St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

Welcome,

We are glad that you selected us to be your healthcare provider. You and your family are very important to us and we look forward to developing a positive and healthy relationship.

Our practice is made up of dedicated staff that will make every effort to see that all your healthcare needs are met as your primary care.

In this packet, you will find several forms. Please fill out each form and return them to the office by means of fax, email, mail or drop them back off. Dr. McKenzie will review your paperwork and have us call you for the next available appointment.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. McKenzie will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient. If we do make you an appointment to be established and you do not show up for this appointment, we will not reschedule your appointment and the paperwork will be shredded.

If you believe you are having a health emergency, contact 911 or go to your nearest emergency department.

Please arrive 15 minutes early to the given appointment time. These are the things you need to bring with you on your first visit:

- **All current insurance cards and a photo ID**
- **All medicine bottles of medication you take on a daily or as needed basis**

If you have any questions regarding the above information please do not hesitate to call. Our number is (706) 769-3362 and will gladly help in any way possible.

Sincerely,

Jana McKenzie MD
and Staff

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

Please Fill Out Completely:

Patient's Last Name	First Name	MI

Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other	Language

Address (Street, Route, Apt. No., etc.)	City	State	Zip Code

Home Phone	Cell Number	Cell phone carrier (ex. Verizon)

Email Address	Best way to contact (Circle one): Home Phone Cell Phone Email Letter

Employed by				
Business Phone	Employer's Address	City	State	Zip Code

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name	Address	City	State	Zip Code

Home Phone	Social Security	Date of Birth	Relationship to Patient

Employed by	Business Phone

Employer's Address	City	State	Zip Code

Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)	Daytime Phone

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.
Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____
_____

INSURANCE INFORMATION **(Please provide your insurance card(s) at the time of visit)**

Primary Health Insurance Company _____

Subscribers Name: _____ Date of Birth _____Relationship to Patient_____

Secondary Health Insurance Company _____

Subscribers Name: _____ Date of Birth _____Relationship to Patient_____

_____ _____
Patient or Guardian Signature Date

ST. MARY'S INTERNAL MEDICINE ASSOCIATES
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. 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.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

_____	_____
Patient Name (Print)	Patient Date of Birth
_____	_____
Patient or Guardian Signature	Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for St. Mary's Internal Medicine Associates owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

☐ The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.

☐ Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure: _____

_____

_____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

_____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

Consent For Disclosure to Family Member and/or Personal Representative for St. Mary's Internal Medicine Associates and St. Mary's Health Care System, Inc.

Patient Name _____
Address: _____
_____
Date of Birth: _____
SSN# _____
Telephone # _____

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

Authorization for Release of Medical Information

Patient: _____ Date of Birth: _____
(First) (Last)
I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

☐ Complete Health Record (or check for certain sections)

☐ ER Record	☐ Office Notes	☐ Echocardiogram Results
☐ History and Physical	☐ Most Recent Lab Work (BMP, CMP, Lipids, LFTs)	☐ Nuclear Stress Test Results
☐ Discharge Summary		☐ CT Scan Results
☐ Consultation Report	☐ EKG	☐ Carotid-Vascular Study Results
☐ Operative Report	☐ Chest X-Ray Report	☐ Other as Specified_____
☐ Nursing Documentation	☐ Exercise Stress Test Results _____	

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

_____ Date: _____/_____/_____
Patient Signature

_____ Date: _____/_____/_____
Printed Name of Legal Representative
If signed by Legal Representative please provide the following:
Relationship to patient: _____
Authority to sign on Behalf of the Patient: ☐ Custodial Parent ☐ Durable Power of Attorney for Healthcare
☐ Other, Please describe: _____

Records may be faxed and/or mailed to the fax number and the address provided above.

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that St. Mary's Internal Medicine Associates may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature (or legal guardian) Print Patients Name

_____ _____

Primary Pharmacy Name Pharmacy Street and City

_____ _____

Secondary Pharmacy if applicable Pharmacy Street and City

_____

Date

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

Dear Patient:

It has come to our attention that there is confusion concerning annual preventive care visits and/or annual Medicare wellness visits that occur on the same day as a follow-up office visit. Follow-up visits can be for your chronic medical problems and/or new problems or concerns that have arisen since your last appointment here in our office.

- Your annual wellness visit, and/or preventive care visit includes: a review of your overall health and recommended screening procedures (such as mammograms, colonoscopies and certain lab tests) and preventive measures (such as vaccinations) that may be beneficial in maintaining overall good health.
- The office visit includes: review of new and/or acute problems or concerns and chronic medical conditions such as hypertension and diabetes.

If you have a new medical problem that needs evaluation and requires your physician to order specific tests and/or medications, this must be billed as a separate office visit. If you have chronic medical conditions that require supervision and surveillance and ordering of specific tests and medications, this is not included in the wellness visit and must be billed as a separate office visit. **As a benefit to you, we offer you the option to have both of these visits done on the same day.** This will prevent you from having to schedule separate exams on separate days.
You can choose to do them on separate visits if you prefer. If you have a health concern, please inform your physician. They will let you know if it will be better to be addressed on the same day as the preventive visit.

If you have any questions concerning this, please ask to speak to the billing staff or the office manager.

I acknowledge receipt and understanding of this policy.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient or Guardian Signature Date

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

NAME: _____ **DOB:** _____

Pharmacy name:_____ Location:_____

CURRENT COMPLAINTS

Reason for visit: _____

_____

CURRENT AND PAST MEDICAL ILLNESSES

1)_____2)_____3)_____

4)_____5)_____6)_____

7)_____8)_____

PAST SURGERIES AND DATES

1)_____2)_____3)_____

PAST MEDICAL HISTORY

□Anxiety	□Heart Attack	□Polio	□Thyroid trouble	□Depression	□Hypertension
□Asthma	□Heart Murmur	□Stroke	□High Cholesterol	□Alcoholism	□Liver disease
□Cancer	□Lung Disease	□Parkinson's	□Rheumatic Fever	□Hepatitis	□Chronic pain
□Diabetes	□Ulcers/PUD	□Arthritis	□Claustrophobia	□Other _____	

CURRENT MEDICATIONS: (Attach a medication list if longer then this section please)

NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS PER DAY

MEDICATION ALLERGIES □No □Yes

If yes, please list:

Name	Reaction

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? □No □Yes

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of: (**Mother, Father, siblings, children, paternal/maternal grandparents)**

Which Family member?/Age Diagnosed/Deceased?

☐	Polio _____	☐	Liver Disease _____
☐	Thyroid Disease _____	☐	Cancer _____
☐	Depression _____	☐	Lung Disease _____
☐	Hypertension _____	☐	Parkinson's _____
☐	Asthma _____	☐	Hepatitis _____
☐	Heart Murmur _____	☐	Diabetes _____
☐	Stroke _____	☐	Ulcers/PUD _____
☐	High Cholesterol _____	☐	Arthritis _____
☐	Alcoholism _____	☐	Psychiatric illness _____

SOCIAL HISTORY

Marital Status: (Check one or more)

☐Single ☐Married ☐Divorced ☐Widowed ☐"Living together" ☐Separated

Number of children: _____ Ages: _____ _____ _____ _____ _____ _____

Do you smoke? ☐No ☐Yes How much? _____

Previous Smoker? ☐No ☐Yes When stopped? _____

Do you drink alcohol? ☐No ☐Yes How much? _____

Coffee, tea, cola beverages (cups/glasses/cans per day) _____

Do you use recreational drugs? ☐No ☐Yes What type/how often? _____

Are you currently employed? ☐No ☐Yes If yes, type of job _____

	Date		Date
Last Pap Smear	_____	Last Menstrual Period	_____
Mammogram	_____	Colonoscopy	_____
Breast Exam	_____	Prostate/Rectal Exam	_____
PSA	_____	Bone Density Scan	_____
Flu Vaccine	_____	Pneumonia Vaccine	_____
Tetanus Vaccine	_____		

St. Mary's Internal Medicine Associates
Dr. Jana McKenzie
2410 Hog Mountain Road, Suite 205
Watkinsville, GA 30677
Phone: (706) 769-3362 Fax: (706) 769-5675

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL
□Fever □Weight gain □Weight loss □Fatigue □Chills

□Weakness □Night sweats □ None of the above

DERMATOLOGIC
□Jaundice □Itching/rash □Lesions □Easy bruising □ None of the above

PULMONARY
□Wheezing □Shortness of breath □Chronic cough □Coughing up blood □ None of the above

HEAD/HEARING& VISION
□Trauma □Headaches □Tenderness □Dizziness □Double vision □Light sensitivity

□Glasses □Blurred vision □Changes/loss □Discharge □Rings around lights

□Ringing in ears □Blindness □ None of the above

CARDIOVASCULAR
□Chest pain □Leg swelling □Shortness of breath with exertion □Racing heart □ None of the above

GASTROINTESTINAL
□Nausea □Abdominal pain □Bloody stool □Constipation □Diarrhea

□Vomiting □Stool color changes □Heartburn □Incontinence of bowels □ None of the above

GENITOURINARY
□Blood in urine □Vaginal discharge □Pregnancy □Pain/burning on urination □Incontinence

□Venereal disease □Sexual problems □Painful menstruation

□Menopause □Urgency/frequency with urination □Irregular menstruation □ None of the above

MUSCULOSKELETAL
□Arthritis □Joint swelling □Trauma □ None of the above

NEUROLOGICAL
□ Loss of Sensation □ Seizures □ Numbness and Tingling □ None of the above

PSYCHOLOGICAL
□ Sadness □ Anxiety □ Depression □ None of the above

Specialist physician's you currently have:

1. Name_____ Specialty_____
2. Name_____ Specialty_____
3. Name_____ Specialty_____