Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Welcome!

Thank you for choosing to become a part of our practice. We will work very hard to ensure that you receive the best care available. Let us take this opportunity to familiarize you with our office policies:

The following is a list of what is necessary to bring to your first visit:

- Insurance cards and picture ID.
- Names and numbers of previous doctors to obtain your medical records.
- The enclosed forms completely filled out and signed.
- **All Medications you are currently taking in the bottle**

Office hours: Monday to Friday 7:00am to 5:00pm

Reminders:

- ***It is your responsibility to know your benefits from your insurance company. This includes wellness/physical coverage, deductible amounts, and co-payment requirements.***
- ***We use Quest laboratories for all lab work. If your insurance requires a different company to be used, it is your responsibility to tell us before labs are draw so you may be given an order sheet to go to an outside laboratory.***
- In compliance with HIPPA laws, no information will be given to anyone, including family, without prior written consent.
- We require a 24 hour cancellation notice for all appointments or a fee will be charged. Future appointments will not be available until the fee is paid.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for Dr. Vaughn will be directed to the nurses.
- We provide same day appointments for our sick patients.
- Our office is capable of ordering some medications at a wholesale price for our patients without prescription insurance. Let us know if we can help you with this.

Our goal is to provide you with the most efficient and up to date health care available. We are always open to suggestions. We look forward to seeing you!

Sincerely,
Dr. Mary Bell Vaughn
and
Vineville Internal Medicine Staff

Your appointment is
Scheduled on: ____/____/_____
With: Cherrice, Erin, Ronda, Dr. Vaughn

Vineville Internal Medicine

Date _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
(As appears on insurance card) Last First Initial

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Are you a Student Y / N Full- Time / Part-Time

Employer _____ Business Phone _____ Occupation _____

In case of emergency who should be notified? _____ Relationship _____ Phone _____

Email _____ Race _____ Religion _____

Pharmacy _____ Pharmacy Phone _____ Pharmacy Address _____

PRIMARY INSURANCE

Primary Card Holders Name _____
Last Name First Name Initial

Relationship to Patient _____ Birth date _____ Soc. Sec. # _____

City _____ State _____ Zip _____

Card Holder Employed By _____ Occupation _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Is Patient covered by additional insurance? Yes No

Subscriber Name _____ Relationship to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

By signing below I certify _____ has submitted true and accurate cards/information, and I understand I can be prosecuted
(Name)
to the full extent of the law for providing false info.

I certify that I (or my dependent) have insurance coverage with _____
(Name of Insurance Company (ies)
I also assign directly to Dr. Mary Bell H. Vaughn all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relation Date

Patient Name _____ Today's Date _____
Age _____ Birth date _____ Date of last physical examination _____
What is your reason for visit? _____

Conditions & Symptoms Check (√) The Conditions or Symptoms you currently have or have had in the past year.

General
Specialist: _____

- Appendicitis
- Chills
- Chicken Pox
- Dizziness
- Fainting
- Fever
- Hernia
- Loss of sleep
- Loss of weight
- Organ Transplant
- _____
- Ulcers
- Sweats
- Measles
- Mononucleosis
- Mumps
- Polio

Muscle/Joint/Bone
Specialist: _____

Pain, weakness or numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders
- Arthritis

Infectious Diseases
Specialist: _____

- AIDS
- HIV Positive
- Typhoid Fever
- Venereal Disease

Pulmonary
Specialist: _____

- Bronchitis
- Emphysema
- Tuberculosis
- Pneumonia
- Asthma

Endocrinology
Specialist: _____

- Diabetes
- Goiter
- Thyroid Problems

Gastrointestinal
Specialist: _____

- Appetite poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Hepatitis
- Liver Disease
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Psychiatric
Specialist: _____

- Alcoholism
- Anorexia
- Bulimia
- Chemical Dependency
- Depression
- Nervousness
- Psychiatric Care
- Suicide Attempt

Hematology/Oncology
Specialist: _____

- Anemia
- Bleeding disorders
- Cancer

Rheumatology
Specialist: _____

- Gout
- Rheumatic Fever
- Scarlet Fever

Nephrology
Specialist: _____

- Kidney Disease
- Dialysis Treatment

Ophthalmology
Specialist: _____

- Cataracts
- Crossed eyes
- Blurred vision
- Double vision
- Glaucoma
- Vision – Flashes
- Vision – Halos

Cardiovascular
Specialist: _____

- Chest pain
- Heart Disease
- High blood pressure
- High Cholesterol
- Irregular heart beat
- Low blood pressure
- Pacemaker
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Neurological
Specialist: _____

- Forgetfulness
- Headache
- Numbness
- Epilepsy
- Migraine Headaches
- Multiple Sclerosis
- Stroke

Ear, Nose, & Throat
Specialist: _____

- Allergies
- Bleeding gums
- Difficulty swallowing
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Tonsillitis

Skin
Specialist: _____

- Acne
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Redness
- Scars
- Sore that won't heal

Genito-Urinary
Specialist: _____

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Gonorrhea
- Herpes

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Prostrate Problem
- Sore on penis
- Other

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Miscarriage
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Vaginal Infections
- Other

Date of last:
Menstrual period _____
Pap smear _____
Mammogram _____
Chest X-Ray _____
Echo _____
Colonoscopy _____

Patient History Fill in health information about yourself: Patient Name: _____

Current Prescription Medications

Name of Drug	Dosage in Milligrams	# of Tablets	# Times Taken per Day	Prescribing Physician

Current OTC Medications (this includes vitamins and Herbal treatments)

Name of Drug	Dosage in Milligrams	# of Tablets	# Times Taken per Day	Prescribing Physician

Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)

Name of Drug/Food	Reaction	Type	Status

Previous Medications Taken (i.e. blood pressure-non therapeutic/cannot tolerate satins)

Name of Drug	Dosage in Milligrams	Reason No Longer Taking

Family History Fill in health information about your family:

Patient Name: _____

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Stroke	

Hospitalizations/Operations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? _____

If yes, please give approximate dates _____

Serious Illness / Injuries	Date	Outcome

Health Habits

Check (√) which you use or do and describe how much you use.

	Caffeine	
	Tobacco	
	Regular Exercise	
	Sodas	
	Raw Fruit	
	Vegetables	
	Alcohol	
	Fiber	

Pregnancies

Year of Birth	Sex of Birth	Complications to Any

Immunizations

Vaccine	Date Given
Tetanus/Tdap	
Pneumovax (pneumonia)	
Flu	
Gardasil (HPV)	
Varicella(chicken pox)	
Meningococcal	
Hepatitis A	
Hepatitis B	
Zostavax (shingles)	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed by Date

Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Patient Financial Policy

To reduce misunderstandings between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager.

Unless other arrangements have been made in advance by either you or your health insurance carrier, all co-pays and deductibles are due at the time of the visit. Additional financial responsibility maybe determined after your insurance has processed your claim. For your convenience we accept Visa, MasterCard, Discover, American Express, Cash and Checks. Checks returned for NSF will incur a $25.00 fee which will be added to your account balance.

Patient Insurance

We have made prior arrangements with many insurers and health plans to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. Our office policy is to collect this co-payment when you arrive for your appointment.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

All patients under the age of 18 will not be seen without a parent or guardian present/or without a signed consent form.

Self Pay Patients

For all services rendered to patients without insurance or proper proof of insurance a self pay charge will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Any test performed that may result out abnormal causing other test to be performed will be charged to your account.

Account Balance

All patient balances must be paid in full unless previous payment arrangements have been made with the billing office. Failure to pay on your account balance will make your account subject to collections with the collection agency of Vineville Internal Medicine's choosing. If your account is turned over to a collection agency, you will be responsible for any and all fees that agency may charge. Any fees incurred pursuing with the courts will also be your responsibility. In the event that your account is sent to collections, you will be dismissed from the practice for lack of payment.

Patient Agreement:

I have read and fully understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name Printed: _____ DOB: ___/___/_____

Patient/Responsible Party Signature: _____

Date: ___/___/____ CC: _____ (account#)

Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Health Information Disclosure

Date: ___/___/_____

I (patient name printed) _____, hereby give my permission to Dr. Mary Bell Vaughn and staff at Vineville Internal Medicine to release my personal health information to the following:

Name (printed): _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

Name printed: _____; Relation to patient: _____
DOB: ___/___/____ & Contact Number: _____

I also understand that it is my responsibility to keep Vineville Internal Medicine informed of any changes of names on this list and must complete a new form each time I am in the office.

Patient DOB: ___/___/_____

Patient Signature: _____

Office Witness Signature: _____

Account#: _____

Vineville Internal Medicine

Mary Bell H. Vaughn, MD

VIM Fee Schedule

To reduce misunderstanding between our patients and practice, we have adopted the following fee schedule. If you have any questions regarding this policy please discuss them with our office manager.

The following fees are fees billed directly to the patient that are not covered by insurance. These fees are administrative fees, and must be paid at the time the request is made.

- Fmla paperwork: $50.00
- Disability Forms: $25.00
- Handicap Parking permits: $10.00
- Miscellaneous Letters written: $15.00
- Miscellaneous Forms (simple): $15.00
- Miscellaneous Forms (complex): $25.00
- Medical Records in accordance with GA Laws O.C.G.A. § 31-33-3

Effective July 1, 2014

Search, Retrieval, and Other Direct Administrative Costs	Up to	$25.88
Certification Fee	Up to per record	$9.70
Copying Costs for Records in Paper Form	Per page for pages 1-20	$0.97
	Per page for pages 21 - 100	$0.83
	Per page for pages over 100	$0.66
Note – Rates do not apply to records requests necessary to make or complete an application for a disability benefits program.		

Patient Agreement:
I have read and fully understand the fee schedule of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name Printed: _____ DOB: ___/___/_____

Patient/Responsible Party Signature: _____

Date: ___/___/_____

CC: _____ (account#)

Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Missed Appointment Fee Policy

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care.

Due to high patient demand and limited availability of appointments we have instituted a "*missed appointment*" fee. You must give 24 hour advance notice to cancel or reschedule appointments; failure to do so will result in a "*missed appointment*" fee charge to your account.

This fee must be paid before you can be seen again.

"*Missed Appointment*" Fees are listed below.

- Physical: $50.00
- Ultrasound: $50.00
- Echo: $50.00
- All other appointments: $35.00

Once signed, this form will be a binding agreement and will become a permanent part of your patient record or chart.

Patient Agreement:
I certify that I have read and fully understand the above information. I understand that I am fully responsible for payment of this fee.

Patient Name Printed: _____ DOB: ___/___/_____

Patient Signature (or responsible party): _____
Date: ___/___/____

Witness Signature: _____
Date: ___/___/____

CC :_____(account #)

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