OCONEE VALLEY HEALTHCARE

Greensboro • Lake Oconee • Wellness Center • Milledgeville

REGISTRATION FORM

Today's Date ____/ _____ / _____ (Please Print) Account Number: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name

Street Address	City	State	ZIP Code

Mailing Address if different than Physical Address	City	State	ZIP Code

Home Phone ( )	Cell Phone ( )	Name of Employer	Work Phone ( )

Birth Date / /	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	Social Security ____ - ___ - ____

Sexual orientation
- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Other _____
- ☐ I don't know
- ☐ Choose not to disclose

Gender
- ☐ Male
- ☐ Female
- ☐ Gender Queer
- ☐ Choose not to disclose
- ☐ Transgender Female/ Male-to-Female
- ☐ Transgender Male/ Female-to-Male
- ☐ Other _____

Email Address

ADDITIONAL PATIENT INFORMATION

Race
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other
☐ Black/African American ☐ White ☐ American Indian/Alaska Native

Ethnicity
☐ Hispanic or Latino
☐ Non-Hispanic or Latino

Language Best Spoken ☐ English ☐ Spanish ☐ Other_____	Homeless ☐ Yes ☐ No	Public Housing Patient ☐ Yes ☐ No

Family Size ☐ _____ ☐ Choose not to disclose	Income ☐ $_____ ☐ Choose not to disclose	Veteran ☐ Yes ☐ No ☐ Choose not to disclose	Student Status ☐ FT ☐ PT ☐ Not a student	Agricultural Worker ☐ Yes ☐ No

RESPONSIBLE PARTY / PARENT / GUARDIAN

Responsible Party / Guardian / Parent	Relationship to Patient	Birth Date / /

Street Address	City	State	ZIP Code	Home Phone ( )

Employer	Employer Address	Employer Phone ( )

INSURANCE INFORMATION

Is this patient covered by Insurance? ☐ Yes ☐ No

Primary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Secondary Insurance Name	Subscriber Name	Subscriber DOB	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT (OTHER THAN PARENT, GUARDIAN, REPSONSIBLE PARTY)

Name of Local Friend or Relative	Relationship to Patient	Home Phone ( )	Cell Phone ( )
Name of Local Friend or Relative (not living at the same address)	Relationship to Patient	Home Phone ( )	Cell Phone ( )

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ADDITIONAL INFORMATION			
Do you have a preferred pharmacy? ☐ Yes ☐ No	Pharmacy Name	Pharmacy Location	Pharmacy Phone ( )
Other Family Members Seen Here:			
Chose Clinic Because / Referred to Clinic By (Please check one box): ☐ Dr. _____ ☐ Hospital _____ ☐ Family _____ ☐ Friend _____ ☐ Internet ☐ Phone Book ☐ Other _____			

_____ **Initial** **ASSIGNMENT OF BENEFITS:** I authorize my insurance company to pay directly to Oconee Valley Healthcare the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments or, if I receive payment from insurance filed by your company, I will forward the payment to your office within one week of receipt of funds.

_____ **Initial** **CONSENT FOR TREATMENT:** I authorize Oconee Valley Healthcare, and such assistants as they may designate, to carry out diagnostic procedures, if needed, to better diagnose my condition and to administer such treatments and medications, as indicated. I understand that my condition may call for a consultation with another physician. If this situation occurs, I authorize Oconee Valley Healthcare to release medical information that may be needed to better provide for my medical treatment.

_____ **Initial** **PAYMENT AGREEMENT:** The foregoing information is true to the best of my knowledge, and I request Oconee Valley Healthcare to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by Oconee Valley Healthcare.

_____ **Initial** **COVID-19 ACKNOWLEDGEMENT:** I understand that the novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious, and is believe to be spread by person-to-person contact. I recognize that the staff of Oconee Valley Healthcare has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I recognize and accept the risk of becoming infected by virtue of seeking services in-person at Oconee Valley Healthcare.

Patient or Guarantor Signature _____

Patient Account Representative Signature _____

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PATIENT AUTHORIZATION
TO RELEASE MEDICAL INFORMATION TO OTHER INDIVIDUALS

I authorize you to discuss my medical information at any time with the following designated person(s):

Name:_____ Relationship _____

Name:_____ Relationship _____

Information that may be discussed is:

_____ Any or all information contained in my medical record

Or

Only: _____ Medical exams, diagnosis and treatment plans

_____ Prescription records

_____ Laboratory results

_____ Billing and insurance

_____ Other

_____ The above information can be **discussed in my presence only.**

_____ The above information can be discussed **when I am not present**.

This authorization is valid until such date as I change or cancel the authorization to release of my information.

_____ Date: _____
Patient Name (Print)

_____ Witness: _____
Signature

Georgia Registry of Immunization Transactions and Services (GRITS)

I authorize Oconee Valley Healthcare to share records related specifically to immunizations with the GRITS data base.

_____ Date: _____
Patient Name (Print)

_____ Witness: _____
Signature

This authorization is valid until such date as I change or cancel the authorization to release of my information.

AUTHORIZATION FOR MESSAGING THROUGH EMAIL, PHONE, AND CELL PHONE

When contacting me with information regarding test results, prescription information or other medical issues, I authorize you to leave messages as follows:
___ Voice Mail ___ Anyone at my contact number ___ Email ___Do not leave messages

When contacting me with information regarding appointments I authorize you to leave messages as follows:
___ Voice Mail ___ Anyone at my contact number ___ Email ___Do not leave messages

When contacting me with information regarding billing issues I authorize you to leave messages as follows:
___ Voice Mail ___ Anyone at my contact number ___ Email ___Do not leave messages

My Email address is: _____@ _____

Text Messaging

Oconee Valley Healthcare would like to contact you via text messaging using your personal phone regarding appointment reminders and updates. Some limited personal information may be included, however, no medical or test results will be specified. Initial below if you wish to be contacted via text messaging or not.

_____Yes, I want Oconee Valley Healthcare to use my cell phone listed below to send text messages for the purposes of appointment reminders/updates.

Cell Number: ( ) _____- _____
Please contact our office immediately with any change in your phone number.

– OR –

_____No, I do NOT want Oconee Valley Healthcare to use my cell phone to send text messages for the purposes of appointment reminders/updates.

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Office Policies

We would like to thank you for choosing our practice as your medical provider. We have written this policy to keep you informed of our current office policies.

Office Hours: All locations are opened Monday through Friday during the hours reflected below:

Office Name	Address	Hours	Phone and Fax #
Oconee Valley Administrative Offices	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 8 AM to 5 PM	Phone:(706) 453-1201 Fax: (706) 453-1441
Greensboro	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 8 AM to 6 PM	Phone:(706) 453-1201 Fax: (706) 454-0337
Pharmacy	803 S. Main St. Greensboro, GA 30642	Mon. – Fri. 9 AM to 6 PM **(Closed for Lunch:1-2)**	Phone:(706) 454-5150 Fax: (706) 454-5151
Dental	803 S. Main St. Greensboro, GA 30642	Mon. 9AM-6PM Tues.-Fri. 8AM-5PM **(Closed for Lunch:1-2)**	Phone: (706) 454-5114 Fax: (706) 454-5199
Lake Oconee	1041 Park Dr. Greensboro, Ga 30642	Mon. – Fri. 8 AM to 5 PM **(Closed for Lunch:12-1)**	Phone:(706) 453-4945 Fax: (706) 400-4414
Wellness Center	1040 Park Dr. Greensboro, Ga 30642	Mon. – Fri. 8 AM to 5 PM **(Closed for Lunch: 12-1)**	Phone:(706) 534-6640 Fax: (706) 453-1441
Milledgeville	510 N. Cobb St. Milledgeville, Ga 31061	Mon. – Fri. 7:15 AM to 5 PM **(Closed for Lunch:12-1)**	Phone:(478) 414-1414 Fax: (706) 453-1205

Appointments: We see most patients by appointment. Any patient needing forms completed, please make us aware at the time you make your appointment. All patients scheduled for an appointment will be notified by phone 24-48 hours before the appointment. We ask that each patient arrive at least 15 minutes prior to the appointment to verify and/or update patient information such as telephone numbers, address, and insurance information.

After Hours and Emergencies: For a serious emergency, call 911 right away. If you are not sure and call our office, please be sure to tell the person who answers the phone that it is an emergency. After hours you will reach our answering service. They will page the provider on call.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient.

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Complete Physical Exams: We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover "wellness" and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

Medications: Please bring your medications, both prescribed and over-the-counter, to your appointment visits. It is important to us and to you to keep your medications and any allergies updated in your medical records.

Prescriptions and Refills:

- If you need to call for refills, don't wait until you have run out. Most refills require the doctor's approval. If your doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
- Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready.
- Refill requests called to us before 2:00 p.m. will be handled by the end of the day. After 2:00 p.m., it may be the next morning before your request can be addressed.
- Some medications have potential side effects that must be monitored. We require check-ups every 3 or 4 months for these medications. Be sure to keep those follow-up appointments.
- Some prescriptions cannot be called in. The prescription must be printed for you to pick up.
- Don't call after hours for prescription refills due to limited access to your chart.
- Narcotic prescriptions and controlled substances will be prescribed and refilled ONLY during regular business hours.

Laboratory/Radiology Results: If you have any laboratory or radiology tests performed, please ask your provider at the time of your visit when you will be notified of the results. If you have not received either a written or verbal response within 10 days, please call the office.

Referrals: Referrals are handled by our Referral Department. Sometimes this can be done on the same day as your appointment or can take 2-3 days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.

Patient Obligation: Patients play a vital role in the success of their healthcare by actively participating with the physician and staff in their treatment. By following a prescribed treatment plan, the patient increases his or her chances for a successful outcome. The physicians of our practice ask their patients to abide by the following responsibilities:

- Provide your physician with accurate and complete information regarding symptoms, complaints, past illnesses, medication history and hospitalizations relating to your health. Report risks and unexpected changes in your condition and provide feedback relating to the prescribed course of treatment.

- Ask questions. If you do not understand the treatment plan, please ask for clarification.

- Follow and do not deviate from the course of treatment. Not complying to the treatment plan may result in a less successful outcome.

- Be considerate of the physicians, staff and the policies of the office. These policies have been put in place in order to serve our patients efficiently and effectively.

- Pay financial obligations in a timely manner. Our business office is available to assist you with your financial concerns.

Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills, or consider us to be your doctor. You have to find a doctor in another practice.

Dismissal Process: We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.