Tanner Medical Group Registration

As a member of Tanner Medical Group, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions.

PATIENT INFORMATION

Patient's Name: ____________________ **Alias:** ____________________

Date of Birth: ____________________ **Social Security #:** ____________________

Sex: Male Female Other **Race:** Caucasian Black Asian Hispanic Other

Patient's Address: ____________________

City ____________________ **State** ____________ **Zip** ____________________

Primary Care Provider: ____________________ **Preferred Pharmacy:** ____________________

Preferred Language: ____________________ **Interpreter Needed?** Yes No

Email: ____________________ **Employer:** ____________________

Home: ____________________ **Cell:** ____________________

Work : ____________________ **Preferred Communications:** Call Text Email

Marital Status: Single Married Divorced Legally Separated Widowed Significant Other Other

GUARANTOR / RESPONSIBLE PARTY

Name: ____________________ **DOB:** ____________ **Phone:** ____________ **Relationship** ____________

Social Security #: ____________________ **Address** ____________________

OTHER / EMERGENCY CONTACT INFORMATION

Name: ____________________ **Relationship** ____________ **Phone** ____________________

INSURANCE INFORMATION

Primary Insurance: ____________________ **Primary Cardholder's Name:** ____________________

Relationship: ____________ **Date of Birth:** ____________ **Social Security #:** ____________

Policy #: ____________ **Group #:** ____________

Secondary Insurance: ____________________ **Primary Cardholder's Name:** ____________________

Policy #: ____________ **Group #:** ____________

Tanner Medical Center, Inc.

Patient Authorization and Consent to Treatment

A. Consent to Treat: I consent and/or authorize the employees and agents of Tanner Medical Center, Inc. and affiliates of Tanner Health System (TMC) to perform such diagnostic or screening examinations, tests, procedures, or services and to provide any medications, care, treatment, services or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries as ordered by the treating physician(s).

I also consent to the transportation of the patient (by air or ground) to and from other facilities for such services.

I understand that the treating physician(s) is responsible for informing and explaining to me the nature of my individual condition , the risks and alternatives to the proposed course of treatment, and the possible results of the care, treatment, or services among other things. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees as to any results have been or will be made.

I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I understand that TMC will request recent pharmacy history.

I understand that TMC participates in a secure Health Information Exchange (HIE). The HIE supports integrated system patient care initiative by allowing physicians and healthcare providers to share and access patients' health information through an HIE for treatment, payment, and health care operations purposes. I understand that I have a right to opt out of having my information available in the HIE by signing an OPT-Out form.

I understand that as part of the HIE, I have the right to elect to participate in MYTanner Patient Portal to obtain secure access to my personal patient information.

B. TMC healthcare education. At times, care, examination, treatment and service may be delivered by students under the supervision of the attending physician or authorized THS personnel. Students will never have primary responsibility for your care; there will always be fully licensed healthcare professionals supervising the students, and available to assist with your care, treatment and service. I consent that these students may be present during my care and treatment, and I further consent that they may perform such examinations, tests, treatment and care as their supervisor directs.

C. Information Privacy: I am automatically included in the Patient Directory and Clergy List which allows TMC to relay my location and general condition if asked for by name, and my religious affiliation to clergy without asking by name. If I do not want to be included in these lists, I will so designate. If I opt out of the Patient list, I understand that if family members, my clergy, neighbors, or friends inquire about me while I am a patient, my presence here will not be disclosed, and that mail or flowers addressed to me will be returned.

D. Consent to Release Medical Records Information to Patient's Insurance Company and Other Health Care Providers: Insurance companies, Medicare, Medicaid, Champus or other health care providers (home health agencies, nursing homes, rehabilitation centers, etc.) may request that TMC provide the patient's admitting diagnosis or other medical information to verify eligibility for payment, to process payment, to ensure appropriate discharge planning needs are met and to provide for continuity of care. I authorize TMC and the patient's physician (s) to release any information acquired in the course of examination and treatment for the purposes stated in this paragraph. I understand that information concerning alcohol, substance abuse, mental health, HIV, AIDS or sexually transmitted diseases may be released. Unless revoked, this consent is valid until the claim is paid.

E. TMC is not a participating provider for all HMO, PPO, POS or independent insurance companies: I understand the TMC facility may be out-of-network or ineligible for payment from the patient's insurance carrier. The patient or responsible party accepts responsibility for being knowledgeable about the insurance information presented and will notify the patient's insurance company the patient sought treatment at the TMC facility. **The fact that TMC is not a participating provider with the patient's insurance company does not waive the patient liability for payment for services rendered**.

Tanner Medical Center, Inc.

Patient Authorization and Consent to Treatment (Continued)

F. Guaranty of Payments to TMC: I hereby guarantee payment of all charges to the patient in connection with the patient's hospitalization, care, treatment or services, in accordance with TMC's standard rates and terms of payment. I am aware that I am not released of any liability by any extension of time granted me for the payment of these charges. I also waive homestead and all other exemptions. Payment for services is due at the time of service or at such time agreed upon by TMC in writing. I also agree to pay all expenses incurred or owed by TMC in collecting this account, including but not limited to fifteen percent (15%) attorney's fees and collection agency fees of up to fifty percent (50%), in the event this account is not paid as stated above. I hereby authorize the hospital to apply credit balances to reduce other outstanding accounts with the hospital which I am responsible before refund of any remaining balance.

G. Authorization for Insurance Company to Pay TMC and the Physician Directly: I authorize payment directly from the patient's insurance company to TMC and physician(s) who provide goods or services to the patient. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying payment under the Social Security Act is complete and correct and request that payment or authorized benefits is made on the patient's behalf. I authorize TMC to act as attorney–in–fact to collect and endorse payment checks from any payment source. In the event of an insurance company request for administrative review or denial of any services obtained, I authorize TMC to appeal on my behalf.

H. Privacy Notification: I acknowledge that I have received a copy of the Notice of Privacy Practices for TMC. In receiving this notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

I. Leaving the Hospital Building: Leaving the hospital building (unless to a designated smoking area) while a patient at Tanner Medical Center, Inc. is prohibited. If I choose to leave the hospital building, I understand it will be documented in my medical record and that it may affect insurance reimbursement. In addition, if I choose to leave the hospital building, I and my next of kin/family members, absolve Tanner Medical Center, Inc., my physician and any other persons caring for me from any present or future liability related to leaving the hospital building prior to receiving a physician's discharge order.

J. Photography, Video, Digital and Other Images: I understand that my photograph or that of my child or ward, may be taken while receiving treatment at the hospital for the following purposes: care, treatment, education, patient safety, and as a measure to prevent identity theft.

K. Responsibility for Valuables: TMC is not responsible for valuables, money, personal or other possessions, which are not deposited with TMC at the time of admission. **TMC assumes no responsibility for the safety of dentures, eyeglasses or other personal property, documents, cash or other valuables.** TMC reserves the right to dispose of checked personal effects if they are not claimed within one (1) month after discharge.

L. Communication: By signing this form, I expressly consent and authorize TMC and its affiliates and agents, including any collection agency or debt collector hired by TMC to communicate with me for any reason, including, but not limited to, past and future medical services, collection of amounts owed for said services, and marketing. This communication may be made using an automatic telephone system or an artificial or prerecorded voice at the telephone number(s) I provided to TMC and also any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service or other radio common carrier service, or any service for which I am charged for the call. In addition, I further expressly consent and authorize TMC to communicate with me at any phone number or email address or other unique electronic identifier or mode that I provided to TMC at any time, or any phone number or email address or other unique electronic identifier or mode Tanner finds or obtains on its own which is not provided by me.

M. Medicare Inpatients and Observation Patients acknowledge that they have received a copy of "An Important Message from Medicare" and "An Important Notice to Medicare Patients." I understand that I am responsible for any deductibles, co–payments, self administered drugs, and/or non–covered outpatient services as defined by Medicare.

N. Credit Reporting: Our institution operates in accordance with all provisions of the Fair Credit Reporting Act and all relevant local, state and federal laws. Information acquired in this process may be used to verify specific demographic information, and provide specific financial data useful in helping some of our patients become eligible for our financial assistance programs. Credit reports and all other 3rd party data may be accessed only for valid, work related purposes.

Tanner Medical Center, Inc.

Patient Authorization and Consent to Treatment (Continued)

O. Disclosure: I understand there are circumstances under which information about the patient must be disclosed or reported. Such circumstances may include requirements for disclosure of information to law enforcement agencies, and cases of HIV, tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention.

P. Smoking: All Tanner Medical Center, Inc. facilities are non–smoking facilities. If I choose to smoke while hospitalized, I agree to smoke only in the designated smoking areas. I hereby absolve Tanner Medical Center, Inc., my physician and any other persons caring for me from any present and future liability caused by smoking and/or going to/from the designated smoking areas while a patient in the hospital. I understand the risks of smoking to my health, and also understand the benefits of not smoking.

Q. Acknowledgement of Physician /Hospital Relationship: Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions, and TMC, its affiliates, subsidiaries and this hospital ("TMC") shall not be liable for the acts or omissions of any such independent contractors.
__________**(Initial)**

R. Complaints: In order to resolve issues promptly, patients and/or their representatives are encouraged to express concerns to TMC staff as soon as possible after the occurrence. Patients are encouraged to report patient safety or quality of care concerns to Risk Management at (770) 836–9842. If the concern cannot be resolved at this level, patients may contact the hospital's accrediting body, The Joint Commission.

Mail to: The Joint Commission Office of Quality Monitoring
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Phone: (800) 994–6610
Fax: (630) 792–5636

Georgia Department of Human Resources
Office of Regulatory Services
2 Peachtree Street, NE
Atlanta, GA 30309
404–657–5700– 1–800–326–0291 (Home Health)
1–800–633–4227 (1–800–MEDICARE)

Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619–0257
(877) 696–6775

Regional IV, Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W.
Atlanta, GA 30303–8909
Voice phone 404–562–7886
Fax 404–562–7881
TDD 404–331–2867

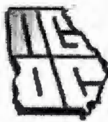
Patient desires:
__________**not to be included in the Patient Directory (initial)**
__________**not to be included in the lists of patients given to clergy for visitation (initial)**

Patient/Responsible Party ______________________ **Date** __________

Responsible Party (if different from patient) ______________________ **Date** __________

Witness ______________________ **Date** __________

PRDCONSENT 06/02/2016



Northwest Georgia Oncology Centers, PC

NEW PATIENT HEALTH HISTORY FORM

Patient Name:______________________________________ **Birth Date**___/___/______ **Today's Date**___/___/______

Referring Physician:________________________________ **Other Physicians you see:**________________________________

____

Reason for visit:____

____

Check any conditions you have:

Illness	Y	N	Diagnosis Year	Illness	Y	N	Diagnosis Year
High Blood Pressure				Kidney problem			
Bypass or Valve replacement				Stomach problem			
Pacemaker or Defibrillator				HIV			
Congestive Heart Failure				Hepatitis			
Heart Attack or rhythm problems				Osteoporosis			
Thyroid problem				Seizures			
Diabetes				Blood clots			
Asthma or COPD				Prior history of cancer			
Gout				Depression			

Other illness not listed above____

Prior Surgeries:

Procedure	Y	Year	Procedure	Y	Year	Procedure	Y	Year
Gallbladder			Spleen			Colon		
Uterus			Lumpectomy			Joint replacement		
Ovaries(one)			Mastectomy			Prostate		
Ovaries (both)			Stomach Bypass					

Health Maintenance: Fill in all that apply

Procedure	Date	Procedure	Date
Colonoscopy		Prostate Exam	
Mammogram		Pap Smear	

Gynecologic History: Fill in all that apply

First menstrual period age? ______ **Last menstrual period (menopause) age?** ________ **Number of pregnancies** ______

Birth control pills ☐ **Yes** ☐ **No** **Hormone replacement therapy** ☐ **Yes** ☐ **No**

Patient Name____DOB______________________

Social History:

Tobacco Use ☐ Yes (Please explain below) ☐ No and Never have

Type	Packs per day/How Often?	How many years?	Type	How Often?	How many years?
Cigarettes			Cigar		
Pipe			Chewing tobacco		

Do you drink alcohol? ☐ No ☐ Yes ☐ Occasionally ☐ Daily ☐ Beer/Wine ☐ Hard Liquor

Marital Status: Please circle one Single Married Life Partner Divorced Widowed

Occupation_______________________________

Family History:

Family Member	Alive	Deceased	Age	List Illnesses or Cause of Death
Mother				
Father				
Siblings (brother/sister)				
Other:				

Are you allergic to any medications? ☐ Yes ☐ No Please list:____

____

Medications: List all medicines and supplements you take:

Name	Start Date	Dose	How often?	Reason

____

Patient Signature Date

Are you allergic to CT dye? _____ Yes _____ No

Are you diabetic? _____ Yes _____ No

If diabetic, are you taking medication ? _____ Yes _____ No

Do you have any metal implants: _____ Yes _____ No

If yes, where? ____

Do you have multiple myeloma? _____ Yes _____ No

Do you have breast implants? _____ Yes _____ No

Do you have a personal or family history of: (check/circle all that apply)

_____ Kidney disease Personal and/or Family

_____ Kidney failure Personal and/or Family

_____ Kidney transplant Personal and/or Family

_____ Other transplants Personal and/or Family

_____ None of the above

Medication Log

Use this form to keep a record of all prescribed medications. Talk to your provider or your pharmacist if you have any questions regarding your medications or if you're experiencing unexpected complications or side effects.

- *If medication or treatment prescribed by your physician doesn't seem to help the problem, please let your provider know.*
- *Please check your medications at the beginning of each week to make sure you will have enough until your next visit.*
- *Please allow a 24 hour notice for prescription refills.*
- *Pain medications require a written prescription from your physician and cannot be refilled on weekends or after office hours.*

Medication Name:________________________________ Prescription #:_____________________

Date Prescribed:__________ Prescribing Doctor: _________________

Dosage: _______________ Date Started:___________ Date Ended: _________________________

Reason Prescribed:____

Notes:____

Side effects experienced: ____

Medication Name:________________________________ Prescription #:_____________________

Date Prescribed:__________ Prescribing Doctor: _________________

Dosage: _______________ Date Started:___________ Date Ended: _________________________

Reason Prescribed:____

Notes:____

Side effects experienced: ____

Medication Name:________________________________ Prescription #:_____________________

Date Prescribed:__________ Prescribing Doctor: _________________

Dosage: _______________ Date Started:___________ Date Ended: _________________________

Reason Prescribed:____

Notes:____

Side effects experienced: ____

Prescription Drug Monitoring Program

Beginning July 1, 2018, the state of Georgia has mandated that all providers utilize the Prescription Drug Monitoring Program that tracks prescription drugs to identify and address inappropriate or unsafe patterns of controlled drug use. For your safety, NGOC will access the Georgia Prescription Drug Monitoring Program (PDMP) as required by law to monitor when you fill controlled substance prescriptions.

The providers and staff at NGOC are committed to make prescriptions safer and to provide you with the treatment you need to reduce side effects. In an effort to safeguard your controlled substance prescriptions, please provide the name and contact information of any caregiver who can request controlled substance prescriptions on your behalf;

____

Name Relationship Phone Number

____

Name Relationship Phone Number

I agree to the following:

- I will communicate with my provider about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve the pain.
- I am responsible for my medicines. I will not share, sell, or trade my medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- I will safeguard my medications from loss, theft, or unintentional use by others.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor.
- Refills of my controlled substance medications will be made only at the time of an office visit or during regular office hours. **No refills will be available during evenings or on weekends.**

My signature below indicates that:

I understand that my provider will be monitoring my receipt of controlled substance prescriptions through the Georgia Prescription Drug Monitoring Program as required by law throughout my treatment period.

Patient Signature: ____Date:____________________

Patient Name (printed) ____

Revised 8-2018