265 Sheraton Blvd., Suite 100
Macon, Georgia 31210
Telephone# (478) 746-8626
Fax# (478) 746-0491

Appointment Date: _____ Time:_____

Enclosed is your patient information packet. In order to expedite your appointment, it is important that you complete the forms and bring them with you on your appointment date. If for any reason you do not bring your paperwork with you, you need to arrange to be 30 minutes early so that the paperwork can be filled out in our office. We reserve the right to reschedule your appointment if you don't have your paperwork prior to your office visit. If you are unable to make your appointment, please let our office know as soon as possible so that we can schedule a more convenient appointment for you. If we are not contacted within 24 hours of the appointment to reschedule, you will be billed a no-show fee of $25.00.

If you are being seen for Diabetes, please make sure you bring your blood sugar numbers with you. If you are currently taking any medications, please bring them with you on the day of your appointment. We will also need to make a copy of your insurance card at your visit. If you have any questions regarding the information attached, please do not hesitate to call. We look forward to serving you.

Sincerely,

Crystal Husbands
Referral Coordinator

Personal Medical History

Appt & Time: _____

Name: _____

Date of Birth: _____

In the past have you ever been diagnosed with?

☐Diabetes ☐Heart Disease ☐Kidney Disease ☐High Blood Pressure ☐Asthma ☐Liver Disease

☐Arthritis ☐Thyroid Disease ☐Lung Disease ☐High Cholesterol ☐Cancer ☐Other (List)

_____

Please list all surgeries you have had in the past (lifetime) and list the year. It's okay if you can not remember the exact year.

_____

_____

_____.

Please list any allergies to medications, food or insects…etc

_____

_____

_____.

What Pharmacies do you use and the phone number?

_____.

_____.

Please list all of your physicians and what you've seen them for.

_____.

_____.

_____

_____.

Do you currently or in the past have you used Tobacco or Alcohol?

☐Cigarettes ☐Currently ☐Past

☐Alcohol ☐Social ☐Regular use ☐Rarely ☐How Much:_____

Place of Employment _____

☐Retired ☐Disabled ☐Homemaker ☐Student ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you have Children? ☐Yes ☐No If yes, how many? _____

☐Living ☐Deceased

FAMILY MEDICAL HISTORY

Name: _____ **DOB:** _____

Family Member	Health Status	Arthritis	Cancer	Diabetes	Heart Condition	Lung Disease	Mental Illness	Stroke	Other	Cause of Death	Age at Death
Father											
Mother											
Siblings											
Grandparents											
Children											
Spouse											

Medication Log

Patient: _____ Birth date: _____

Home Phone: _____ Work Phone: _____Occupation: _____

Pharmacy: _____ Pharmacy Phone: _____

Medication	Dosage	Qty.	Freq.				

Notes: _____

_____.

The Jones Center for Diabetes and Endocrine Wellness

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Patients Registration Form

Patient's Name: _____
Street Address: _____
_____
Date of Birth: _____ Age: _____Sex:_____
SSN: _____DL #:_____State:_____
Expiration Date: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____
Marital Status:_____ Employer:_____
Spouse's Name:_____
Spouse's SSN_____ Spouse's DOB:_____
Spouse's Employer: _____
Emergency Contact Person: _____
Emergency Contact #:_____ Relationship: _____

Insurance Information

Primary Insurance Company: _____
Address: _____
_____
ID#:_____ Group #:_____
Subscriber: _____ Relationship: _____
Secondary Insurance Company: _____
Address: _____
_____
ID#:_____ Group #:_____
Subscriber: _____ Relationship: _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO MY INSURANCE COMPANY, OR TO THE SOCIAL SECURITY ADMINISTRATION, ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICAL CLAIM. I REQUEST PAYMENT OF MEDICAL BENEFITS TO DR. THOMAS C. JONES. I UNDERSTAND THAT THE CHARGES I INCUR ARE MY RESPONSIBILITY. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW IF MY PHYSICIAN IS IN A NETWORK PLAN. IF MY INSURANCE COMPANY FAILS TO MAKE PAYMENT IN A TIMELY MANNER, I AM RESPONSIBLE FOR MEDICAL SERVICES RENDERED.

Signature: _____ Date: _____

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ACKNOWLEDGMENT OF PHYSICIAN ASSISTANT SERVICES

I understand that Dr. Thomas C. Jones employs a team approach to the delivery of my health care. This includes the provision that medical services be provided by Physician Assistants. As well I understand that my signing this form if giving my consent to be seen and evaluated by John Sink II, PA-C, Steve Parker, PA-C, or Lori Parker, PA-C. I understand that they are under the supervision of Dr. Jones. This does not mean that I will never see Dr. Jones, but it allows my care to be followed by both the Doctor and the Physician Assistants. By signing this form I also acknowledge that my prescriptions given to me by the Physician Assistants, I have been informed of my rights under Georgia law to have said prescriptions reviewed by Dr. Jones before filling it at the pharmacy.

Signature: _____ Date: _____

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New Federal Regulations require us to have your permission to discuss your treatment, personal information or anything pertaining to you with anyone other than yourself. If a person's name is not listed on this form, we cannot discuss your information with anyone unless in an emergency situation.

Please Review and Then Sign In One of the Areas Below

I hereby give my consent to Dr. Thomas C Jones, Dr. Andrea Gatchair-Rose, John Sink PA-C, Steve Parker PA-C, Lori Parker PA-C and their staff to review or discuss my medical treatment, lab results, pathology reports, medication changes, personal or financial information etc. to the following persons OTHER THAN MYSELF (i.e. spouse, parent, child etc.)

1. **_____ Relationship _____**
2. **_____ Relationship _____**
3. **_____ Relationship _____**

Patient Signature _____ Date_____

I DO NOT WANT ANY TYPE OF INFORMATION DISCUSSED WITH ANYONE OTHER THAN MYSELF.

Patient Signature _____ Date _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

☐ Home Telephone: _____
- ☐ OK to leave a message with detailed info.
- ☐ Leave message with call back number only

☐ Work Telephone: _____
- ☐ OK to leave message with detailed info.
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ OK to mail to home address
- ☐ OK to mail to work/office
- ☐ OK to fax to this number

☐ Other _____

_____

_____ _____

Patient Signature **Date**

_____ _____

Patient Name **Birth Date**

The Privacy Rule generally requires healthcare providers to take responsible steps to limit use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

These provisions do not apply to uses or disclosures made pursuant to an authorized requested by an individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and Disclosures for TPO may be permitted without prior consent in an emergency

Record of disclosures of protected health information

DATE	Disclosed to Whom Address or Fax	(1)	Description of Disclosure Purpose of disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if disclosure is authorized
(2) Type Key T=treatment records P=payment information O=Healthcare operations
(3) Enter how disclosure was made F=fax P=phone E=email O=other

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Cancellation and No Show Policy

Our vision is to provide quality care for the needs of our patients in the community. Numerous no shows and cancellations, without proper notice, has caused us to institute this policy.

You will be billed a fee of **$25** under the following conditions:

A minimum of a twenty-four hour notice of cancellation needs to be given to allow us the opportunity to fill that appointment with someone from our wait list. We realize that certain health obstacles may arise and we'll view these on an individual basis.

Any no show will be billed the above fee and after two consecutive no show's or repeated cancellations, it may require us to limit medication refills or possibly discharge you from our practice.

If you arrive for your appointment late it will at the discretion of your health care provider to fit you in or reschedule your appointment.

We apologize in advance for having to take these measures but our facility takes pride in serving you and the needs of our community.

Thank you,

Thomas C. Jones M.D., F.A.C.E.
Andrea Gatchair-Rose M.D.
John Sink II PA-C, CDE
Steve Parker PA-C
Lori Parker PA-C

I have read, understand and agree to the above conditions.

Signature: _____ Date: _____

Financial Policy

Thank you for choosing The Jones Center for Diabetes and Endocrine Wellness as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All co-payments and deductibles are due at time of service. Full payment is due at time of service for all non-covered services. Our contract with your insurance company requires us to collect these from you. With the rising cost of medical care, paying at the time of service is essential in keeping these costs at a minimum. Payment in full is required without proof of insurance coverage.

It is your responsibility to check with your insurance company prior to your appointment for verification of benefits such as preventive services, lab and X-ray procedures, etc. Many insurance plans now require you to go to specific labs, X-ray facilities, pharmacies, etc.

It is your responsibility to give us accurate and updated insurance information at each visit. Failure to do so may result in you being responsible for a balance that your insurance company may have otherwise paid. Many managed care insurance plans have strict guidelines regarding timely filing which makes accurate information a necessity. If you are covered under more than one insurance plan, please remember to give us information on all plans at the time of service.

It is important for you to respond to your insurance company when any information is requested from you. Often they will send questionnaires regarding other coverage and will not process your claim until you respond. Some insurance companies require this with your first claim each calendar year. Do not make the mistake of thinking you have already given them this information and it is not necessary for you to respond. When you insurance company notifies us they have requested information from you, the balance then becomes your responsibility and remains your responsibility until the claim is paid.

We understand unforeseen circumstances such as hospitalizations, uncovered services, and unplanned emergencies occur. In these situations when you incur a balance, we require monthly payments with the expectation of paying the balance in full in 3 to 4 months. If this is not possible please set up payment arrangements with our office.

If monthly payments are not received regularly, your account will automatically move into our collection process. We are willing to work with you on your balance but communication with our billing office is essential. If you have questions regarding your bill or wish to set up payment arrangement, contact our billing office at (478) 746-8626. If you receive a bill that you feel is not your responsibility, it is important for you to call the billing office.

Never ignore a bill simply because you feel it is not your obligation or you think your insurance company should pay it. You cannot assume your insurance company will cover any balance once we have transferred the responsibility of that balance to you. We only transfer responsibility to you after we have had response from your insurance company.

It is important for you to read the explanation of benefits (EOB's) sent to you from your insurance company. This will explain why certain charges are not covered. If you have any questions regarding the coverage of your claim, you should contact your insurance company. If you have questions regarding your bill or wish to set up payment arrangements, please contact our billing office at (478) 746-8626.

_____ _____

Signature of Responsible Party Date

The Jones Center for Diabetes and Endocrine Wellness

NORTH 75 **Take I-75N/ GA 401-N**

171 EXIT **Take Exit 171/ Ga-87**

Turn Right onto Riverside Dr.

Turn Right onto Sheraton Blvd. Just Before The BP Gas Station

STOP **Stop At The 4 Way Stop And Continue Going Straight**

END **End at 265 Sheraton Blvd**

SOUTH 75 **Take I-75-S/ Ga-401-S**

171 EXIT **Take Exit 171/ Ga-87**

Turn Left onto Riverside Dr.

Turn Right onto Sheraton Blvd. Just Before The BP Gas Station

STOP **Stop At The 4 Way Stop And Continue Going Straight**

END **End at 265 Sheraton Blvd**