20**. The no show fee must be paid prior to being scheduled for another appointment.

\_\_\_\_ (Initial) **NO SHOWS - 1, 2, 3 strikes you're out.** I'm aware that if I miss a new patient appointment twice, I will not be rescheduled. And, if I have 3 no shows throughout the past 12 months, I understand Dr. Benjamin Ho will no longer be my PCP, I will not be able to make an appointment but I can try to come in as a walk in.

\_\_\_\_ (Initial) **CONSENT TO OBTAIN PRESCRIPTION HISTORY.** I hereby authorize Family Care of Middle Georgia to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages. I understand prescriptions may be shared with other healthcare providers, pharmacies, insurance companies for treatment purposes.

I have read, I understand, and I agree to the provisions of this consent form.

Printed name of patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or legal guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

*Thank you for choosing **Family Care of Middle Georgia** for your healthcare needs.  
Please view our office policies below.*

### **Financial Policy**

We have updated our financial policy, and we'd like you to stay informed with our office policies so we can continue to provide you the best services.

**Insured Patients:** Our practice files directly to your insurance and it is important we always have the correct insurance information from you. If your insurance has changed in anyway, you must inform us. Otherwise, the bill will be your responsibility in full. Additionally, you will be responsible for any co-payments, deductibles, co-insurances and cost shares. All co-pays are to be paid in full before services rendered. A \$5 billing fee will be applied any time a copay is asked to be billed.

**Non-Insured Patients:** Our office will expect payment before services are rendered. There will be no exceptions. Any procedure or lab charges will be explained to you and they will need to be paid before services are rendered.

**Payment Methods:** At the time of your check-in, you will be notified of any balance due. Our office accepts cash, VISA, Mastercard, and Discover. A payment can be made over the phone using a credit/debit card.

**Billing Cycle:** Please read and be familiar with the following information - this information can make the difference between an account in GOOD STANDING or in collections status. Statements are mailed monthly on the 15th.

- **First Statement:** You will receive your first mailed statement after your insurance is filed, insurance pays and if a patient balance is due. You will not receive a statement if there is no patient balance due. Any balance is patient responsibility and should be promptly paid in full within 30 days.
- **Second Statement:** You will receive a second mailed statement requesting payment in full. An alert is put on your account if balance is past due 60 days. Account is in jeopardy of good standing.
- **Third Statement:** You will receive a third and last mailed statement with a final notice warning of outside collections. Our intent is to inform you of the seriousness of your delinquent account. Your account is past due 90 days. The agency will start the collections process on the 91st day as well as notify the credit companies. **No appointments can be made until balance is completely paid.**

**Paperwork:** A fee of \$10 is charged for all paperwork and is due when you pick-up the paperwork or before it is mailed/faxed. The fee may be increased due to length and complexity at the discretion of the provider.

**Missed appointment:** There is a \$20 missed appointment fee. If a patient misses three consecutive appointments, he or she will be dismissed from the practice.

### **Reasons for Terminating Physician - Patient Relationships**

Our providers strive to work with you to treat and manage your health, and it's a teamwork approach. The following are situations in which termination of the physician-patient relationship will be made:

- **Treatment non-adherence:** The patient does not or will not follow the treatment plan
- **Follow-up non-adherence:** The patient repeatedly cancels follow-up visits or is a no-show. 3 strikes and you're out.
- **Verbal abuse:** The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions
- **Non-payment:** The patient has an outstanding balance and has declined to work with the office to establish a payment plan.

I have read and understand the financial and relationship policies at Family Care of Middle Georgia.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Patient or Guardian's Name

\_\_\_\_\_  
Date