1000 Towne Center Blvd, Suite 604, Pooler, GA 31322 | Phone: 912-561-7001 | Fax: 912-561-7002 |
info@primecareofga.com

**Welcome to Prime Care of Georgia!**

We are delighted that you have joined our patient family. At Prime Care of Georgia, your health and well-being are our top priorities. Our dedicated team is committed to providing compassionate, high-quality primary care tailored to your unique needs. Whether it's preventive care, management of chronic conditions, or simply peace of mind, Prime Care of Georgia is your partner in health.

**What to Expect at Your First Visit**

**Arrival:** Please arrive 15 minutes early to complete any pending paperwork.
**What to Bring**:
- Photo identification
- Insurance card(s)
- List of current medications (including dosages)
- Any relevant medical records or test results

**Your Appointment:** Your provider will conduct a comprehensive health review, discuss your medical history, and address any immediate concerns.

**Important Information:**

**Office Hours:**
Monday–Friday: 8:00 AM – 5:00 PM
Saturday: 8:00 AM – 12:00 PM
Closed on Sundays

**After-Hours Care**: For urgent needs outside of regular office hours, please go to the nearest emergency room or dial 911.

**Patient Portal**: Access your health records, request refills, and send messages to your care team 24/7. Login instructions will be provided during your visit if you choose to enroll in portal access.

**Insurance and Billing**: We accept most major insurance plans as well as self-pay options. Copayments and service payments are due at the time of service. Questions? Contact our billing team at 1 (803) 400-8480.

If you need to reschedule, please call us 24 hours in advance to avoid any cancellation fees. Thank you for trusting us with your care! We look forward to meeting you.

Sincerely,
Shital Patel, MD
Prime Care of Georgia

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Follow us on Facebook and Instagram: @PrimeCareofGA for health tips, clinic updates, and seasonal wellness reminder

## PATIENT DEMOGRAPHICS

Patient Name: _____
First Middle Maiden Last

Patient DOB: _____ Patient SSN: _____ Gender: ( ) Male ( ) Female

Marital Status: _____ Patient's Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Patient's Home Address (if different from above): _____

Patient's (or Family Member's) Email Address: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

**PERSON/PARENT RESPONSIBLE FOR ACCOUNT (other than patient):**

Name: _____ Relationship to Patient: _____

Responsible Person/Parent SSN:_____

Address:_____ City:_____ State: _____ Zip Code:_____

**INSURANCE INFORMATION: PRIMARY**

Insurance Company: _____

Insurance Cardholder's: Name _____ DOB: _____ SSN: _____

Insurance Cardholder's Address: _____

Relationship to Patient: _____ Employer: _____

Policy Number:_____ Group Number: _____

**INSURANCE INFORMATION: SECONDARY**

Insurance Company: _____

Insurance Cardholder's: Name _____ DOB: _____ SSN: _____

Insurance Cardholder's Address: _____

Relationship to Patient: _____ Employer: ____ Policy Number: Group Number: _____

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# NEW PATIENT INTAKE FORM

**PATIENT INFORMATION-** **DATE_____**

Special Communication Needs: _____Occupation:_____
Employer: _____Language:_____
Race:_____ Ethnicity: _____

Are you a Veteran? ☐ NO ☐ YES Organ Donor? ☐ NO ☐ YES Right Handed ☐ Left Handed ☐

***EMERGENCY CONTACT INFORMATION-***

| Name: | Relationship: | Phone Number: | Address: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

***ADVANCE CARE DIRECTIVE -***

Do you have an Advance Directive or Living Will? NO YES
Have you designated a Durable Power of Attorney?? NO YES *If yes please enter information below*

| Name: | Relationship: | Phone Number: | Date: |
|---|---|---|---|
| | | | |

***SPECIALISTS CONTACT INFORMATION***- (Please provide first and last names)

| Name | Office Phone | Location |
|---|---|---|
| Cardiologist: | | |
| Eye Doctor: | | |
| Gynecologist: | | |
| Endocrinologist: | | |
| Urologist: | | |
| Other: | | |

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Patient Name:_____ Date of Birth: _____

| Wellness Screening History | Date | Address | Result |
|---|---|---|---|
| Wellness/Routine Physical Exam | | | |
| Colonoscopy | | | |
| Mammogram | | | |
| Dexa (Bone Density) Scan | | | |
| Pap Smear | | | |
| PSA | | | |
| Full Body Skin Cancer Exam | | | |
| Hepatitis C Screening | | | |
| Diabetic Eye Exam | | | |

***Adult Vaccination/Immunization History (If available please attach childhood immunizations separately)***

| | Date | | Date | | Date |
|---|---|---|---|---|---|
| Tetanus | | Zoster | | Prevnar 20 | |
| TDAP | | Shingrix | | Pneumovax 23 | |

***Health History- Have you ever been diagnosed with any of the following:***

| | | | | |
|---|---|---|---|---|
| ☐ Measles/ Mumps | ☐ Gout | ☐ Seizures / Epilepsy | ☐ Bone/Joint Disorder | ☐ Pneumonia |
| ☐ Chicken Pox | ☐ Stomach Ulcer | ☐ Parkinson's Disease | ☐ Eye Disease | ☐ Asthma |
| ☐ Rheumatic Fever | ☐ Reflux Disease | ☐ Multiple Sclerosis | ☐ Glaucoma | ☐ Seasonal Allergies |
| ☐ Scarlet Fever | ☐ Gall Bladder | ☐ High Blood Pressure | ☐ Kidney Disease | ☐ Emphysema / COPD |
| ☐ Polio | ☐ Pancreatitis | ☐ Stroke | ☐ Kidney Stone | ☐ Pulmonary Clotting |
| ☐ Lyme Disease | ☐ Colitis | ☐ Heart Disease / CAD | ☐ Urinary Disorders | ☐ Depression |
| ☐ Tuberculosis | ☐ Diverticulitis | ☐ Heart Attack | ☐ Erectile Dysfunction | ☐ Anxiety |
| ☐ Diabetes | ☐ Irritable Bowel | ☐ Heart Murmur | ☐ Prostate Disease | ☐ Eating Disorder |
| ☐ Sleep Apnea | ☐ Hepatitis | ☐ Heart Failure | ☐ Reproductive Issues | ☐ Psychiatric Care |
| ☐ Anemia | ☐ Liver Disease | ☐ High Cholesterol | ☐ Menstrual Problems | ☐ Drug Addiction |
| ☐ Bleeding Disorder | ☐ Thyroid Disorder | ☐ Arthritis | ☐ Vaginal Infection | ☐ Alcoholism |
| ☐ Blood Clot | ☐ Migraines/Headache | ☐ Osteoporosis | ☐ Breast Lump | ☐ Sexual Dysfunction |
| ☐ Cancer Type:_____ | ☐ Autoimmune Disease Type:_____ | ☐ Peripheral Vascular Disease | ☐ Skin Disease Type:_____ | ☐ STD Type:_____ |
| Other Health Conditions: | | | | |
| Blood Transfusion: ☐ NO ☐ YES If yes, date: Reason: | | | | |

***Surgical History-*** *None*

| Procedure: | Date: |
|---|---|
| | |

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| | |
|---|---|
| | |
| | |

***CURRENT MEDICATIONS WITH DOSAGES-*** *None*

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***Allergies-*** No Known Drug Allergies Latex: Yes No

| | | |
|---|---|---|
| | | |
| | | |

***Social History***

| | | |
|---|---|---|
| Tobacco Use: ☐ YES ☐ NO<br>☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew<br>Amount per day: _____<br>Number of years you have used tobacco:<br>_____<br>☐ QUIT Years quit:_____ | Alcohol Consumption: ☐ YES ☐ NO<br>Number of drinks per week:_____<br>Preferred drink (ie: beer, wine, spirits):<br>_____<br>☐ QUIT Years quit:_____ | Recreational Drug Use:<br>☐ YES ☐ NO<br>Type: _____<br>Amount per week:_____<br>Last used:_____<br>☐ QUIT Years quit:_____ |
| Caffeine: ☐ YES ☐ NO<br># of caffeine drinks per day:_____ | Regular Exercise: ☐ YES ☐ NO<br>Type exercise:_____<br>How often:_____ | Do you share a home with anyone else?<br>☐ YES ☐ NO<br>☐ Spouse ☐ ___Children ☐ Friend |
| Are you regularly exposed to second- hand smoke or other potentially harmful substances at home or work?<br>☐ YES ☐ NO<br>If so what? | Do you routinely need physical assistance with activities of daily living such as cooking, dressing, hygiene? ☐ YES ☐ NO | Are guns kept in your home:<br>☐ YES ☐ NO<br>If yes is gun safety a priority at home?<br>☐ YES ☐ NO |
| Does everyone in your home receive all routinely recommended immunizations?<br>☐ YES ☐ NO | Is it important to you that you always wear your seatbelt?<br>☐ YES ☐ NO | Do you have working smoke detectors in your home? ☐ YES ☐ NO |
| Do you have regular problems with a lack of food in your home? ☐ YES ☐ NO | Do you have regular problems with transportation? ☐ YES ☐ NO | Do you have regular problems paying for the following:<br>Housing ☐ YES ☐ NO<br>Medications ☐ YES ☐ NO |
| Are you in an abusive relationship or afraid of physical harm from anyone you know?<br>☐ YES ☐ NO | Are you at risk of acquiring HIV infection or other sexually transmitted disease?<br>☐ YES ☐ NO | Do any members of your family have genetically linked health problems?<br>☐ YES ☐ NO |

**Over the <u>past two weeks</u>, how often have you been bothered by any of the following?**

| | Not at All- 0 | Several Days- 1 | Half the Days- 2 | Nearly Every Day- 3 |
|---|---|---|---|---|
| Little interest or pleasure in doing things | | | | |
| Feeling depressed or hopeless | | | | |

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If 65 years or older please answer the following:

| | | |
|---|---|---|
| Have you felt unsteady or fallen more than once in the past year? | Yes | No |
| Can you switch a light on/off easily from your bed without fear of falling? | Yes | No |
| Are floors and walkways in your home safe and in good repair? | Yes | No |
| Is it difficult to get out of bed or off a chair or toilet without assistance? | Yes ☐ | No ☐ |
| Is the lighting in your home sufficient for you to see safely? | Yes ☐ | No ☐ |

**FAMILY HISTORY**

| Relation | Current Age, if living | Age at Death | High Blood Pressure | Heart Disease | Stroke | Cancer | Diabetes | Glaucoma | Asthma | Seizures | Bleeding Disorder |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | |
| Mother | | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | | |
| Sibling | | | | | | | | | | | |
| Sibling | | | | | | | | | | | |

**GENERAL CONSENT FOR TREATMENT, FINANCIAL AGREEMENT AND RELEASE FORM 2026**

_____ (initial) **CONSENT FOR TREATMENT:** By this document, I do hereby request and authorize Prime Care of Georgia (PCG), its medical practices and providers including physicians, nurse practitioners, physician assistants, technicians, nurses, and other qualified personnel, including appropriately supervised students to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning a diagnosis or results of treatments, examinations or procedures.

_____ (initial) **TREATMENT OF MINOR CHILDREN:** I understand that minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

_____ (initial) **MEDICAL TEACHING AND TRAINING**: I understand and give my consent for the providers, clinicians, and other health professionals who may be involved in training to participate in my treatment. I understand and give consent to PCG and providers to allow non-employees, such as students and associated health care providers who are participating in educational programs, access to the patient care areas. I understand that they may have access to incidental health information. I understand that they have the right to question the provider regarding such training and can choose not to authorize such access during the examination and treatment.

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_____ (initial) **PHOTOGRAPHY/VIDEO:** I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property PCG unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

_____ (initial) **INSURANCE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized medical benefits is made on my behalf directly to the PCG provider of service(s) furnished to me. I authorize PCG to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my commercial, governmental or group health insurance plan, directly to PCG. I hereby authorize that photocopies of this form to be valid as the original.

_____ (initial) **SELF-PAY PATIENTS:** I understand that if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges incurred at time of service.

_____ (initial) **PAYMENT AND FINANCIAL GUARANTEE:** I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through PCG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a PCG billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with PCG's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by a third-party business associate associated with our Electronic Health Records (EHR). I hereby consent to have my payment information collected and stored securely by our EHRs**.**

_____ (initial) **CREDIT CARD ON FILE:** I understand that PCG has implemented a credit card on file policy to streamline administrative processes and enhance the convenience of managing patient accounts. This policy requires that all patients provide a valid credit card to be securely stored in our system. The card will be used to cover any outstanding balances, including co-pays, deductibles, or services not covered by insurance, after claims have been processed. This approach helps reduce the need for manual billing and ensures timely payment, allowing us to focus more on delivering quality care to our patients. We assure you that all credit card information is stored securely and in compliance with applicable privacy and security regulations. If you have any questions or concerns regarding this policy, please feel free to contact our office for further clarification. I authorize Prime Care of Georgia to charge my credit card for any unpaid balance due on my account. I understand that my credit card on file will be charged 14 days after the original billing statement is mailed.

_____ (initial) **RESTRICTED SERVICE:** I understand that all account balances must be in good standing prior to receiving additional services and will contact PCG's staff if I am unable to pay your balance. Past Due Accounts of 120 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

_____ (initial) **ADDITIONAL SERVICE CHARGES:** I understand that PCG may assess fees for missed appointments, returned checks for insufficient funds, and collection activities.

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_____ (initial) **NO SHOW POLICY**

**A "no show" occurs when a patient does not arrive for a scheduled appointment and does not notify the office in advance.**

**Fees for No Show Appointments for Primary Care appointments:**

• Established Patients: $50 no show fee/same day cancellation fee

• New Patients: $75 no show fee/same day cancellation fee

**Fees for No Show Appointments for Allergy, Asthma, & Immunology appointments:**

• Established Patients: $75 no-show fee/ same day cancellation fee

• New Patients $100 no-show fee/ same day cancellation fee

• Allergy Testing $150 no-show fee/ same day cancellation fee

These fees will be charged to the patient's account and must be paid before scheduling future appointments. Insurance providers do not cover these charges. In the event of a no-show of a scheduled appointment, I understand that I must the no-show fee prior to being seen.

_____ (initial) **SAME DAY CANCELLATION POLICY**

A same day cancellation is defined as canceling or rescheduling an appointment less than 24 hours before the scheduled time. If you cancel/reschedule an appointment within 24 hours of your appointment time, you will be charged the same respective fee as the above listed no-show fees.

I understand that I must pay any fees incurred prior to being seen in the event I cancel the same day of an existing appointment.

_____ (initial) **ELECTRONIC HEALTH RECORD:** I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. PCG has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries may automatically be sent to designated PCG and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. PCG and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

_____ (initial) **PATIENT PORTAL:** If I have provided my e-mail address, I am requesting the ability to access my medical information through the PCG online Patient Portal. I hereby consent to use the patient portal provided by PCG for accessing my personal health information and communicating with my healthcare providers. I understand that the patient portal is intended for non-urgent communication, such as scheduling appointments, requesting prescription refills, and viewing my medical records and not for consultation. I understand that the office will respond during business hours and it may take up to 72 hours for a reply. I acknowledge that I am responsible for maintaining the confidentiality of my login credentials and agree not to share them with

unauthorized individuals. I understand that the portal should not be used for emergencies or urgent medical issues, and I will contact the office directly or seek immediate medical attention in such cases.

_____ (initial) **HEALTH INFORMATION EXCHANGE**: I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). PCG will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records

_____ (initial) **ELECTRONIC PRESCRIBING:** I understand that PCG medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my PCG providers and my pharmacy. I have been informed and understand that PCG providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my PCG providers to see this health information.

_____ (initial) **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:** I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

_____ (initial) **CONSENT FOR ARTIFICIAL INTELLIGENCE:** I hereby consent to the use of an AI medical scribe by PCG and its providers before and during my medical visits. I understand that this technology assists in accurately documenting my clinical encounters, allowing my healthcare provider to focus more on my care. The AI medical scribe operates within a secure, HIPAA-compliant environment to protect my personal health information. I acknowledge that I can ask questions about this technology at any time and that I have the right to decline its use without impacting the quality of my care.

_____ (initial) **IMMUNIZATION REGISTRY:** I understand that PCG participates in the Georgia and South Carolina Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws. I do hereby grant permission for PCG to send or fax childhood immunization records to schools, upon request.

_____ (initial) **CELL PHONES:** I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the PCG, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my

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medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time

_____ (initial) **RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:** I have been made aware and understand that all PCG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release PCG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a PCG medical practice, office or facility.

_____ (initial) **CONSENT FOR ELECTRONIC COMMUNICATION:** I hereby consent to the use of secure electronic communication by PCG and its providers, including pre-visit and post-visit patient engagement tools, to enhance my healthcare experience. I understand that these tools will facilitate efficient communication and management of my health information, ensuring that I receive timely updates and reminders regarding my care. All communications will be conducted within a secure, HIPAA-compliant framework to protect my personal health information. I acknowledge that I can ask questions about these tools at any time and have the right to opt out of using electronic communication tools if I prefer, without impacting the quality of my care.

_____ (initial) **OFFICE POLICIES:** I have reviewed the office policies and procedures available on the PCG website or upon request, and any questions I had have been answered to my satisfaction. I agree to comply with all PCG policies.

_____ (initial) **NOTICE OF PRIVACY PRACTICES:** Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of PCG's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at PCG, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

_____ _____

**Signature** **Date**

_____

**Printed Name**

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## Authorization for Disclosure of Health Information

***All sections must be completed and legible in order for request to be processed***

**Patient Information:**

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

**Release Records From:** ☐ _____

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

**Release Records To:** Prime Care of Georgia

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

**Information To Be Released:** *Please check each item to be released

_____Clinical Notes _____Radiology Reports _____Labs/Pathology Reports _____EKG _____Immunizations
_____ Hospital Notes _____ Specialist Consult Notes _____ Other: _____

**Dates of Records To Be Released:**

_____ to _____ _____Past 3 Months _____Past 6 Months
_____ Past Year _____ Past 2 Years
** Records requested for dates prior to 2011 will incur an additional fee _____ Past 5 Years

**Reason for Request:**

_____Continued Patient Care _____Social Service/Disability _____Insurance
_____ Attorney/Legal _____ Workman's Compensation _____ Personal _____ Other: _____

**How would you like your records sent:**

_____Mail to address above _____Fax to # above _____Pick up in office

I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it and would then no longer be protedted by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of meon whether I sign this authorization or not. Upon receipt of requested medical records to our facility, Prime Care of Georgia will continue to protect the information under federal law.
A fee may be charged for copying the protected health information. Please contact Prime Care of Georgia to obtain fee information at 912-561-7001.
Unless otherwise revoked, this authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire automatically ninety (90) days from the date of signature.

I have read and understand the information in this authorization form.

Patient's Printed Name: _____ Patient's Signature: _____
Patient's Representative & Relation: _____ Date

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# REQUEST FOR LIMITATIONS AND RESTRICTIONS OF HEALTH INFORMATION

**Which methods of communication may we use to contact you?**

Home phone – leave message to return call *without* details
Home phone – leave message *with* details
Cell phone – leave message to return call *without* details
Cell phone – leave message *with* details
Letter *with* details
E-mail *with* details

**With whom do you authorize us to discuss your health information?**

| NAME (please print) | RELATIONSHIP TO PATIENT | Contact Number | Date |
|---|---|---|---|
| NAME | RELATIONSHIP TO PATIENT | Contact Number | Date |
| NAME | RELATIONSHIP TO PATIENT | Contact Number | Date |
| NAME | RELATIONSHIP TO PATIENT | Contact Number | Date |

*THIS AUTHORIZATION MAY BE REVOKED OR REPLACED AT ANY TIME. SIGNING THIS FORM WILL RENDER ANY PRIVIOUSLY SIGNED FORM ON FILE VOID*

**SIGNATURE OF PATIENT / LEGAL GUARDIAN** **DATE**

**NAME OF LEGAL GUARDIAN / LEGAL REPRESENTATIVE (*Please Print*)** **RELATIONSHIP TO PATIENT**

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## Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____Patient Name:_____Date of Birth: _____

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *PHQ-9* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy. | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores): _____**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.***

| *GAD-7* | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things. | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing. | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still. | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable. | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen. | 0 | 1 | 2 | 3 |
| ***Add the score for each column*** | | | | |

**Total Score (add your column scores): _____**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

**Not difficult at all** **Somewhat difficult** **Very Difficult** **Extremely Difficult**

PRIMECARE OF GEORGIA
LIVE WELL. BREATHE WELL. FEEL WELL
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info@primecareofga.com

# CONTROLLED SUBSTANCES CONTRACT

The purpose of this contract is to define the expectations between the physician and the patient regarding the use of controlled medications.

I understand that I have a medical condition requiring the use of controlled substances. In addition, I understand that the use of chronic controlled medication carries the risk of addiction as well as side effects from the medication. I understand that controlled medications may impair my ability to operate a motor vehicle or heavy equipment.

To reduce the chances of abuse of the medication, certain parameters regarding the prescription are agreed to:

1. I will not use the medicines at doses higher than prescribed.
2. I will not ask for or receive controlled prescriptions from other medical providers, except as authorized by my physician.
3. I will not ask for early prescription refills. Medications are to be taken as prescribed. Doses may not increased without specific instructions from your provider. Medications must last from one appointment to the next scheduled appointment. If you run out early, the remaining days will endure without medications.
4. No replacements will be provided for lost or stolen medications or prescriptions, even with a police report.
5. While using such medications, I understand that my ability to drive and/or operate machinery or equipment may be impaired. These medications may cause me to feel sleepy and delay my reaction time thus placing others at risk if I ignore these warnings.
6. I understand that my physician will need to see me for regularly scheduled visits, every 1 to 3 months, to follow up on my chronic medical conditions. It is my responsibility to schedule the appointments so that I do not run out of medication.
7. I agree to release information from all pharmacies where I obtain medications. I will choose one pharmacy to fill my controlled medications and I will notify my physician if I change pharmacies.
8. I will consent to random drug testing. Any tampering with the urine drug screen, such as adding water or other liquids, will result in immediate termination of controlled drugs and you will be dismissed from Prime Care of Georgia.

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9. No refills will be made at night, on holidays or weekends. Please be diligent in keeping count of your medication and do not wait until you have 1-2 doses left. I will request medication refills as least 3 business days ahead of the time I will run out.
10. Repeated calls to the office will lead to further delays and practice reserves the right to terminate patient-doctor relationship.
11. Obtaining any controlled substance from any individual is a violation of the law and this contract. Violator will be dismissed from Prime Care of Georgia and reported to law enforcement. Selling any controlled substance to any individual is a violation of the law and this contract. Violators will be dismissed from PCNC and reported to law enforcement.
12. I agree to remain respectful to office staff and providers when requesting refills and refrain from excessively calling the office when requesting my prescription to check the status. I understand that I may leave 1 voicemail and utilize the patient portal to initiate a refill request and will respectfully check with my pharmacy to see if the refill has been sent in.

I have been informed that I may not take other drugs such as stimulants, tranquilizers, sedatives, or antihistamines without first consulting with my physician. I understand that I should not mix my medications with alcohol. The combination use of the above drugs may produce profound sedation, respiratory depression, and in worst cases, death. I understand that I must not misuse nor share my prescribed medication. Failure to abide by these parameters will be grounds for termination of the prescription of controlled medication by the physician and may result in termination from this practice.

**I have read, understand, and agree to follow the rules of this agreement. I authorize a copy of this agreement to be released to my pharmacist.**

_____ _____

**Signature** **Date**

_____

**Printed Name**

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