Physicians Pointe
Family Medicine, Minor Emergencies, Aesthetics Norvin Ona, D.O.

OFFICE POLICIES

MAINTENANCE MEDICATIONS: Any maintenance medications for Diabetes, Hypertension, Cholesterol, Thyroid, or Depression/Anxiety, once your dosage has been set, you will need to be seen every 6 months for a follow up and fasting blood work. Please schedule your appointment at least 1 week before you run out of your medication to allow time for lab-work to return. Refills will not be given without a 6-month re-check. If you were just started on a medication you will need to follow up every 3 months until dosage is established then every 6 months.

Please allow 24 to 48 hours for a call back on any messages.

ANY WEIGHT MANAGEMENT MEDICATIONS: To get a medication refill you must be seen every month. This is to verify that the medication is working and that you are losing weight. Refills will not be called in without a re-check visit. Please verify with your insurance if weight management is covered, some policies do NOT cover weight loss visits.

ADD/ADHD MEDICATIONS: Patients must be seen every 3 months after establishing medication and dosage. Refills will not be given without a follow-up visit. If you are on a schedule 2 medication and it was to get lost or stolen these are also not replaced without a follow-up visit and proper documentation. Drug screen monitoring is required for new patients and at provider discretion. Please verify coverage with your insurance, these visits are often denied to behavior health.

PAIN MEDICATION: Refills are not given on any pain medications. You must be seen each time a pain medication is needed. Our providers will not do long-term pain management.

PRIOR AUTHORIZATIONS: Contact your insurance and find out if there are alternative medications that are covered/preferred. After contacting your insurance and getting the alternative medications call the office and let them know if you have previously taken any of these medications and if there were any side effects. If the office has to do a PA for your medication there will be a $25 charge.

FORMS: Any forms or paperwork completed by the office will be charged an administrative fee for completing. Turn around time for completion is 7-10 business days. FMLA $35, Immunization forms $10, Patient letters $10

CANCELLATION POLICY: A cancellation fee will be charged for any "no show" or cancellations that are less than 24 hours from appointment. Cancellation fee is $25 for regular appointment, $50 for physical or procedure.

INSURANCE POLICY: Current insurance card must be provided at every visit along with all necessary information needed to file and verify. A picture ID is required to file insurance. It is the patients responsibility to know plan limitations and benefits, as well as to verify network eligibility.

PAYMENT POLICY: Payment is due at time of service. All co-pays/deductibles and out of pocket are collected at your visit.

I, _____, acknowledge that I have received a copy of Physicians Pointe office policy.
Patient Name

_____
Patient Signature Date of Birth

1925 Old Peachtree Road, Lawrenceville, GA 30043
770-339-5999 Fax 770-277-9159

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Insurance Waiver for Behavioral Health

In order to accommodate the needs and requests of our patients, we have enrolled in numerous insurance plans. While we are please to be able to provide this service, it is extremely difficult for us to keep track of the many individual requirements from each company, as each one has different stipulations regarding how, when, and where services may be performed.

It is the responsibility of the patient/policy holder to make sure your particular policy covers any services that you are being seen for.

In the event that your insurance company denies a service as Behavioral Health, since we are a Primary Care Office and are unable to file services under Behavioral Health, we will have no choice but to bill you directly and expect payment for all charges related to your visit.

I have read and understand the office policy stated above and agree to accept responsibility as described above.

Patient Name _____ Date of Birth _____

Signature of Patient/Guardian _____ Date _____

Behavioral Health Services could include any of the following:

ADD/ADHD

DEPRESSION

ANXIETY

OBESITY/WEIGHT MANAGEMENT

EATING DISORDER

INSOMNIA

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Payment Policy on Delinquent Insurance Claims

Per our contract with insurance companies, all claims should be paid within 30 days. Due to delinquent claims processing by insurance companies, especially self-funded and third-party plans, we will no longer be able to hold these claims after the 30 day period.

These unprocessed and unpaid claims will be turned over to the ***patient's responsibility***, which means the patient is responsible for any balances accrued with our office. The patient will have to follow-up with their insurance plan regarding reimbursement.

Your signature below signifies your understanding and willingness to comply with this policy.

_____	_____
Patient Name	Patient Date of Birth
_____	_____
Patient/Responsible Party Signature	Date

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PATIENT INFORMATION (Please Print) Today's Date ____/____/____

Last Name_____First Name_____M.I._____

Address_____
City State Zip

Home Phone_____Work Phone_____Cell Phone_____

Date of Birth ___/___/___ SS#_____ Marital Status _____ Sex Assigned at Birth_____ ☐ Decline to respond

Gender Identification ____ ☐ Decline to respond / Self-identification Pronoun (Circle) She / He / They ☐ Decline to respond

Email address:_____Can we contact you by email _____

Employer_____ Occupation_____

PARENT/GUARDIAN (for minors)

Last Name_____First Name_____M.I._____

Address_____

Home Phone _____Work Phone_____ Cell Phone_____

Date of Birth____/____/____ Sex_____ SS# _____

Employer_____

INSURANCE

Primary Insurance_____ Secondary Insurance_____

Policy Holder name: (if different from patient) _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Relationship of patient to the Insured _____

****In case of Emergency** _____ Phone _____ Relationship_____

I authorize the release of medical information to referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

****Patient/Responsible Party Signature** _____ **Date** ____/____/____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your overdue account balance of $100.00 or more must be turned over to collections, a $50.00 collection fee(or 35%, which-ever is greater) will be added to your Account, as well as you will be responsible for any and all attorney fees and court costs. If you have an overdue account balance that is less than $100.00, then an additional $50.00 late fee will be added to your account and must be paid in full prior to any further visits. Your signature below signifies your understanding and willingness to comply with this policy.

****Patient/Responsible Party Signature** _____ **Date** ____/____/____

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PHYSICIANS POINTE
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, _____ have been informed that a copy of PHYSICIANS
Patient's Name Date of Birth

POINTE Notice of Privacy Practices is available in the office. A copy will be furnished to me upon my request.

_____

Signature of patient Date

It is our policy not to leave confidential and/or unauthorized information on answering machines, work voicemail and/or cell phone voicemail. ***However with your permission we will leave a message for a normal test result.*** Whenever returning phone calls and the answering machine picks up, we will leave a message asking you to call our office back. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize PHYSICIANS POINTE to contact me at the following places:

Home telephone: Yes_____ No _____ Answering Machine: Yes_____ No _____

Cell phone/voice mail: Yes_____ No_____ Cell phone #_____

Work telephone: Yes_____ No_____ Work #: _____

E-Mail: yes_____ No_____ Email Address: _____

Please list names of people with whom we may discuss your medical care:

Name/Relation: _____ Phone # _____

Name/Relation: _____ Phone # _____

Name/Relation: _____ Phone # _____

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PATIENT'S SOCIAL HISTORY **Date: ___/___/___**

Name:_____ D.O.B _____

E-Mail Address:_____ OK to e-mail: Yes No

Ethnicity **(Circle One)** **Non**-Hispanic or Latino Hispanic or Latino: Specify _____ Decline to respond

Race **(Circle One)** White American Indian Asian African American Other Decline to respond

Primary Language: _____ Additional Languages: _____

Yes No- - - - -Current smoker Pack per day: _____ # Years smoked: _____ Start Date/Age: _____

Yes No- - - - -Former smoker Pack per day: _____ # Years smoked: _____ Quit Date/Year: _____
Yes No- - - - -Never smoked
Yes No- - - - -Alcohol use, IF YES, #of drinks _____ per day / week / month / year (circle one)
Yes No- - - - -Past drug use
Yes No- - - - -Lives alone, IF NO, then, lives with (spouse, family members, roommate, etc.): _____
Yes No- - - - -Exercise, IF YES, **circle one**: 1-2 times a week 2-3 times a week 4-5 times a week
Yes No- - - - -Have pain presence in day to day life, IF YES, overall pain score: **0 1 2 3 4 5 6 7 8 9 10**
Yes No- - - - -Have an Advance Care Plan IF YES, **circle** what applies:
Living Will **Medical Power of Attorney** **Advanced Directive Plan** **Decline to respond**
Yes No- - - - -Concerned with stable housing in the next 2 months
Yes No- - - - -Financial resources concerns (Circle what applies) Employement / Finances / Food / Insurance
Yes No- - - - -Transportation issues to appointments or necessary activities
Yes No- - - - -Require support in daily activities
Yes No- - - - -Feels isolated / without support

HAS THERE EVER BEEN A ***FAMILY HISTORY*** OF:

☐ Cancer of the breast Family member: _____

☐ Cancer of the colon Family member: _____

☐ Cancer of the ovaries Family member: _____

☐ Cancer of the prostate Family member: _____

☐ Cancer of the uterus Family member: _____

☐ Cancer, other unspecified Family member: _____

☐ Colon polyps Family member: _____

☐ Depression Family member: _____

Other family medical history not listed above: _____

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Name:_____ D.O.B _____

IN *YOUR* (THE PATIENT'S) **PAST MEDICAL HISTORY** HAS THERE BEEN

☐Yes ☐No- - - - -Cancer, if yes, please specify: _____

☐Yes ☐No- - - - -Colonoscopy, Month_____/_____Yr, Normal☐ Abnormal☐ Facility _____

☐Yes ☐No- - - - -Cologuard; Month_____/_____Yr, Normal☐ Abnormal☐
☐Yes ☐No- - - - -COPD
☐Yes ☐No- - - - -Depression
☐Yes ☐No- - - - -Diabetes, How many times a day do you check your blood sugar? _____

Date of diabetic Foot Exam: _____ Date of diabetic Eye Exam: _____

☐Yes ☐No- - - - -Heart attack
☐Yes ☐No- - - - -Heart disease (CAD)
☐Yes ☐No- - - - -Heart murmur
☐Yes ☐No- - - - -High blood pressure
☐Yes ☐No- - - - -High cholesterol
☐Yes ☐No- - - - -Mammography, Month _____/_____Yr, Normal☐Abnormal☐ Facility _____

☐Yes ☐No- - - - -PAP Smear, Month_____/_____Yr, Normal☐ Abnormal☐ Facility _____

☐Yes ☐No- - - - -Pneumonia Vaccine, Date/Year: _____
☐Yes ☐No- - - - -Prostate exam

☐Yes ☐No- - - - -Sexually transmitted disease, type: _____

☐Yes ☐No- - - - -LAST Bone Density: Month_____/_____Yr., Normal☐Abnormal☐Facility_____

☐Yes ☐No- - - - -Surgeries-Date/Year: _____

_____

☐Yes ☐No- - - - -ER Visit(s) in past year, Date(s)/Reason(s): _____

_____

Other past medical history not listed above: _____

_____

List Specialists/Other Doctors (ex. Cardiologist)/Reason for seeing that specialist: _____

_____

Vaccines:

- ☐ Flu Vaccine, Date _____
- ☐ Shingles (Zostavax) Vaccine, Date _____
- ☐ Tetanus Vaccine, Date _____
- ☐ Hepatitis B Vaccines, Date(s) _____

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Name:_____ D.O.B _____

WOMEN ONLY-Menstrual History

Age at onset _____

Regular? ☐Yes ☐No ☐Varies

Number of days of cycle _____

Flow: ☐Heavy ☐Medium ☐Light

Date of last period _____

Do you take birth control pills? ☐Yes ☐No

If so, how long have you taken them? _____

Have you had a hysterectomy? ☐Yes ☐No

If so, was it a **total** hysterectomy (no longer have cervix or uterus), a **partia**l hysterectomy (no uterus, still has cervix), or **radical** hysterectomy (no cervix, uterus, or upper part of vagina)? _____ Age/Date of hysterectomy_____

Have you had a trachelectomy (no cervix, still has uterus)? ☐Yes, Date_____ ☐No

Pregnancies:

How many children born alive _____

How many stillbirths _____

How many premature births _____

How many Cesarean Sections _____

How many miscarriages _____

Any complications with pregnancy? ☐Yes ☐No

If so, describe _____

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Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit:

ANY Allergies:

ANY medications INCLUDING over-the-counter:

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