Patient Information Form

Thank you for choosing Bowers Family Medicine. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Have you previously been a patient of Dr. Bowers? Yes / No (Please Circle One)	Marital Status Single / Married / Widowed (Please Circle One)
Patient name	Social Security Number
Date of Birth	Address City State/Zip
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation
Primary Insurance Information (*see your insurance card*) Company___________________________________ ID/Member #_______________________________ Group #____________________________________ Effective date______________________	Secondary Insurance Information (*see your insurance card*) Company___________________________________ ID/Member #_______________________________ Group #____________________________________ Effective date______________________

If patient is a minor, please name Responsible party:____

DOB:_______________SSN:___________________Address:____

Is the patient covered under another person's policy? Yes / No

If yes, please describe the patient's relationship to the policyholder: Spouse / Child / Grandparent / Other:________

Policyholder's name	Social Security Number
Date of Birth	Address
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation

Release of Medical Information and Insurance Assignment Form

TO MY PHYSICIAN AND INSURANCE CARRIER(S) FOR INSURANCE AND SELF-PAY PROCESSING OF CLAIMS:

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits directly to my physician(s).
3. If I am a participant in a preferred provider arrangement or a member of a health management organization, I authorize the release of my medical information for utilization reviews and such other procedures as provided by the plan.
4. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
5. I agree that a photocopy of this form may be used in lieu of the original.
6. I understand that unless I am a participant in a preferred provider arrangement or health management organization, which may limit my liability, I am personally responsible for the payment of all charges that occur as a result of my medical treatment. I also understand that even if I am a participant in a preferred provider arrangement or health management organization, I still may be personally responsible for the payment of all charges that occur as a result of my medical treatment. Further, if it is determined through the Utilization Management review under such plan that any medical services that any medical services that I hereafter receive are not covered under the plan, I agree that I am personally responsible for the payment of the charges that occur of said medical services, and I agree to pay the charges for said services.
7. I authorize any holder to bill Medigap-covered services.

____________________________________ ______________________

Signed (Patient or Responsible party) **Date**

____

Patient's Name (Printed)

MEDICARE LIFETIME AUTHORIZATION (TO BE SIGNED BY MEDICARE RECIPIENTS):

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier and information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

____________________________________ ______________________

Signed (Patient or Responsible party) **Date**

____

Patient's Name (Printed)

CONSENT TO TREAT:

I (or my legal guardian or parent) authorize Bowers Family Medicine to provide care reasonable by today's standards.

____________________________________ ______________________

Signed (Patient or Responsible party) **Date**

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability act of 1996 (HIPPA) I have received a copy of the Notice of Privacy Practices of Bowers Family Medicine on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Bowers Family Medicine.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

PRIVACY COMPLIANCE OFFICER
PO BOX 606
204 N. DUKE STREET
LAFAYETTE, GA 30728
Phone: 706-639-9055 FAX: 706-639-9057

____
SIGNATURE OF PATIENT

____
PRINT NAME OF PATIENT

____
DATE

THIS SPACE TO BE USED BY PRACTICE ONLY

Patient signed acknowledgment of Notice of Privacy Practices: Yes No (Circle)

If refuse to sign, document reason in chart:____

Signed acknowledgment documented in computer: Yes No (Circle)

Name and initials of employee documenting same:____________________________________

R. Edward (Ted) Bowers, II, M.D.
PO Box 606
204 N. Duke St.
La Fayette, GA 30728
Phone: (706) 639-9055 · Fax: (706) 639-9057

POLICY ON NARCOTIC DRUGS FOR NEW PATIENTS

Patient Name: ____ Date of Birth: ____________________

Bowers Family Medicine does not prescribe or refill any narcotic medications for pain, anxiety, weight loss, or Adult Attention Deficit Disorder. These medications include, but are not limited to, the following:

- Adipex
- Alprazolam
- Ativan
- Avinza
- Carisoprodol
- Clonazapam
- Darvocet
- Demerol
- Diazepam
- Dilaudid
- Duragesic
- Fentanyl
- Hydrocodone
- Klonopin
- Librium
- Lorazepam
- Lorcet
- Lortab
- Mepergan
- MS Contin
- Norco
- Oxycontin
- Percocet
- Percodan
- Phentermine
- Provigil
- Redux
- Soma
- Stadol
- Tylenol # 3
- Tylenol w/Codeine
- Tylox
- Valium
- Vicodin
- Vicoprofen
- Xanax
- All Attention Deficit Disorder medications (applies only to patients age 18 and over)

I acknowledge notification that Bowers Family Medicine will not provide prescriptions or refills for any narcotic medication. I understand that my choice to continue or initiate these medications will require me to make arrangements with the original prescriber or another provider for management of these medications.

____ ____________________________
Patient (or person authorized to sign for patient) Date

____ ____________________________
Witness Date