Rehabilitation Physicians of Georgia, P.C.

Patient Information

Name: _____ Social Security #: _____/_____/_____

Address: _____ Date of Birth: _____/_____/_____ Age: _____

_____ Sex: M F Marital Status: S M D W

Email address: _____

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black ☐ Hispanic ☐ Pacific Islander ☐ White

☐ Refused to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refused to Answer Preferred Language: _____

Home Phone: _____ Spouse's Name: _____

Cell Phone: _____ Spouse's Cell: _____

Emergency Contact: _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Contact number: _____ Contact Number: _____

Claims Address: _____ Claims Address: _____

_____ _____

Policy Number/ID: _____ Policy Number/ID: _____

Group Name: _____ Group Name: _____

Group Number: _____ Group Number: _____

Policy Holder: Self Spouse Mother Father Policy Holder: Self Spouse Mother Father

☐ *Worker's Compensation* ☐ *Automobile Accident*

Date of Accident: _____ Send Claims to: _____

Adjuster: _____ Contact Number: _____

Case Manager: _____ Contact Number: _____

Claim Number: _____

Please read and sign: I consent to treatment by any medical professional associated with Rehabilitation Physicians of Georgia, P.C. I authorize the release of any medical information needed by a physician's office, insurance company, attorney or hospital. I authorize payment for medical benefits directly to the physicians for his/her services. I understand that I am financially responsible for charges not covered by my insurance.

Signature: _____ Date: _____

Patient / Parent / Guardian

Medical History

Date of visit: _____

Patient name: _____ Weight: _____ Height: _____

What is the reason for your visit: _____

What is your pain level on a scale of 0-10: **0 1 2 3 4 5 6 7 8 9 10** Was your pain caused by an injury: **Yes No**

If yes, when was the injury: _____

Please describe the location of your pain: _____

Your pain is: **Sharp Dull Burning Aching Stinging Throbbing Numbness Tingling**

When did your pain first begin: _____ Did it start suddenly: **Yes No**

How often do you have pain: **Constantly Frequently Intermittently Occasionally Rarely Daytime Nighttime**

Severity of your pain: **Mild Moderate Severe** Is your pain: **Improving Unchanged Worsening**

What makes your pain worse: _____ What helps your pain: _____

What does your pain keep you from doing: _____

What tests have you had done regarding your pain: _____

What treatments have you received for your pain: (Medications, injections, therapy, etc) _____

_____

Please list all health problems: _____

_____

List any surgeries: _____

List family medical history: _____

Are you currently working: **Yes No** If yes, what is your job: _____

If not, why: **Retired Student Disabled** Are you seeking disability: _____

Do you smoke: **Yes No** If yes, how long and how many per day: _____

Do you drink alcohol: **Yes No** If yes, how often: _____

Have you ever used any illegal drugs: **Yes No** If yes, describe: _____

Do you or your family have any history of addiction: _____

Please list all medications you are currently taking: _____

_____

List any allergies: _____

Review of Systems (Please circle all that apply)

Constitutional	Eyes	Ear/Nose/Throat	Skin
Chills	Eye pain	Difficulty swallowing	Rash
Fever	Eye discharge	Nose bleeds	Skin changes
Weight loss	Vision loss	Hearing loss	Lesions/Incisions
Fatigue	Visual disturbance	Neck swelling	Itching
Difficulty sleeping		Vertigo	Excessive sweating
Weakness			

Cardiovascular	Respiratory	Gastrointestinal	Psychiatric
Chest pain	Cough	Nausea	Depression
Palpitations	Shortness of breath	Vomiting	Anxiety
Pain in legs with walking	Coughing up blood	Diarrhea	Panic attacks
Swelling		Constipation	Suicidal thoughts
		Abdominal pain	Suicidal planning
			Substance abuse
			Insomnia
			Inability to concentrate

Musculoskeletal		Neurological
Neck pain	Elbow pain	Headaches
Back pain	Wrist pain	Weakness
Muscle pain	Hand pain	Numbness
Joint pain	Hip pain	Confusion
Joint swelling	Leg pain	Memory loss
Joint redness	Knee pain	Seizure
Joint popping	Foot pain	Abnormal walking
Shoulder pain	Ankle pain	Radiating pain to arms or legs
Arm pain		Aura

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Rehabilitation Physicians pf Georgia, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provide, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my heath information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Rehabilitation Physicians of Georgia, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Rehabilitation Physicians of Georgia, P.C reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Rehabilitation physicians of Georgia, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following **restrictions** or **authorization** (circle one) to the use or disclosure of my health information:

Name	Relationship

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully [ ] accept or [ ] decline the terms of this consent

_____ _____

Patient's Signature Date

Rehabilitation Physicians of Georgia, P.C. rpg

PAIN MANAGEMENT AGREEMENT

I, _____, agree to use _____ Pharmacy,
PRINT NAME

located at _____,

telephone number _____ , for filling all my pain medication prescriptions.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I will communicate openly and completely with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.
2. I will not use any illegal controlled substances, including, but not limited to, marijuana and cocaine; nor will I abuse alcohol while being treated. I understand that I will be denied serviced by RPG if, in their clinical judgement, I am impaired by any medication and/or alcohol and may be required to seek alternative transportation in the event of such impairment.
3. I will not to share, sell or trade my medications with anyone.
4. I will not obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other doctor or clinic without RPG's knowledge and consent.
5. I will safeguard my medication from loss or theft. **Lost or stolen medication will not be replaced.**
6. Refills of my prescriptions for pain medication will be made only at the time of an office visit during regular office hours. I will not miss my regularly scheduled appointments.
7. Aggressive behavior towards office staff or any RPG provider will not be tolerated.
8. I will submit to a blood or urine test, if requested by my doctor, to determine my compliance with my program of pain control medication. I may have to pay for this test at my own expense.
9. I will use my medication at the rate no greater or any less than the prescribed rate, and that use of my medication at a greater rate will result in my being without mediation until my next prescription is due.
10. I will not use my medication for any other purpose than that which it is prescribed by my doctor or to control pain other than which I am in treatment for.
11. I will not inject or inhale opioids intended for oral use.
12. I will not alter in any manner a prescription written by my doctor.
13. I will follow all applicable laws as they relate to my use of controlled medications.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Georgia's State Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waiver my applicable privilege or right of privacy or confidentiality with respect of these authorizations subject to applicable law.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me for my records.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this Agreement. **I understand that if I break any portion of this Agreement, my doctor will stop prescribing these pain control medications and my actions could lead to the permanent termination of the relationship with my doctor and RPG.**

This agreement is entered into on this _____ day of _____ , 20___ .

Patient's Signature: _____

Physician's Signature: _____

Rev.: 07-26-18

Financial Policy and Consent Form

Rehabilitation Physicians of Georgia, PC (RPG) recognizes the need for a clear understanding between the patient and medical provider regarding financial arrangements for healthcare and protected health information. The following information is provided to avoid any misunderstanding concerning payment for professional services and protected health information.

Payment: Payments are required at the time of service; this includes any insurance copays. Checks cannot be accepted for payment in the office, only cash or debit/credit card payments will be accepted. For convenience, RPG will file the patient's valid, active insurance. Even though the patient's insurance will be filed, he or she is responsible for any balance after insurance processes the claim. The patient is also responsible for any coinsurances and/or unmet deductible amounts; any overpayment of coinsurances/unmet deductible amounts will not be refunded, but added as a credit to the patient's account. Payment arrangements for billed services must be approved by Kelly O'Neal, RPG billing manager. Checks or debit/credit cards are acceptable forms of payment for billed statements. A $35 service fee will be charged on all returned checks. If no payment arrangements have been made or payment has not been received within ninety (90) days of the initial billing statement date, the patient's account will be filed under a "collections status," and the patient will not receive any additional treatment (including medications) until payment is made in full.

Secondary Insurance: The state of Georgia requires the patient to provide secondary insurance coverage to providers if applicable. The patient agrees to provide such information. The patient agrees to notify RPG of any additions, deletions, or other changes to the policy coverage: this includes both primary and secondary insurance policies.

Self Pay (private, cash pay): All self pay patients are required to pay fees at the time of service. This may include any additional service fees such as, but not limited to, in-office injections and urine drug screens. If a patient is considered self pay at the time of service and then receives insurance, RPG will not reimburse any previously paid fees at the self pay rate.

Please note, RPG will NOT retroactively file insurance, with the only exception being Medicaid.

Please note the following changes that apply to ALL patients:

Medical Records: In accordance with RPG practice policy, a processing fee of $25.00 (not payable by insurance) will be charged for sending medical records to the patient. Please allow up to five (5) business days for request processing.

Missed/Late Appointments: A minimum notice of 24-hours is required for cancellation of the office visit or surgery center appointments. A fee of $25.00 will be charged for all missed appointments without prior sufficient notice.

RPG firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need additional information or clarification regarding these policies, please call Kelly at 770-985-6936. By signing below, you agree to the terms and conditions of the RPG financial policy and provide your consent regarding outlined policies.

_____ _____

Patient Name (Please Print) Patient Date of Birth

_____ _____

Signature (Insured Patient/Guardian) Date

Rehabilitation Physicians of Georgia, PC

Urine Drug Screen Payment Policy

Urine Drug Screens are performed periodically per state regulations and as your health care provider deems necessary. While it is our priority to utilize a preferred lab of your health insurance policy, this cannot be guaranteed. If you are aware of the preferred lab of your health insurance policy, please make your Physician and his/her Medical Assistant aware of this information. If your health insurance policy denies the charges for the Urine Drug Screen due to usage of a non-preferred lab, you will be responsible for a $25 charge. The $25 charge will be the only charge from Rehabilitation Physicians of Georgia, P.C. If you receive a bill from the laboratory you will need to contact their billing department regarding any outstanding charges.

By signing below you attest that this policy has been explained to you, and that you have read and understand your personal responsibilities, that you have had adequate time to review the policy, and that all questions pertaining to the policy have been answered. Further, you attest that you have been provided with a copy of this form. The original will be filed in your medical record.

Signature of Patient (or Representative): _____

Print Name: _____

Date: _____

If you know the name of your preferred lab please list it here:

_____

Ernest L. Howard, II, M.D. Mark W. Feeman, D.O. Eric D. Solomon, D.O. Lisha Davis, P.A.-C
Meredith Magner, P.A.-C Connie Cowden, APRN-BC
2450 Atlanta Hwy Suite 904 Cumming, GA 30040
Tel: (404) 659-5909 Fax: (770) 399-9449

EXHIBIT 4:

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Rehabilitation Physicians of Georgia, P.C.

I, _____, have been made available a copy of Rehabilitation Physicians of
Patient Name

Georgia, P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Rehabilitation Physicians of Georgia, P.C.

Board Certified Physicians Specializing in Pain Management

Informed Consent Regarding After Hours Phone Calls

Notice Regarding After Hours Phone Calls: Our Practice specializes in chronic musculoskeletal pain management and is not an urgent care or emergency medicine clinic. Therefore any calls after normal clinic hours regarding emergent care requirements are to be directed to 911 or the closest emergency department. All calls made to our Practice when the clinics are closed will be returned the next day.

_____

Patient Name (Please Print)

_____

Patient Signature

____/____/____

Date

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication? 0 1 2 3 4

12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4

13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Rehabilitation Physicians of Georgia, P.C.

Mark W. Feeman, D.O.
Ernest L. Howard, II, M.D.
Dayna J. London, M.D.
Mark J. Hinrichs, M.D.
Celine Mathew, D.O.
Meredith Magner, P.A.-C
Lisha Davis, M.P.A.S., P.A.-C
Tamara Harris, P.A.-C
Kenneth Obimpeh, P.A.-C
Rebecca J. Pope, NP-C

Mark F. McGreevey
Chief Operating Officer

Ajori N. Burkhammer
Executive Director of Operations

Medical Records Release Policy and Procedure

In response to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, physicians have been faced with greater complexities when releasing medical records. In an effort to protect patient confidentiality, as well as comply with government regulations, Rehabilitation Physicians of GA., has developed policies and procedures to insure that your confidential medical records are handled in a manner meeting all necessary guidelines. Medical Records will be released only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act. Rehabilitation Physicians of GA., will only release records that were created and maintained by our doctors and clinic.
We will not release records received from other clinics or providers.

The requirements for a valid authorization to release medical records are:

- In writing, dated and signed by patient, from the requesting office
- Specifically identifies patient
- Specifically identifies the healthcare provider who is to make the disclosure
- Specifically identifies the information to be disclosed

Note: an authorization which affects a medical record in which information concerning the performance or results of HIV (AIDS virus), STD testing, substance abuse, and mental or psychiatric treatment must specifically authorize the release of such test and/or treatment information or it will be excluded from the records release.

If you are in need of your Medical Records, please refer to our policy for collecting below.

Notes for one Office Visit, should be collected at your visit if available, or at your next visit.

Complete Chart, Contact Kristie, @ 404-659-5909 ext 103. Please note fees will be charged.

If you have been discharged, Contact Kristie, @ 404-659-5909 ext 103. They can be mailed to your home, or requested by the new doctor, attorney, etc., by fax @ 770-399-9449

Records being sent anywhere else, will need to be requested by fax @ 770-399-9449 from the requesting facility with a HIPAA form signed by the patient.

Rehabilitation Physicians of Georgia, P.C.

Sebastiaan M. Bens, D.O.
Dayna J. London, M.D.
Lisha Davis, P.A.-C
Tamara Harris, P.A.-C
Meredith Magner, P.A.-C
Kenneth Obimpeh, P.A.-C
Adonness Bell, NP-C
Martha Friedl, NP-C
Rebecca Jill Pope, NP-C

Mark W. Feeman, D.O.
Medical Director
Ernest L. Howard, M.D.
Medical Director

Mark F. McGreevey
Chief Executive Officer
Ajori N. Burkhammer
Executive Director of Operations

REQUEST FOR MEDICAL RECORDS

Date: _____

I, _____ request that _____ Fax# _____, Fax my medical records to Rehabilitation Physicians of Georgia. I understand that these records contain protected health information.

Patient Name: _____

Patient Signature: _____

Patient Date of Birth: _____

Patient Contact Number: _____

Date of Request: _____

Please include the patient's demographic information, last 3 office notes,, diagnostics reports, urine drug screens, and discharge letter if applicable. Thank you!

Please fax requested information to:
Rehabilitation Physicians of Georgia, PC
Attn: Victoria - New Patient Coordinator
Fax 770-399-9449

Your Pain Management Agreement Says:

KEEP FOR YOUR RECORDS!

1. I will tell the truth about my pain and how my medication(s) works.
2. I will not use any illegal drugs. If I come to the office under the influence, as decided by my provider, I may be denied my prescriptions.
3. I will not SHARE, SELL or TRADE my medication(s).
4. I will not get any other narcotics from any other provider than RPG.
5. I will keep my medication safe, because I know they will not be replaced before the due date.
6. My medication(s) will only be refilled at my regular follow up visit, which I will not miss.
7. Aggressive behavior, as decided by the RPG staff, will NOT be tolerated.
8. I will have regular urine or blood tests and may have to pay for the test.
9. I will use my medication(s) as prescribed by my provider. If I run out of medication(s) early, my medication(s) will not be refilled early. I will not inject, inhale or abuse my medication(s).
10. I will follow all laws, as it applies to my use of controlled medication(s).
11. I will allow my provider and pharmacy to cooperate with any law enforcement agency in the investigation of any POSSIBLE misuse, sale or diversion of my medication(s).

Rehabilitation Physicians of Georgia, P.C.

RPG

Late Appointment Policy

Our doctors, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 15 minutes late for an appointment, the appointment will be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

For example: Appointment time 10:00am
Arrival 10:00am-10:15am (SEEN)
Arrival at 10:16am (RESCHEDULE)

New patients are encouraged to print off new patient paperwork from the website and fill it out prior to coming in.

- Incomplete NP Forms: New patients need to arrive at the office at least 30 minutes prior to the scheduled appointment to complete the paperwork or appointment will be rescheduled.

For example: Appointment at 10:00am, paperwork is incomplete
Arrival at 9:30am-9:45am (SEEN)
Arrival at 9:46am (RESCHEDULE)

- Complete NP Forms: If a new patient's paperwork is already completed, patient must arrive before appointment time to avoid rescheduling.

For example: Appointment at 10:00am, paperwork is complete
Arrival at 9:30-10:00am (SEEN)
Arrival at 10:01am (RESCHEDULE)

The doctors and staff at Rehabilitation Physicians of Georgia appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.