Dear New Patient,

We would like to welcome you as a patient and to thank you for choosing Mercer Medicine—the multi-specialty physician practice of the Mercer University School of Medicine—for your health care needs.

We have prepared this packet of information and patient forms for you to help make your visit with us an informative and pleasant experience. **We ask that you please complete the attached paperwork and bring it with you to your scheduled appointment.**

In order to better serve you, please bring a list of all the medications you are currently taking, as well as your current insurance cards and driver’s license. If you do not have a valid driver’s license, please bring your state-issued identification card.

By completing the requested patient information prior to your visit, you will help us provide you with more efficient and timely care during your visit. If you have any questions while completing the attached paperwork, please call us at (478) 301-4111.

**Date/Time of Appointment:**  
______________________________________________

**Physician Name:**  
______________________________________________

**Appointment Location:**  
______________________________________________

Thank you for choosing Mercer Medicine as a partner in your health care and we look forward to serving you!

Sincerely,

The Staff of Mercer Medicine
PERSONAL INFORMATION

Patient Name: __________________________________________________________________________________

Street Address: ______________________________________________ City: _____________________________

State: __________  Zip: __________  Cell Phone: (_____) _______ - ________________

Date of Birth: ____/____/______     Sex: Male / Female     Social Security Number: _________________________

Married ___  Widowed ___ Divorced ___ Separated ___ Single ___

Spouse’s Name: _______________________________________ Date of Birth: _____/_____/_______

Social Security Number: _________________________________ Phone: (______) ______-_______________

Primary Care Physician: ____________________________________  Pharmacy: ____________________________

**Mercer Medicine has a contract with Solstas Lab Partners. Please inform us if your insurance requires you to use a specific lab.

**Health Insurance Provider In-Network Lab _________________________________________________________

EMPLOYMENT

Employer: _____________________________________________ Phone: (______) ________-_______________

Occupation: ___________________________________________________________________________________

Spouse’s Employer: _____________________________________ Phone: (______) ________-_______________

Occupation: ___________________________________________________________________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____________________________________________________________________________

Relationship to Patient: __________________________________________________________________________

Home Phone: (______) ________-_____________  Cell Phone: (______) ________-_____________

INSURANCE INFORMATION: Please present your insurance card and driver’s license on check-in.

Primary Insurance: ____________________________________ Member Name: _______________________

Member Number: ____________________________________ Group Number: _______________________

Primary Insurance Phone: (_____ ) ______ - __________

Secondary Insurance: ____________________________________ Member Name: _________________________

Member Number: ____________________________________ Group Number: _________________________

Secondary Insurance Phone: (_____ ) ______ - __________

______________________________________________   __________________________

Signature of Patient or Patient Representative     Date
Patient Name: ______________________________________ Date of Birth: _____/_____/_______

What is the reason for your visit today? ___________________________________________________________

PAST MEDICAL HISTORY: Circle all medical problems you have or have had.

Heart disease  Blood disease  Bruise easy  Colon polyps
High blood pressure  Cancer  Breast lumps or mass  Anemia
Lung disease  Heart attack  Discharge from the breast nipple  Depression
Arthritis  Kidney disease  Stroke  Diabetes
Ulcers  Dizziness  High cholesterol  Chest pain
Thyroid disease  Swelling in legs  Hernia  Hemorrhoids
Chronic cough  Heart failure  Kidney stones  Liver disease
Change in moles  Sinus problems  Slow healing sores  Varicose veins
Hearing loss  Eye disease  Glaucoma/cataracts  Positive TB test

Other: ______________________________________________________________________________________

Do you have any allergies to food/medications/environment?  Y / N

If yes, please list: ____________________________________________________________________________
_____________________________________________________________________________________________

MEDICATIONS: Please list all medications and doses. Include vitamins, herbs and over-the-counter medications.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PREVIOUS SURGERIES: List the types of surgeries and dates.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**FAMILY HISTORY:** Please list your family’s health problems.  [ ] I’m adopted

<table>
<thead>
<tr>
<th>Relatives</th>
<th>Age</th>
<th>Deceased Y / N</th>
<th>What is the medical history?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOCIAL HISTORY:**

Do you smoke cigarettes/pipe/cigar/chew tobacco or dip snuff? Y / N
How many per day? ___________
How much per day? ______________ Do you use street drugs? Y / N
How much? ______________
Do you exercise regularly? Y / N
What types of exercise do you do? ______________________________

**IMMUNIZATIONS:** Please list any recent vaccines you have had. (Example: flu shot)

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEN ONLY:**

Have you ever had undescended testicles? Y / N
Have you been circumcised? Y / N
Do you regularly exam your testicles for lumps or swelling? Y / N
Do you use contraception? Y / N
What type? ______________________________
Do you have a history of sexual abuse? Y / N
Do you now or have you in the past had any communicable diseases? (Example: syphilis, hepatitis B, HIV, gonorrhea) Y / N
If yes, please list: _______________________________________________________

**WOMEN ONLY:**

Date of your last menstrual cycle? ___________ Regular? ____ Irregular? ____
Age at onset of menses? _____
Date of your last pap smear? ___________ Pelvic exam? ___________ Self-breast exam? ___________
Date of your last mammogram? ___________ Any nipple discharge? Y / N
Do you use contraception? Y / N
What type? ______________________________
Have you ever been pregnant? Y / N
How many live births? ____ Miscarriages? ____
Do you have a history of sexual abuse? Y / N
Do you now or have you in the past had any communicable diseases? (Example: syphilis, hepatitis B, HIV, gonorrhea) Y / N
If yes, please list: _______________________________________________________

---

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: ___________________________________________ DOB: ___/___/_____

Address: ____________________________________________________________________

City: ___________________  State: _______  Zip: _____________

Phone: (_____) _________________________  SSN: __________________________________

I authorize the custodian of records of: ____________________________________________

_________________________ _______________________to disclose/release the following information.

Check all applicable:

____ Complete medical record
____ Lab/Pathology records
____ X-ray/Radiology records
____ Other (describe specifically):

These records are for services provided on the following date(s): __________________________

The purpose(s) for obtaining this information is __________________________________________

Initial if applicable:

_____ I specify that this authorization extends to cover release of information related to HIV/AIDS.

_____ I specify that this authorization extends to cover release of information related to Psychiatric and/or

_____ Drug and Alcohol abuse treatment information.

Please send the records listed above to the following address:

☐ 707 Pine Street
Macon, GA 31201

☐ 250 Martin Luther King Jr. Blvd.
Macon, GA 31201

☐ 1327 Stadium Drive
Macon, GA 31207

This authorization shall expire no later than: ____/____/_____ or upon the following event ___________________
(whichever is sooner), and may not be valid for greater than one year from the date of signature. You have a right
to revoke this authorization.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal
privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My
refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by
law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or
disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit,
limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________________________ _________________________________
Signature of patient (or patient’s personal representative)  Date

______________________________________________ _____________________________________________
Printed name of patient representative  Representative’s authority to sign for patient
(i.e. parent, guardian, power of attorney for healthcare, executor)
Patient Portal Consent

Mercer Medicine provides a patient portal web site (“Portal”) for the use of our established patients. Access to the Portal must be established during an office visit, at which time the patient or legal guardian will be required to fill out and sign this consent form. There are no fees for using the Portal.

Through the Patient Portal, you can:

- Review upcoming appointments
- Review contact information (address, phone number, etc.)
- View last visit summary(s) and/or download a copy of your personal medical history
- Review laboratory results

It is the patient’s responsibility to notify our office if there is a change of address, phone number, insurance information or email address. Please call your physician’s office if changes are needed.

**DO NOT USE THE PORTAL TO COMMUNICATE URGENT OR EMERGENCY MEDICAL ISSUES.**
Please contact your physician’s office or call 911.

By using this Portal you agree to protect your password from any unauthorized individuals. It is your responsibility to notify Mercer Medicine should your password be compromised. You agree to not hold Mercer Medicine responsible for any network infractions beyond our control.

You will receive a “A Welcome to the Portal” email from Mercer Medicine that will provide instructions on how to use the Portal, along with your Portal password.

Print Patient Name: ____________________________________________ Date of Birth: ____________

Your e-Mail Address: _______________________________________________________________________

(Please print clearly and differentiate between 7 and 1 and the number 0 and letter O)

Patient/Guardian Signature: __________________________________________________________________

Relationship to patient: ____________________________________________ Date: ________________
Patient E-Newsletter Consent

Mercer Medicine distributes a monthly health e-newsletter called Health Notes to our patients.

If you would like to receive this monthly health e-newsletter from Mercer Medicine, please provide your e-mail address below:

Print Patient Name: ________________________________________________________________

Your e-Mail Address: ________________________________________________________________
(Please print and differentiate between 7 and 1 and the number 0 and letter O)

Patient /Guardian Signature: _________________________________________________________

Relationship to patient: ___________________________ Date: ___________________________
<table>
<thead>
<tr>
<th>Section I</th>
<th>Acknowledgement of Mercer Medicine NPP Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding the Mercer Medicine Privacy Practices (NPP) and to request a copy, if desired.</td>
</tr>
<tr>
<td></td>
<td>_________ Initial</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section II</th>
<th>Central Georgia Health Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I, the patient, hereby accept or deny consent for my health information to be loaded in the Central Georgia Health Exchange, which has been established for continuity of care.</td>
</tr>
<tr>
<td></td>
<td>_________ Accept _________ Deny</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section III</th>
<th>Georgia Registry of Immunization Transactions &amp; Services (GRITS)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I, the patient, hereby accept or deny consent for my immunization data to be submitted to the Georgia Registry of Immunization Transactions and Services, which has been established to collect and maintain accurate, complete and current vaccination records to promote effective and cost-efficient disease prevention and control.</td>
</tr>
<tr>
<td></td>
<td>_________ Accept _________ Deny</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section IV</th>
<th>MEDICARE PATIENTS ONLY Georgia Physicians for Accountable Care (GPAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mercer Medicine is a participating member of the Georgia Physicians for Accountable Care Organization, a group of Georgia doctors and other health care providers who voluntarily work together to coordinate care for Medicare beneficiaries like yourself. Because your physician is a member of GPAC, Medicare may share your health information with other physicians who are participating members of GPAC in order to provide you with the highest quality of care. If you do not wish to share your health information as part of GPAC, please ask a Mercer Medicine front desk staff member for a form to opt out of this program.</td>
</tr>
<tr>
<td></td>
<td>_________ N/A _________ Accept _________ Deny</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section V</th>
<th>Healthcare Formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I, the patient, acknowledge that I am aware that Mercer Medicine could review my insurance provider’s prescription formulary in order to prevent potential adverse medication effects.</td>
</tr>
<tr>
<td></td>
<td>_________ Initial</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section VI</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To protect you and your privacy, your health information may be released by Mercer Medicine for research purposes only when you—the patient—give your permission.</td>
</tr>
<tr>
<td></td>
<td>_________ Accept _________ Deny</td>
</tr>
</tbody>
</table>
### Section VII  Access to Protected Health Information

The people listed below may access my health records if needed for medical decision making on my behalf:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section VIII  Financial Responsibility

- I understand that it is the patient’s responsibility to verify insurance benefits prior to the office visit even though Mercer Medicine will attempt to verify benefits on my behalf.
- I understand if a procedure is performed which is NOT covered by my insurance I will be responsible for the charge.
- I authorize the release of any medical or other information necessary to process claims and/or appeals.
- I authorize payment of Medical benefits to the providers of Mercer Medicine for services rendered.
- In the event that any of the above parties or companies fail to make prompt payment, I hereby give my PERSONAL GUARANTEE OF PAYMENT FOR ALL CHARGES INCURRED. I am also aware that in the event my account becomes delinquent, collection action may be taken.

### Section IX  Cancellation Policy

Please allow 24 hour notice for all cancellations. Failure to notify Mercer Medicine staff of a cancellation at least 24 hours in advance could result in your being charged $50 for that visit.

I have read the cancellation policy and understand that I may be charged for all appointments that I do not cancel within at least 24 hours in advance.

__________________________
Patient Signature

### Section X  Patient Acknowledgement that I have read and understand all information provided on this form.

__________________________
Patient Signature

__________________________
Employee Signature

__________________________
Date
Permission to share my medical information from The Corporation of Mercer University with my healthcare providers through the Central Georgia Health Exchange

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, The Corporation of Mercer University would like your permission to share your Health Information (as defined below) through the Central Georgia Health Exchange electronic medical record program (Health Exchange). You may already have authorized the sharing of your Health Information into the Health Exchange by signing a permission form when visiting the office of another doctor who participates in Central Georgia Health Network (CGHN). Due to differences in various computer systems, this specific authorization is required by law to release your Health Information to the Health Exchange. If you already have given your permission, then we will update your Health Exchange record with your Health Information from The Corporation of Mercer University. If you have NOT previously given permission, then the Health Information disclosed by The Corporation of Mercer University will NOT be used to update the Health Exchange, even if you check “Yes” below.

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 agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient ________________________________ Printed Name of Representative ________________________________

Signature of Patient or 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):

[Signature of Authorized Representative]

A signed copy of this permission will be provided to the patient/representative.

This authorization will allow The Corporation of Mercer University to disclose your Health 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 Health Information. The Health Exchange system will allow your providers access to your Health Information more quickly and accurately than with paper charts.

By signing this form, I authorize The Corporation of Mercer University to use and disclose my Health Information and to make such 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 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: 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 of 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 doctor’s office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange MSC 98, 777 Hemlock Street, Macon, GA 31201. 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 other providers (including The Medical Center of Central Georgia) through the Central Georgia Health Exchange.
Georgia Registry of Immunization Transactions and Services (GRITS)

Opt-In To Registry Form

Note: This Form is required to allow a person who has previously opted out of the registry to opt back in to the registry thereby allowing collection of immunization data on the person.

Name of Client: ___________________________ ___________________________ ___________________________

Last First Middle

Date of Birth: __________ Sex: __________________ Race: __________________

MM/DD/YYYY M/F or Unknown

Name of Parent or Guardian: ___________________________ ___________________________ ___________________________

Last First Middle

Relation: __________________ Telephone Number: __________________

Area Code Number

Street Address: ___________________________ ___________________________ ___________________________

City: ___________________________ State: __________________ ZIP: __________________

I request this person be reinstated into the Georgia Registry of Immunization Transactions and Services (GRITS). I understand this action will allow the state to add all immunization data on this person from participating physician offices to the registry as a result of this action. The registry will be the official source of immunization history for this person.

The Opt In form will be maintained at the Georgia Immunization Program's office where it is available for review in accordance with OCGA sec. 31-12-3.1 and Department of Human Resources, Division of Public Health, Immunization Program rules and regulations.

I understand immunization information may be added to the registry for this client until the Georgia Immunization Program receives a notification from the parent or legal guardian wishes to opt out of the registry. An Opt-Out Form is available from the service provider through the GRITS on line system. The Georgia Immunization Program must receive a completed Opt-Out Form signed by a responsible person prior to changing the status of the individual named above.

_________________________________________ ___________________________
Signature of Parent or Guardian Date

This form must be mailed to the following address. Action to add a person into the registry can occur only after receipt and processing of the signed form:

GRITS – OPT-IN
DHR – DPH – Immunization Program
2 Peachtree Street NW
13th Floor, Room 476
Atlanta, GA 30303-3142

FORM – GRITS007
Our Practice is participating in a Medicare Shared Savings Program Accountable Care Organization

Mercer Medicine Is Participating in a New Care Coordination Program in Medicare

What’s An Accountable Care Organization (ACO)?

- ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give you high quality service and care at the right time in the right setting.

- Your doctor has agreed to participate in a Medicare Shared Savings Program ACO and to work closely with other doctors and health care providers in the ACO to coordinate care for Medicare beneficiaries, like yourself, who have traditional Medicare.

- The ACO may share in any savings that result from providing you with high quality and more coordinated care.

ACOs Don’t Change Your Medicare Benefits

- An ACO is not a Medicare Advantage plan or an HMO plan.

- If you have traditional Medicare, you still have the right to see any doctor or hospital who accepts Medicare, at any time.

- Mercer Medicine may continue to recommend that you see particular doctors for your specific health needs, but it’s always your choice about what doctors you see or hospitals you visit.

How Will An ACO Help My Doctor Coordinate My Care?

- You benefit because your doctors will be part of a better coordinated team.

- You may not have to fill out as many medical forms that ask for the same information.

- Each of your doctors will not only know about the health issues they’ve treated, they will have a more complete picture of your health through talking with your other doctors.

Questions

If you have questions or concerns, you can talk with Mercer Medicine at any time. You can also visit www.medicare.gov/acos.html or call 1-800-MEDICARE (TTY users should call 1-877-486-2048).