1016, 1025 & 1027 Keith Dr
Perry Ga 31069

PERRY FAMILY PRACTICE | PRIVIA MEDICAL GROUP

Ph: 478-988-1515
Fax: 478-988-1550

Policies and Procedures:

Thank you for choosing Perry Family Practice. We know that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Perry Family Practice strive to exceed expectations in care and service and to make your experience with us as comfortable as possible. Our goal is to provide quality medical care in a timely manner. The following information outlines some of the policies and procedures established for this practice:

Office Hours: Monday through Thursday 7:30am to 5pm (closed for lunch from 12:15 to 1:15pm) and Friday from 7:30 am to 12:15 pm.

Appointments: In our effort to provide quality care we ask patients to please call to schedule appointments. We strive to schedule appointments in a timely manner and provide ample time to address your problem. As emergencies can occur in primary care, we ask that you understand if a delay occurs on the day of your appointment. We encourage you to schedule appointments for preventative health/annual physicals and follow up for chronic conditions as far in advance as possible to ensure you get the day and time that you prefer. We do require an appointment for any paperwork that needs filled out- such a sports physical, FMLA or disability forms. As well, our providers have several appointments dedicated for same day appointments. If you need a same day appointment, please call the office as soon as possible; please leave a message and wait for a call back. Walk-in appointments should be reserved for emergency appointments only and we ask that you please call in first so we can assist you as to the need for urgent care or emergency care, if necessary.

-Preventative Physical/Annual appointments- Commercial insurance generally covers this visit once yearly per your insurance company plan. This is a screening appointment to discuss your overall health, recommended screening procedures (such as a mammogram or colonoscopy) and preventative measures that are beneficial to your health. If there are other health concerns, we will gladly address these at this appointment, but if the concern results in orders for additional tests or medications we are required per insurance to attach a regular appointment to the visit, which may result in a co-payment, payment towards deductible or coinsurance payment.

-Medicare annual wellness appointments- Once a year Medicare requires the documentation of specific paperwork (AWV) to update them about your health. To limit your trips to the office, Perry Family Practice collects this information with a regular appointment. This appointment monitors any chronic illnesses and is a general health check-up to monitor recommended screening procedures. The Medicare annual wellness appointment is filed as a regular appointment and does require a co-payment, payment towards deductible or co-insurance payment if this is applicable to your insurance.

Cancellation, No-Show and Late Arrivals Policy: If you are unable to attend your scheduled appointment, please call Perry Family Practice one business day in advance of the appointment so we can open this appointment to another patient requiring care. A no-show is someone that misses an appointment without cancelling in advance. An administrative fee of $50 will be billed to your account for this missed appointment without notice- *please note this $50 fee is a patient responsibility and insurance companies do not cover this fee. If you arrive more than thirty minutes late to an appointment, we will make every attempt to see you; however, your appointment may need to be rescheduled.

Telephone Call Policy: Every phone call is important to us at Perry Family Practice, and we will attempt to answer your calls and return your messages promptly. When calling the office for any reason please pick the correct extension for your needs If you get a voicemail, please leave all important information, including the best number to reach you, and we will call back to take care of your needs as soon as possible. Also, please do not leave multiple messages or call multiple lines and leave messages as this can delay response times. Please be aware that our nurses are not always available via telephone. They do not leave scheduled patients to return messages, and these are generally answered after patient care sessions are finished.

After Hours and Weekend Contact: For non-emergencies during the hours our office is closed, a provider from Perry Family Practice can be reached by calling our main office and choosing option 8. If you have an emergency, please call 911, or go to an Urgent Care or the Emergency Room as appropriate to your needs.

Insurance Collections: We accept dozens of insurance plans requiring various deductibles and co-pays. It is important that you read and understand your policy. If necessary, please ensure that your assigned provider is listed as primary with your policy. You are responsible for paying for all services not covered by your insurance plan. Please bring your insurance card to every appointment and please update any changes to your insurance plan while checking in for appointments. All co-pays and account payments are due at time of service and will be collected at each appointment. Perry Family Practice will make all reasonable attempts to collect outstanding balances should they occur. If reasonable attempts to collect outstanding balances fail, account in poor standing will be outsourced to a third-party for collections.

Third Party Liability: This means that someone else's insurance is to cover your illness/injury, such as workers compensation or from a motor vehicle accident. We do not file charges for payment to any third-party payor. These instances will require you to work through the required provider per the third-party. We apologize for any inconvenience.

Urine Drug Screens: There are certain medications that the Drug Enforcement Agency requires all providers to monitor their distribution. Due to this you may be asked to return every 30 or 90 days for drug testing, as necessary, to have medications that are controlled refilled.

PLEASE ENSURE YOU ACCESS THE PATIENT PORTAL, ONCE ESTABLISHED, TO REQUEST APPOINTMENTS, CHECK RESULTS AND REQUEST REFILLS

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Please circle Provider of Choice:

Sarah Harris FNP-C Tausha Rhoades AGACNP-C Madison Odom PA- C Hannah Revell FNP-C

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Mobile Phone: _____ Home Phone: _____

Sex: ☐ Male ☐ Female ☐ Other Social Security Number: _____

Immediate Relative Seen Here: _____ Provider: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone: _____ Address: _____

PARENT / GUARDIAN INFORMATION

If patient is under 18 or insurance is in parent/guardian's name, please fill out the following:

Father/Guardian Name: _____ Phone: _____

Mother/Guardian Name: _____ Phone: _____

PATIENT MEDICAL HISTORY

Previous Primary Care Provider: _____

Pharmacy Name: _____ Location: _____

Current Specialists/Other doctors: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Member ID Number: _____ Group/Policy Number: _____

Insurance holders name: _____ DOB: _____

Effective/ issued Date: _____ Expiration/ Termination Date: _____

Secondary Insurance: _____

Member ID Number: _____ Group/Policy Number: _____

Insurance holders name: _____ DOB: _____

Effective/ issued Date: _____ Expiration/ Termination Date: _____

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ALLERGIES:

Medication	Reaction

SOCIAL HISTORY:

Marital Status:	Single	Married	Widowed	Divorced	Legally separated	
Number of Children:		**Occupation:**				
Ethnicity and/or Race (Mark all that apply)	White	African American	Hispanic or Latino/ Spanish	Hawaiian/Pacific Islander	Indian	Not Hispanic or Latino/ Spanish
	Asian	American Indian	European	Other	Decline to Answer	
Last level of education:						

CURRENT MEDICATIONS:

(Including all prescribed medications, vitamins, herbal supplements):

NAME	DOSE	FREQUENCY
*Please bring all medication bottles to all appointments **Provide medication list document or write on back if needed		

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PAST SURGICAL HISTORY:

SURGERY	YEAR (if known)

MEDICAL HISTORY:

Please select all current and past medical problems you've been diagnosed with:

- ☐ Hypertension (High Blood Pressure)
- ☐ Diabetes-Last A1C: _____ Date_____
- ☐ High Cholesterol
- ☐ Thyroid Disorder: LOW HIGH
- ☐ Anemia – Type: _____
- ☐ Seizure Disorder / Epilepsy
- ☐ Migraines
- ☐ CVA (Stroke)/ TIA (Mini-Stroke)
- ☐ Memory Difficulties
- ☐ Liver Disease – Type: _____
- ☐ Kidney Disease – Type: _____
- ☐ Glaucoma
- ☐ Heart Disease – Type: _____
- ☐ GERD (Chronic Heartburn)
- ☐ Autoimmune Disorder – Type: _____
- ☐ Chronic Pain – Body Part(s): _____
- ☐ Urinary Incontinence
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Seasonal Allergies
- ☐ Depression/ Anxiety
- ☐ Other Mental Health Issue - _____
- ☐ Substance Abuse - _____
- ☐ Sleep Apnea
- ☐ Cancer – Type: _____
- ☐ Other: _____
- ☐ *Women Only*: osteopenia/osteoporosis
  Date of last Bone Density Study: _____
- ☐ *Women Only*: abnormal Pap Smear / HPV
  Date of last Pap: _____
- ☐ *Women Only*: abnormal Mammogram
  Date of last Mammo: _____

Have you had any major changes to your health in the past year? _____

Have you had any new surgeries in the past year? _____

Have any of your immediate family members suffered from major medical conditions in the past year?

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FAMILY HISTORY	MAJOR MEDICAL CONDITIONS	DECEASED	AGE DIAGNOSED (IF KNOWN)
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
GRANDMOTHER			
GRANDFATHER			

Please check each symptom that you have now or that is chronic/recurrent:

General ○ Fever ○ Weight Loss ○ Weight Gain	**Lungs** ○ Cough/Wheeze ○ Shortness of breath ○ Sleep apnea ○ Chest wall pain	**Skin** ○ Open sores ○ Rashes ○ Changes in moles
Eyes ○ Pain ○ Dryness ○ Vision change	**Abdomen** ○ Abdominal pain ○ Diarrhea ○ Constipation ○ Heartburn	**Neurologic** ○ Headaches ○ Tremors/Restless legs ○ Memory loss ○ Imbalance/Falling
Head ○ Head injury ○ Hearing changes ○ Nose bleeds ○ Sinus problems ○ Teeth problems	**Urinary** ○ Incontinence ○ Difficultly Urinating ○ Increased Frequency ○ Abnormal Vaginal Bleeding ○ Erectile Dysfunction	**Psychiatric** ○ Anxiety ○ Depression ○ Sleep disturbance ○ Alcohol or drug abuse
Heart ○ Chest Pain ○ Palpitations ○ Swelling of extremities	**Skeletal** ○ Back pain ○ Joint pains/ swelling	**Endocrine** ○ Fatigue ○ Increased thirst ○ Heat/Cold intolerance

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PHQ2 – Over the past 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than ½ days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

How many alcoholic drinks do you drink per day? _____ How many per week? _____

Tobacco Screening				
Do you, or have you ever smoked tobacco or use(d) smokeless tobacco? (CIRCLE)		NEVER SMOKER	FORMER SMOKER/YEAR QUIT	CURRENT SMOKER
How many years using tobacco?	_____ years	Packs per day? _____		