SGMA SOUTH GEORGIA MEDICAL ASSOCIATES, P.C. (SGMA)

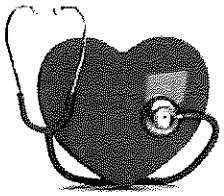
410 CONNELL ROAD – VALDOSTA, GEORGIA 31602 – (229) 244-4720 – FAX (229) 316-1370

Welcome to South Georgia Medical Associates, P.C. Cardiology

Your Provider: Staton Luke

Appt. Date:_____

Appt. Time:_____



The information regarding your appointment is listed above. For your convenience, we have enclosed a Cardiology Questionnaire. Prior to your appointment, we will request the medical records pertaining to your visit from your referring provider and any other physicians. We must have these records two (2) weeks prior to your appointment or your appointment will be rescheduled. This above information is vital for the providers to provide quality care.

After the visit, we will send the referring provider a report of your visit. Coming to the appointment prepared enables you and your provider to make the best use of your time.

Please remember to bring the following information with you when you come for your appointment:

1. Your insurance card - You are responsible for contacting your primary care physician and obtaining your referral. We will be unable to see you without proper authorization.

2. Your medication bottles so that we may accurately list all medications that you are currently taking.

If you are unable to keep your appointment, a 48-hour cancellation notice is appreciated. Thank you very much for choosing South Georgia Medical Associates, P.C. Cardiology, we look forward to seeing you.

Sincerely,

Dr. Staton and Dr. Luke

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Dr. George S. Staton, M.D. - Dr. William D. Luke, M.D.

Please fill out the enclosed forms and return to office at least 2 weeks before your scheduled appointment.

If forms are not returned your appointment will be rescheduled

Forms Included are:

- Appointment Card with date and time of your appointment (Please Keep this card)
- New Patient Information Sheet - Fill this out NEATLY and COMPLETELY
- HIPAA Authorization Form (to get your medical records) **This information must be turned in as soon as possible so we can obtain your medical records.**
- HIPAA Privacy Notice
- Insurance Card(s) to your appointment or when dropping off your paperwork to our office. We will scan them into your chart
- You will need to bring a Picture ID

If you come to your appointment and we have not received your information you will be asked to reschedule your appointment until we have your documentation.

If you have any questions please call 244-4720

ALL INFORMATION MUST BE FILLED OUT COMPLETELY

ABOUT YOU:

Your Name (Last, First, Middle Initial)

Address

City State Zip

Telephone ( ) Marital Status Single Married Separated Divorced Widow

Employer's Name Telephone ( )

Employer's Address
City State Zip

About Your Insurance

Your Primary Insurance Company's Name Date Effective

Address Telephone ( )

City State Zip

Policyholder's ID Number _____

Group Plan Number _____

Your Secondary Insurance Company's Name Date Effective

Address Telephone ( )

City State Zip

Policyholder's ID Number _____

Group Plan Number _____

If we do not receive information before your appointment you will be rescheduled

SOUTH GEORGIA MEDICAL ASSOCIATES, P. C.

Gregory S. Beale, M.D. • Milledge C. Newton, M.D. • Larry E. Smith, M.D.
Lynn S. Lee, M.D. • George Sidney Staton, M.D. • William Douglas Luke, Jr., M.D.

DATE: _____ ACCOUNT # _____ CHART # _____

Referring Doctor: _____ Doctor to be seen: _____

PATIENT INFORMATION

Social Security # _____ Name _____
(First) (Middle) (Last) (Suffix)

MUST HAVE
PHYSICAL ADDRESS: _____ CITY _____ ST _____ ZIP _____

P. O. Box or Mailing Address Only _____

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail Address _____ Best number to call (for appointment reminders) _____

Sex: M / F DOB: _____ Marital Status: S / M / W / D Race _____ Language _____
(Circle One) (Date of Birth) (Circle One)

Pharmacy: _____ Labs: Dr.'s Lab / Quest / Lab Corp. / SGMC
(Name) (Location) (Circle One)

Employment Status: (circle one) Retired / Full Time / Part Time / Disabled / Other _____

Employer _____ Work Number _____

MEDICAL INSURANCE INFORMATION

PROVIDE A COPY OF EACH INSURANCE CARD

Is the patient covered by insurance? YES / NO (Circle one) If so, who is the policy holder? _____

Name of Primary Insurance _____ Secondary Insurance _____

Patient's relationship to subscriber: SELF / SPOUSE / CHILD / OTHER (Circle one)

Is the policyholder a patient here? YES / NO (Circle one)

Primary Care Provider (PCP) / Manager (PCM) _____

SUBSCRIBER INFORMATION

Name _____ Date of Birth _____ Social Security # _____

Employer _____ Work # _____ Cell # _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship to Patient _____

Address _____ Phone _____

INFORMATION ON FORM IS PROTECTED HEALTH INFORMATION (PHI) AND IS TO BE TREATED AS CONFIDENTIAL UNDER HIPAA RULES -- PRIVACY & SECURITY OF THIS INFORMATION IS ESSENTIAL. ALL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT, AND THE PATIENT OR THE PATIENT'S REPRESENTATIVE REMAINS PERSONALLY RESPONSIBLE FOR PAYMENT, AS A COURTESY, WE WILL FILE INSURANCE CLAIMS FOR OUR PATIENT: HOWEVER, **THE PATIENT'S PORTION OF THE FEE AND/OR CO-PAY IS ----- DUE AT THE TIME OF SERVICE.**

ACKNOWLEDGEMENT: I CONSENT TO USE OF PHI FOR PURPOSES OF TREATMENT, PAYMENT AND OPERATIONS AND AUTHORIZE THE ENTITY TO USE THE PHI AS NEEDED. I AUTHORIZE THAT PAYMENT OF BENEFITS, INCLUDING MEDICARE BENEFITS, BE MADE ON MY BEHALF DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. IN MEDICARE ASSIGNED CASE, THE PHYSICIAN AGREES TO ACCEPT THE CHARGES DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE, CO-INSURANCE AND NON-COVERED SERVICES.

PATIENT SIGNATURE	REPRESENTATIVE'S SIGNATURE (PARENT / GUARDIAN)	DATE

HIPAA AND OUR PATIENTS

* The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in April 2001. This rule essentially controls the use and disclosure of what is known as Protected Health Information. Implementation of and compliance with this rule is not optional for our practice. We are required to give you the attached information.

* Please read and familiarize yourself with the attached material. It is your copy so feel free to take it with you.

* Sign this page and turn it in to the medical assistant taking care of you. It will be a permanent part of your medical record.

FROM: _____
PATIENT'S NAME

TO: SOUTH GEORGIA MEDICAL ASSOCIATES, P.C.

RE: HIPAA NOTICE OF PRIVACY PRACTICES

As a patient of the physicians of one of the above medical practices, I acknowledge receipt of the HIPAA Notice of Privacy Practices for their practice.

_____ _____
PATIENT SIGNATURE DATE

or

_____ _____
PATIENT'S REPRESENTATIVE (PARENT/GUARDIAN) DATE

***To go green the HIPAA (Health Insurance Portability and Accountability Act)**

is posted next to check in.

If you would like a copy we will be happy to supply you with it.

effective 6/05/2014

COLSON PRINTING COMPANY 84270-1

SOUTH GEORGIA MEDICAL ASSOCIATES, P.C. (SGMA)
410 CONNELL ROAD – VALDOSTA, GEORGIA 31602 – (229) 244-4720 – FAX (229) 316-0474

Patient No-Show Policy and Automated Telephone Calls, E-mails and Text Messages

South Georgia Medical Associates schedules many patients every day. It is important to honor scheduled appointments or cancel them with enough notice so that another patient can be scheduled in the appointment time. Effective **April 1, 2016** our Practice has implemented a new no-show policy to assist in the scheduling of patients and manage missed appointments by charging a no-show fee.

Appointments not cancelled or rescheduled **within 24 hours** of the scheduled appointment time will be charged a **$20.00** no-show fee. The no-show fee applies equally to all appointment types and is not covered by insurance; therefore the fee is the patient's responsibility and must be paid prior to your next office visit.

Reminders are provided as a courtesy, prior to a scheduled appointment. Patients are responsible for notifying the office in advance, if they are not able to keep an appointment.

Patients who miss **two (2)** or more scheduled appointments or who chronically reschedule appointments in a **twelve (12)** month period may be dismissed from the Practice.

Please be advised that you may be contacted by telephone by any telephone number you have provided including wireless telephone numbers which could result in a charge to you.

You may also be contacted by sending texts messages or E-mails using any E-mail address you have provided.

Methods of contact may include using a pre-recorded, artificial voice message and/or use of an automatic dialing service.

This applies to appointment reminders and/or to collect balances on accounts

Acknowledgement of No-Show Policy - Automated Telephone Calls, E-mails and Text Messages

By signing below, I acknowledge receipt of this notice and agree to abide by the terms of the policy.

_____ _____

Patient Name Date

_____ _____

Patient /Responsible Party Signature Responsible Party Relationship to Patient

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Gregory S. Beale, MD. • Milledge C. Newton, M.D. • Larry E. Smith, M.D. Lynn S. Lee, MD. • George Sidney Staton, MD. • William Douglas Luke, Jr., M.D.

PHONE (229) 244-4720 FAX (229) 316-1370

HIPAA AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize South Georgia Medical Associates to ( ) release ( ) receive information from the Medical Records of:

Patient: _____ SS #: _____
(Print Last Name, First Name, Middle Name)

Date of Birth: _____ Date range of records : _____

Information to be released to whom: _____

Tel. #_____ Address: _____

If information is to be released to SGMA please fax to# _____ Dept. _____

The following information is to be released : _____

Information is needed for: ( ) Personal Request ( ) Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. (Federal law prohibits the re-disclosure of the above information without written consent of the patient or authorized representative).

I understand that I have the right to revoke this authorization at any time by presenting a written revocation to the Medical Records or designee. I understand that the revocation will not apply to any information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the rights to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date below.

I understand that authorizing the disclosure of this health information is voluntary, and that I need not sign this form in order to assure treatment.

I understand that any disclosure of the information has the potential for an unauthorized re-disclosure and that the re-disclosure may not be protected by federal confidentiality rules.

Date: _____

Name of Requestor: _____
(Patient or Authorized Person)

Signature: _____

Relation to Patient: _____
(If other than patient)

Witness: _____

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AUTHORIZATION TO SHARE MEDICAL AND FINANCIAL INFORMATION

Patients Name:_____

Account #_____ SSN#_____ Date of Birth_____

I authorize the physicians and staff of South Georgia Medical Associates, P.C. to reveal and share personal and confidential medical and financial information with:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Excluding anything listed_____

_____

_____

This authorization is valid until a written notice of revocation is provided to resend.

Signature _____ Date _____

THIS IS NOT A MEDICAL RECORD RELEASE

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DR. GEORGE SIDNEY STATON, M.D. **DR. WILLIAM DOUGLAS LUKE,JR., M.D.**

Cardiology Questionnaire

PATIENT HISTORY FORM

Name _____ Phone Number _____ Date of Birth _____

Appointment Date: _____ Appointment Time _____ Soc. Security Number: _____

Referring Physician _____ Other Physician (if any) _____

Presenting problem (reason for your visit) _____

Current Medications

(including aspirin, vitamins, antacids, eye drops, laxatives, herbal medicines, etc.)

	Drug Name	Tablet size (e.g., 5 mg)	# of tablets taken at a time	# of times per day you take & when
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Do you have **ALLERGIES TO IODINE**, seafood or x-ray contrast dye?

No ☐ Yes ☐ Describe _____

Do you have **ALLERGIES or Reactions** to any other medication? No ☐ Yes ☐ (Describe below)

	Drug Name	Reaction
1.		
2.		
3.		

Cardiac Risk Factors

Have you ever used tobacco? No ☐ Yes ☐ (Complete below)
# of packs____ or cans of chew____ per day. How many years? ____ Stopped when?_____

Do you have high cholesterol? No ☐ Yes ☐ Controlled with meds ☐ Don't know ☐

Do you have high blood pressure? No ☐ Yes ☐ Controlled with meds ☐ Don't know ☐

Do you have diabetes? No ☐ Yes ☐ Borderline (diet controlled) ☐

Have you ever had a heart attack, angioplasty (balloon procedure) or stent, bypass surgery, or been told you have blocked arteries? No ☐ Yes ☐

Cardiac History

Have you ever had any previous cardiac tests? No ☐ Yes ☐ (Complete below)

Date(s) and location(s)

- ☐ Stress test (treadmill, etc.)_____
- ☐ Echocardiogram (heart ultrasound)_____
- ☐ Holter monitor (day-long EKG)_____
- ☐ Heart CAT scan_____
- ☐ Heart catheterization_____
  (angiogram, dye injection in heart arteries)
- ☐ Electrophysiology Study_____
  (electrical stimulation by wires in the heart)

Have you ever had any of the following? No ☐ Yes ☐ (Complete below)

Date(s) and location(s)

- ☐ Heart attack_____
- ☐ Angioplasty or stenting of heart arteries_____
- ☐ Angioplasty or stenting of other arteries-e.g. neck, legs, etc. (describe)_____
  _____
- ☐ Heart bypass surgery_____
- ☐ Surgery on other arteries (describe)_____
- ☐ Heart valve or other heart surgery_____
- ☐ Cardioversion (shocking heart back to normal rhythm)_____
- ☐ Pacemaker_____
- ☐ Implanted defibrillator_____
- ☐ Surgery on varicose veins_____
- ☐ Congestive Heart Failure (fluid around the heart)_____
- ☐ Atrial Fibrillation_____

Past Medical History

Have you had any significant infections or childhood illnesses? No ☐ Yes ☐ (Complete below)

	Describe	Date(s) and location(s)
1.		
2.		
3.		

When was your last hospitalization?_____ For what reason?_____

_____

Social History

Do you drink any alcohol? No ☐ Yes ☐ (Complete below)

What is your typical consumption:

glasses wine_____ # bottles beer_____ oz. liquor_____ in a (check one): day ☐ week ☐ year ☐

Typically, what is the most you will drink at one time?_____

Have you reduced or stopped drinking recently? No ☐ Yes ☐ If so, when?_____

Do you follow a special diet? No ☐ Yes ☐ Describe_____

Do you exercise regularly? No ☐ Yes ☐ (Complete below)

Type of exercise_____ Intensity: Mild ☐ Moderate ☐ Intense ☐

Duration of exercise in minutes_____ Typically how often per week_____

Do you have a history of alcohol or drug abuse? No ☐ Yes ☐ Describe_____

What is the highest level of education you achieved?_____

Are you: Single ☐ Divorced ☐ Living w/ a partner ☐ Married ☐ Widowed ☐

What is or was your predominant occupation?_____

Are you working: Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Disabled ☐

What type of residence do you live in? (i.e. house, appt, assisted living)_____

Who else lives with you? (i.e., spouse, children, parents)_____

What town or community do you live in or near to?_____

Family History

Has anyone in your immediate family had a heart attack, angioplasty (balloon procedure) or stent, bypass surgery, or been told they had blocked arteries? No ☐ Yes ☐ (Complete below)

	Age of first problem	Describe
☐ Father		
☐ Mother		
☐ Brother/Sister (circle which)		
☐ Brother/Sister (circle which)		
☐ Brother/Sister (circle which)		
☐ Brother/Sister (circle which)		
☐ Son/Daughter (circle which)		

List Any Other Surgeries, include the date performed.

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

Has anyone in your immediate family had any of the following problems?

Relationship and age of onset

- ☐ Sudden, unexplained death_____
- ☐ Unexplained passing out spells_____
- ☐ Heart rhythm problems_____
- ☐ Heart failure or weakened heart_____
- ☐ Aneurysm of the aorta_____
- ☐ Aneurysm of the brain_____
- ☐ Stroke_____
- ☐ Congenital heart disease (birth defect)_____
- ☐ Heart surgery other than above_____
- ☐ High cholesterol_____
- ☐ High blood pressure_____
- ☐ Diabetes_____
- ☐ Tuberculosis_____
- ☐ Bleeding disorder_____

Review Of Cardiovascular System

Respiratory

Do you have problems with shortness of breath?	☐ No	☐ Yes
Do you get short of breath when lying down or wake up short of breath?	☐ No	☐ Yes
Do you have a chronic cough or wheeze? (circle which)	☐ No	☐ Yes
Have you ever coughed up blood?	☐ No	☐ Yes
Are you a heavy snorer or do you ever fall asleep inappropriately (e.g., while driving)?	☐ No	☐ Yes
Has anyone told you that you stop breathing while sleeping?	☐ No	☐ Yes

Describe any other respiratory problems_____

Cardiovascular

Do you get chest pain, tightness, or pressure?	☐ No	☐ Yes
Have you had palpitations or rapid, irregular heart beats?	☐ No	☐ Yes
Have you ever lost or almost lost consciousness?	☐ No	☐ Yes
Do you get pain or cramps in your legs when you walk?	☐ No	☐ Yes
Do you have a history of blood clots in your legs?	☐ No	☐ Yes
Do you get significant swelling in your legs?	☐ No	☐ Yes

Describe any other cardiovascular problems_____