Vineville Internal Medicine

Mary Bell H. Vaughn MD

Welcome!

Thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to 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 Card(s) and picture ID
- The names, phone and fax numbers to your previous doctors to obtain you medical records.
- The enclosed forms completely filled out and signed.
- **All medications you are currently taking in the bottles.**

OFFICE HOURS: Monday - Friday from 7am to 5pm

Reminders:

- *It is your responsibility to know the benefits that you receive from your insurance company. This includes wellness/physical coverage, deductible amounts, and co-payment requirements.*
- *We use QUEST lab for all lab work. If your insurance requires a different company to be used, it is your responsibility to tell us before labs are drawn so that you may be given an order sheet to go to an outside lab that insurance covers.*
- 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 of $50 will be charged if not notified prior to appointments. 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 and walk in appointments for our established patients.

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: ____/____/_____ at _____ with
Building A
Erin Caves, Cherrice Clay-Austin and Ashley Dykes
And Dr. Mary Bell Vaughn
Building B
Ronda Toole, Lauren Lambeth, Shandora Hayman-Jones
Dr. Leslie Tidwell and Dr. James Thigpen

3448 Vineville Ave * Macon, Ga 31024 * Phone: 478-405-0045 * www.vinevilleinternalmedicine.com

Vineville Internal Medicine

PATIENT INFORMATION:				
Patient's Legal Last Name:	First:	Middle	Marital Status (circle one) ( ) Single ( ) Married ( ) Divorced ( ) Separated ( )Widowed	
Email Address:		Race (circle one): ( )American Indian ( ) Alaska Native ( )Asian ( ) Hawaiian ( )Black or African American ( ) White ( ) Hispanic ( ) Other		
Date of Birth:	Sex (Circle One) ( ) Male ( ) Female	Social Security No:		
Street Address:	Cell Phone: ( )	Home Phone: ( )	**For Reminder Calls, I prefer** ( ) Calls ( ) Text	
City:	State:	Zip Code:		
Occupation:	Employer:	Employer Phone: ( )		

HEALTH INFORMATION DISCLOSURE:

List anyone that may call on your behalf or pick up any prescriptions if you are unable to do so

Name/Phone Number	1. / ( )	2. / ( )
3. / ( )	4. / ( )	

INSURANCE INFORMATION:			
Name of Primary Insurance:	Subscriber's SSN: (if different from patient)		
Subscriber's Name: (if different from patient)	DOB:		
ID/Policy Number:	Group Number/Plan Code:		
Patient's Relationship to Subscriber: ( ) Child ( ) Self	( ) Spouse ( ) Other		
Name of Secondary Insurance: (if Applicable)	Subscriber's SSN: (if different from patient)		
Subscriber's Name: (if different from patient)	DOB:		
ID/Policy Number:	Group Number/Plan Code:		
Patient's Relationship to Subscriber: ( ) Child ( ) Self	( ) Spouse ( ) Other		
Other Insurance:	ID/Policy Number:	Group Number/Plan Code:	

IN CASE OF EMERGENCY:			
Name:	Relationship to Patient:	Cell Number:	Home Number:

The above information is true to the best of my knowledge. I hereby authorize direct payment to my physicians from my insurance company when applicable. I understand that I am responsible for any balance(s) not paid by my insurance carrier and is to be paid to VIM. Said balance is to be paid in a timely manner. I also authorize the release of any medical information to a referring physician or insurance company.

Patient/Guardian Signature: Date:

(CONFIDENTIAL)

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
- Arthritis
- Hips
- Legs
- Neck
- Shoulders

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

Pregnancies

Year of Birth	Sex of Birth	Complications to Any

Health Habits

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

	Caffeine	
	Tobacco	
	Regular Exercise	
	Sodas	
	Raw Fruit	
	Vegetables	
	Alcohol	
	Fiber	

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

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: _____ DOB: ___/___/____

Records being requested from:
Dr. _____ Phone Number: _____ Fax Number: _____
Dr. _____ Phone Number: _____ Fax Number: _____

The information you may release subject to his signed release form is as follows:

( ) Complete Records
( ) Progress Notes
( ) H&P
( ) Other (Please specify below)
( ) Lab Reports
( ) Radiology Report
( ) Rx Records
( ) Pathology Reports
( ) Immunization Records
( ) Hospital Reports

_____

_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies, please initial and date this form. Initial:_____ Date:__/__/___

Release my protected health information to the following physician/facility:

Dr. Mary Bell Vaughn
Vineville Internal Medicine
3448 Vineville Ave
Macon, Ga 31204

Phone: 478-405-0045
Fax: 478-405-0054

Patient Name (Please Print) _____ DOB: ___/___/_____

Signature: _____ Date: ___/___/_____

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 of $50 to your account.

Once signed, this form will be a binding agreement and will become a permanent part of your patient record and 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: _____

Date: ___/___/____

Witness Signature: _____

CC: _____ (Account #)

Vineville Internal Medicine

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Patient Financial Policy

In order to take preventative measures and help reduce misunderstandings; 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 your health insurance carrier:

- All co-pays and deductibles are due at the time of the visit.
- Additional financial responsibility may be determined after your insurance has processed your claim.
- For your conveniences we accept Visa, MasterCard, Discover, American Express, Cash and Checks.
- Checks returned for NSF will incur a $30.00 fee which will be added to our 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 you appointment, or you may be subject to a finance processing fee $10, for charging your required co-payment.* If you have insurance coverage with a plan that we do not have a prior agreement with, 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 service. In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Should any test performed result with any abnormalities, additional testing may be required-and will fall under the patients' responsibility for those charges.

Minor Patients

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

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

Self-Pay Patients

For all services rendered to patients without insurance or proper proof of insurance, a self-pay discounted 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. Should any test performed result with any abnormalities, additional testing may be required-and will fall under the patients' responsibility for those charges. Payment is due upon receipt of all statements from out office.

Account Balance

All patient balances must be paid in full when statement is received. Failure to pay a minimum of 20% of the statement 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 collection agency, you will be responsible for the collection fee of 40% that the agency charges. Any other feed incurred pursing 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: ___/____/_____

Vineville Internal Medicine

Mary Bell H Vaughn, MD

VIM Fee Schedule

In order to take preventative measures and to help reduce misunderstandings 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. There fees are administrative fees, and must be paid at the time the request is made.

- FMLA paperwork: $50 / Next Day: $75 – Rush fee
- Disability Forms: $25
- Handicap Parking permits: $10
- Miscellaneous Letters Written: $15
- Miscellaneous Forms (simple): $15
- Miscellaneous Forms (complex): $25
- 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
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 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 (please print): _____ DOB: ___/___/_____

Patient/Responsible Party Signature: _____

Date: ___/___/_____

Exhibit A

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ **Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record**
☐ **No, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time**

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:
Relationship to Patient: _____
[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 111 Perimeter Parkway Macon, GA 31210. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) through the *Central Georgia Health Exchange*.

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