MIDDLE GEORGIA SURGICAL

420 Charter Blvd. Suite 302
Macon, Ga 31210
478-330-6755 phone
478-330-6759 fax
www.middlegeorgiasurgical.com

Welcome to our practice!

Office Hours are by Appointment

Monday thru Friday 8:30PM to 5:30PM and Friday 8:30AM to 2PM.
If you see you are going to be more than 15 minutes late, please call. If you cannot make your scheduled appointment, please call 24 hours in advance. This time has been set aside especially for you. There are a limited number of patients that can be seen on a daily basis.

Items you need to bring with you to your appointment:

( ) **Your medications list**
( ) **Insurance cards and driver license or picture ID**
( ) **Completed medical information forms for new patients or updated information**

I have read and understand the requests mentioned above: _____
Signature and date

We are honored by your consideration of our practice, offering healthcare of high quality and value. We also consider the referral of your friends and family to our practice as the highest compliment and pledge our best efforts to serve their needs and yours. Thank you and we look forward to seeing you.

Demographic Information
PLEASE ANSWER ALL INFORMATIONOR PLACE NONE WHEN NEEDED

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev **Name:** _____
FIRST MI LAST SUFFIX

D.OB: _____ ☐ **Male** ☐ **Female** **Social Security Number:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ other: _____

Address: _____
STREET **CITY** **STATE** **ZIP**

Phone: (H) _____ (W) _____ (C) _____

Messages can be left on phone: ☐ Home ☐Cell ☐Work ☐ Email

Email: _____

Emergency Contact name: _____ **Phone:** _____

Relation to patient:_____

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Race (per census bureau categorization):

☐American Indian ☐Asian ☐Black or African American ☐Black Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander

☐White ☐White Hispanic or Latino ☐ Unknown

How did you find us: ☐ Referred ☐ Friend ☐ Family ☐ Phonebook ☐ Website ☐ Other: _____

Employer/School Name or Retired/Disabled: _____

Spouse's name: _____ Phone: _____

Spouse's DOB: _____ Spouse's Place of employment: _____

Preferred Pharmacy: _____
NAME **CITY** **PHONE**

Primary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number**:_____

Guarantor's Name: _____ **D.O.B**:_____

Relationship to Guarantor: _____

Secondary Insurance Plan Name: _____

Insurance ID Number: _____ **Group Number**:_____

Guarantor's Name: _____ **D.O.B**:_____

Relationship to Guarantor: _____

Primary Doctor: _____
NAME **CITY/STATE** **PHONE**

Referring Doctor: _____

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PAYMENT POLICY

This office is committed to providing patients with the best possible care. In order to achieve this, we need your assistance and understanding of our payment policy.

AS A COURTESY, our office will bill most insurance companies.

HOWEVER, THE PATIENT IS RESPONSIBLE FOR ANY NON-COVERED CHARGES OR UNPAID BALANCES.

Your insurance coverage is a contract between you and your insurance company. All services will be filed with your insurance carrier providing you furnish all pertinent information to our office. Insurance co-pays are expected to be paid at the time services are rendered. We accept CASH, CHECK, CREDIT CARD, and DEBIT CARD. If you cannot make payment in full at the time of visit, you will be expected to participate in a payment plan program if applicable. We cannot accept sole responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract.

I have read the above Payment Policy and understand that even with insurance coverage, IF CHARGES ARE DENIED I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED. If I need to set up an extended payment arrangement, I will contact the office immediately. If no payment has been received from either myself or my insurance company after 90 days from the date of service, necessary collection procedures may begin.

_____

Patient/Guardian Signature **Date**

_____

Printed Name

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Medication Agreement & Refill policy

As part of your treatment, I may prescribe medication for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are very important to us and we need your help to make sure your treatment follows our guidelines. **If Middle Georgia Surgical has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.** For refills, please have your pharmacy fax a refill authorization to **478-330-6755** one week prior to your completion of your dosing schedule. Prescriptions have a turnaround time of 24 to 48 hours. If this is a new problem, you will need to schedule an appointment to be seen. We will need the prescription name and dosage, along with the pharmacy name and number. These will be called in as time permits. Check with the pharmacy before calling the office back. Prescriptions are legal documents and forgery and copying is a felony. Please keep them in a safe place.

1. I agree to follow the dosing schedule prescribed to me by my doctor.

2. I agree to **never** share my medications with others, nor will I sell or exchange my medication for any reason.

3. I agree to always keep my medications safeguarded and within my control.

4. I agree to notify Middle Georgia Surgical if I experience any adverse effects or dosage problems with my prescribed medications. I will not discard any unused medications before any new medication can be prescribed. You may be asked to bring any unused medications to Middle Georgia Surgical for disposal.

5. I agree that if I receive narcotic prescriptions from Middle Georgia Surgical, I am **not** allowed to receive the same type of medications from other physicians without express consent or consultation with Middle Georgia Surgical.

6. I agree to use only one pharmacy for my pain-related medication unless extenuating circumstances prevent this from being possible. In this event, I will notify Middle Georgia Surgical of all pertinent information pertaining to additional pharmacies, mail-order, or other sources.

7. I understand that medication refill prescriptions involving narcotic pain medicine requires a **SCHEDULED** office visit when the doctor is on duty in the office. **Narcotic pain**

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medication refills will not be called into a pharmacy, nor will they be increased over the telephone.

8. **I agree to keep all scheduled appointments and I understand that no medication will be given for cancelled or no-show appointments.** I understand that if I am more than 15 minutes late to my appointment time, I will have to reschedule – unless you have spoken to someone in the office.

9. I understand that medication refills cannot be made **AFTER HOURS, ON WEEKENDS /HOLIDAYS** or when the **DOCTOR IS OUT OF TOWN**. Our physician on call will **NOT** prescribe narcotics for any reason.

10. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.

11. I understand that I am solely responsible for the safekeeping of my medications and I must treat my medications as I would my money or valuable possessions. *Middle Georgia Surgical will have no obligation to replace **LOST or STOLEN** prescriptions or medications*.

12. I understand that abusive behavior or harassment toward any Middle Georgia Surgical staff will **NOT** be tolerated. Harassment includes, but is not limited to, more than two (2) calls to the office in one business day.

13. I understand that I cannot present to Middle Georgia Surgical unannounced seeking medication refills.

14. I understand that dealing with a forged or falsified prescription will result in immediate dismissal from Middle Georgia Surgical.

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15. I understand that I may be dismissed from Middle Georgia Surgical if I do not abide by the terms of this medication agreement.

By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have **read, understood, and accepted these terms**. NO medication will be prescribed without acceptance of this agreement.

Patient Signature: _____ **Date**: _____

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PLEASE ANSWER ALL QUESTIONS

Symptom/Problem	Have you had or currently have;	Family History (Blood Relations only)
Alcoholism	☐ YES ☐ NO	☐YES ☐NO Who?
Angina/Chest Pain	☐ YES ☐ NO	
Angioplasty/Stent	☐ YES ☐ NO	☐YES ☐NO Who?
Asthma	☐ YES ☐ NO	
Arthritis	☐ YES ☐ NO	☐YES ☐NO Who?
Arial Fibrillation of Flutter	☐ YES ☐ NO	
Back Pain of Sciatica	☐ YES ☐ NO	☐YES ☐NO Who?
Bladder Infection/UTI	☐ YES ☐ NO	☐YES ☐NO Who?
Cancer (type _____)	☐ YES ☐ NO	☐YES ☐NO Who?
Carotid Disease/blockage	☐ YES ☐ NO	☐YES ☐NO Who?
Cirrhosis or Liver Disease	☐ YES ☐ NO	
Confusion/Disorientation	☐ YES ☐ NO	
COPD/Emphysema/Bronchitis	☐ YES ☐ NO	
Depression or Anxiety	☐ YES ☐ NO	☐YES ☐NO Who?
Diabetes: ☐type 1 ☐type 2 Taking Insulin?	☐ YES ☐ NO ☐ YES ☐ NO	☐YES ☐NO Who? _____ Who?
Dry Skin	☐ YES ☐ NO	
Fatigue	☐ YES ☐ NO	
Headaches	☐ YES ☐ NO	
Heart Attack/MI	☐ YES ☐ NO	☐YES ☐NO Who?
Heart Surgery (bypass or valve)	☐ YES ☐ NO	☐YES ☐NO Who?
Heartburn/GERD	☐ YES ☐ NO	
Hepatitis	☐ YES ☐ NO	
Hematuria/Blood in urine	☐ YES ☐ NO	☐YES ☐NO Who?
High Cholesterol	☐ YES ☐ NO	☐YES ☐NO Who?
Hypertension	☐ YES ☐ NO	☐YES ☐NO Who?
Implanted Defibrillator	☐ YES ☐ NO	
Irritable Bowel Syndrome	☐ YES ☐ NO	
Joint Replacement (Which one? _____)	☐ YES ☐ NO	☐YES ☐NO Who? _____
Kidney Disease	☐ YES ☐ NO	☐YES ☐NO Who?
Leg artery blockage	☐ YES ☐ NO	
Mental Illness	☐ YES ☐ NO	☐YES ☐NO Who?

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Mitral Valve Prolapsed	☐ YES ☐ NO	
Muscle Pain or Fibromyalgia	☐ YES ☐ NO	☐YES ☐NO Who?
Osteoporosis/Osteopenia	☐ YES ☐ NO	☐YES ☐NO Who?
Other Arrhythmias	☐ YES ☐ NO	
Pacemaker	☐ YES ☐ NO	
Pain or difficulty urinating	☐ YES ☐ NO	☐YES ☐NO Who?
Pancreatitis	☐ YES ☐ NO	
Recurrent Pneumonia	☐ YES ☐ NO	
Skin Disease	☐ YES ☐ NO	
Stomach Ulcer	☐ YES ☐ NO	
Stroke or TIA/mini-stroke	☐ YES ☐ NO	
Thyroid problem	☐ YES ☐ NO	☐YES ☐NO Who?
Tuberculosis	☐ YES ☐ NO	☐YES ☐NO Who?
Unexplained weight loss or gain	☐ YES ☐ NO	
Wounds/sores/skin tears	☐ YES ☐ NO	

Surgical History

Type of Procedure	Procedure Date or Age When Performed

Allergies: To	**Reaction**

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Significant other person

Occupation: _____ Current Employer: _____

How much caffeine (coffee, tea, soda, etc.) do you drink? _____# Servings per (circle one) day week

How much alcohol do you drink? _____# Servings per (circle one) day week

Do you use tobacco? ☐ Yes ☐ no (check all that apply) ☐ Cigarettes ☐ Cigars ☐ Chewing tobacco ☐ snuff/dip

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How long have you (or did you) smoke? _____ Years Number of packs per day _____ Quit year _____

Do you now or have you ever used: ☐ marijuana ☐ cocaine ☐ other street drugs (specify) _____

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your health information. We also required by Federal law to maintain the confidentiality of your health information. Although these laws are complicated, all medical providers are required to provide you with the following important information;

The HIPAA law permits the use and disclosure of personally-identifiable health information as needed for diagnosis, treatment, or billing of health care services, provided that any such disclosure must be limited to the minimum necessary information to accomplish these purposes, and only to properly qualified persons. Special safeguards must be maintained to minimize any chance of inadvertent disclosure of personally-identifiable health information to unauthorized person, particularly of especially sensitive information such as psychological or HIV status. We are committed to maintaining the security and privacy of all information (including billing information) contained in my medical records, including electronic records and data transmission.

Use and disclosure of your health information in certain circumstances:

The following additional circumstances may also require me to use of disclose your health information;

1. To public health authorities and health oversight agencies that are authorized by law to collect such information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety or another individual or the public. I will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or Foreign Military Forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.

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7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In order to advert a serious threat to the health and safety of you or any other person pursuant to applicable law.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in my use of disclosure of your health information treatment, payment, or health care operations. Additionally, you have the right to request that I restrict my disclosure of your health care operations. Additionally, you have the right to request that I restrict my disclosure of your health information to only certain individuals involved in your care of payment for your care, such as family members and friends as provided by 45CFR § 164.522. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be use to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes as outlined in 45CFR § 164.524. You must submit your request in writing to the office of Dr. Burnette.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for my practice as provided for in 45CFR § 164.526. To request an amendment, your request must be made in writing and submitted to Dr. Burnette, M.D. You must provide a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice, contact the receptionist.
6. Accounting of disclosures. You have a right to receive an accounting of all disclosures made of your health information as provided by 45CFR § 164.526.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with my practice or with the secretary of the U.S. Department of Health and Human Services. To file a complaint with our office, contact Dr. Burnette. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. My practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
9. If you have any questions regarding this notice or my health information privacy policies, please contact Dr. Burnette, M.D.

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

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Printed Name of patient: _____

Signature of patient/guardian: _____ **Date Signed**: _____

I AGREE FOR THE FOLLOWING PEOPLE TO HAVE ACCESS TO AND/OR OBTAIN ANY AND ALL OF MY MEDICAL RECORDS. (List the names of friends, family, etc. who are allowed to obtain your medical records. If you do not have anyone to list, leave this list blank.)

1.) _____

2.) _____

3.) _____

SIGNATURE OF PATIENT: _____

Agreement for the Prescription of Controlled Substances

I understand narcotic pain medicine is being provided to me to manage my pain. I am responsible for my narcotic medicine and will agree to the following:

- Only one doctor will prescribe narcotics for my pain. I will not ask for or take narcotic pain medicine from any other doctor while receiving such medicine from this clinic unless both doctors agree that it is best for my condition.
- I understand that my pain medicine will not be replaced if it is lost or stolen. It will not be replaced if I use them up too soon. If I take for medicine than my doctor prescribed, I understand that it could make my condition worse.
- If I have a new injury or pain problem, I might need a new prescription. If this happens, I will call or make an appointment with my doctor to find out if my dose needs to be changed.
- My doctor may refer me to other doctors to help manage my pain. I agree to have urine and/or blood test by my doctor or another doctor to check on the levels of medicine in my body. If other controlled substances show up in a test, my doctor will stop my pain prescription. Examples of other substances are cocaine, marijuana and street drugs. Also, if any prescribed medicines do not show up in the urine test, my doctor will stop my pain prescription.
- I understand that it is against the law to change or forge a prescription. It is also against the law to sell, trade ort give my pain medicine to someone else. Is this happens; my doctor will stop providing me with pain medicine.
- I will provide the pharmacy information where I last refilled my pain medicine to verify if needed.

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I have read this entire agreement and fully understand it. I also understand that my compliance with this agreement will be reviewed each time my pain medicine prescription is renewed. My doctor and I will discuss my need to keep using controlled substances on a regular basis.

_____ _____

Patient Signature Doctor's Signature

Consent for Treatment

I hereby authorize Middle Georgia Surgical to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operations. Treatment includes, but is not limited to, the administration and performance of all treatments, and the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically acceptable laboratory tests, all of which is in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable. Healthcare Operations include, but are not limited to release of my medical information to any of my physicians and their offices or insurance companies participating in my care of treatment and the quality of that care. I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photo copy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient signature_____

Date_____ Patient DOB_____