The Jones Center for Diabetes and Endocrine Wellness

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John Sink, PA-C Leslie Harvill, PA-C Jenny Stanfield, NP-C Jennifer Sheldon, NP-C Marita Hockstedler, NP-C

Patient Name: ______________________________ DOB: ________________________

Office and Financial Polices

Welcome to The Jones Center. Our goal is to provide you with quality care by qualified Medical Physicians.
Below are a few policies to review and sign.

Laboratory Test and Ultrasound Results

In an effort to provide our patients with the highest quality of care, we require any test results you have done outside our office to be brought with you the day of your appointment. Your Primary Care Physician can also fax them to us prior to your appointment. If your Jones Center Provider does not have test results by the day of your appointment, your treatment may be delayed.

Initial here: _______________

Physician Assistants and Nurse Practitioners

I understand that The Jones Center employs Physician supervised Physician Assistants and Nurse Practitioners. I understand that by signing this form is giving my consent to be seen and evaluated by **John Sink, PA-C, Leslie Harvill, PA-C, Jenny Stanfield, NP-C, Jennifer Sheldon, NP-C and Marita Hockstedler, NP-C**. This does not mean that you will never see one of the M.D.'s, but it allows my care to be followed by the Doctor and Physician Assistant/Nurse Practitioner.

Initial here: _______________

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

**Initial here:* _______________

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

***Initial here:** __________________*

Referrals and Preauthorization's

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

***Initial here:** __________________*

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring $170 at the initial appointment. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

***Initial here:** __________________*

Missed Appointments

The Jones Center requires 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of ***$35.00***. Repeat cancellations and more than two consecutive no shows may result in limited medication refills and/or possible discharge from our practice.

***Initial here:** __________________*

Returned Checks

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

***Initial here:** ______________*

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

***Initial here:** ______________*

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Patient Name: ______________________ Initial: _______________ Date: ____________

The Jones Center HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (*Health Insurance Portability and Accountability Act of 1996*) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we mail any health information such as lab results to your home address? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If ***YES***, please name the members allowed:

____

____

This consent was signed by: ____
(**PRINT NAME PLEASE**)

Signature: ____ Date: ______________

Patient Registration Form

Last Name: __________________ First Name: ____________________ Middle Name: __________________

Gender: ____________ SSN#: ____________________ Marital Status: _______________ DOB: _______________

Race: ___________________ Ethnic Group: ____________________ Language: _____________________

Address: ____ Zip Code: ______________________

City: _________________ State: ________________ Phone: ______________________ Cell: _________________

Employer: ____ Position: _____________________________

Spouses Name: ____________________________________ Spouses SSN#: ______________________

Spouses DOB: _________________ Spouses Employer: ____

Emergency Contact: _____________________ Phone: _____________________ Relationship: ________________

Insurance Information

Primary Insurance: ____________________________ Address: ____

ID#: _____________________ Group#: _____________________________ Subscriber: ________________________

Relationship: ____________________________

Secondary Insurance: _________________________ Address: ____

ID#: _____________________ Group#: _____________________________ Subscriber: ________________________

Relationship: ____________________________

Personal Medical History

In the past have you ever been diagnosed with?

- [ ] Diabetes
- [ ] Heart Disease
- [ ] Kidney Disease
- [ ] High Blood Pressure
- [ ] Asthma
- [ ] Liver Disease
- [ ] Arthritis
- [ ] Thyroid Disease
- [ ] Cancer
- [ ] High Cholesterol
- [ ] Lung Disease
- [ ] Other

List:

Please list all surgeries and year performed:

Surgery: ______________________________ Doctor: ____________________ Year: ____________

Surgery: ______________________________ Doctor: ____________________ Year: ____________

Surgery: ______________________________ Doctor: ____________________ Year: ____________

Surgery: ______________________________ Doctor: ____________________ Year: ____________

Surgery: ______________________________ Doctor: ____________________ Year: ____________

Please list any allergies to medications, food or insects...

Allergy: __________________________________ Allergy: ________________________________

Allergy: __________________________________ Allergy: ________________________________

Allergy: __________________________________ Allergy: ________________________________

Allergy: __________________________________ Allergy: ________________________________

Allergy: __________________________________ Allergy: ________________________________

What pharmacy do you use with the telephone number?

Pharmacy: ____ Phone#: _______________________

Please list all of your physicians and what you've seen them for:

Physician or Practice: ________________________________ Specialty: ______________________

Physician or Practice: ________________________________ Specialty: ______________________

Physician or Practice: ________________________________ Specialty: ______________________

Physician or Practice: ________________________________ Specialty: ______________________

Physician or Practice: ________________________________ Specialty: ______________________

Physician or Practice: ________________________________ Specialty: ______________________

Do you currently or in the past have you used Tobacco or Alcohol?

☐ Cigarettes ☐ Currently ☐ Past Packs per day? ___________________

☐ Alcohol ☐ Social ☐ Regular use ☐ Rarely How much? __________________________

Employment?

Place of Employment: ____

☐ Retired ☐ Disabled ☐ Homemaker ☐ Student ☐ Other: ___________________________

Do you have Children?

☐ Yes ☐ No If yes, how many? ___________________

Name: _________________________ ☐ Male ☐ Female ☐ Living ☐ Deceased

Name: _________________________ ☐ Male ☐ Female ☐ Living ☐ Deceased

Name: _________________________ ☐ Male ☐ Female ☐ Living ☐ Deceased

Name: _________________________ ☐ Male ☐ Female ☐ Living ☐ Deceased

Family Medical History:

Family Member	*Cancer*	*Diabetes*	*Heart Condition*	*Lung Disease*	*Stroke*	*Other*	*Cause of Death*	*Age at Death*
Father								
Mother								
Siblings								
Children								

Medication Log:

Medication	Dosage	Quantity	Frequency				

Permission to share my medical information from Thomas C. Jones, MD PC 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, Thomas C. Jones, MD PC 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 Central Georgia Health System. **If you have NOT previously given permission, then the Health Information disclosed by Thomas C. Jones, MD PC 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 wish to participate in the Central Georgia Health Exchange electronic medical record at this time**

_____________________ _______________ ________________________________

Printed Name of Patient *Patient Date of Birth* *Printed Name of Representative*

_______________________________________ _______________________

Signature of Patient or Representative *Date Signed*

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):

____

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

This authorization will allow Thomas C. Jones, MD PC 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 provider's access to your Health Information more quickly and accurately than with paper charts.

By signing this form, I authorize Thomas C. Jones, MD PC 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 re 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*.

The Thomas C. Jones CENTER for Diabetes & Endocrine Wellness

Patient Portal - Informed Consent

Purpose of this Form

The Jones Center for Diabetes and Endocrine Wellness offers secure, HIPAA compliant viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

How the secure Patient Portal works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site.

How to participate in our Patient Portal

You can pick up secure messages or view information sent to you through a website. Once this form is agreed to and signed, we will provide you a user name and password with instructions that tell you how to register for the first time. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record (**NOT LAB RESULTS**). You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can view more clinic specific information or access the Patient Portal through our clinic web page at www.thejonescenter.com

Protecting your private health information and risks

This encrypted method of communication prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up your secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. If you are unable to, please call so we may de-activate your account. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including email addresses.

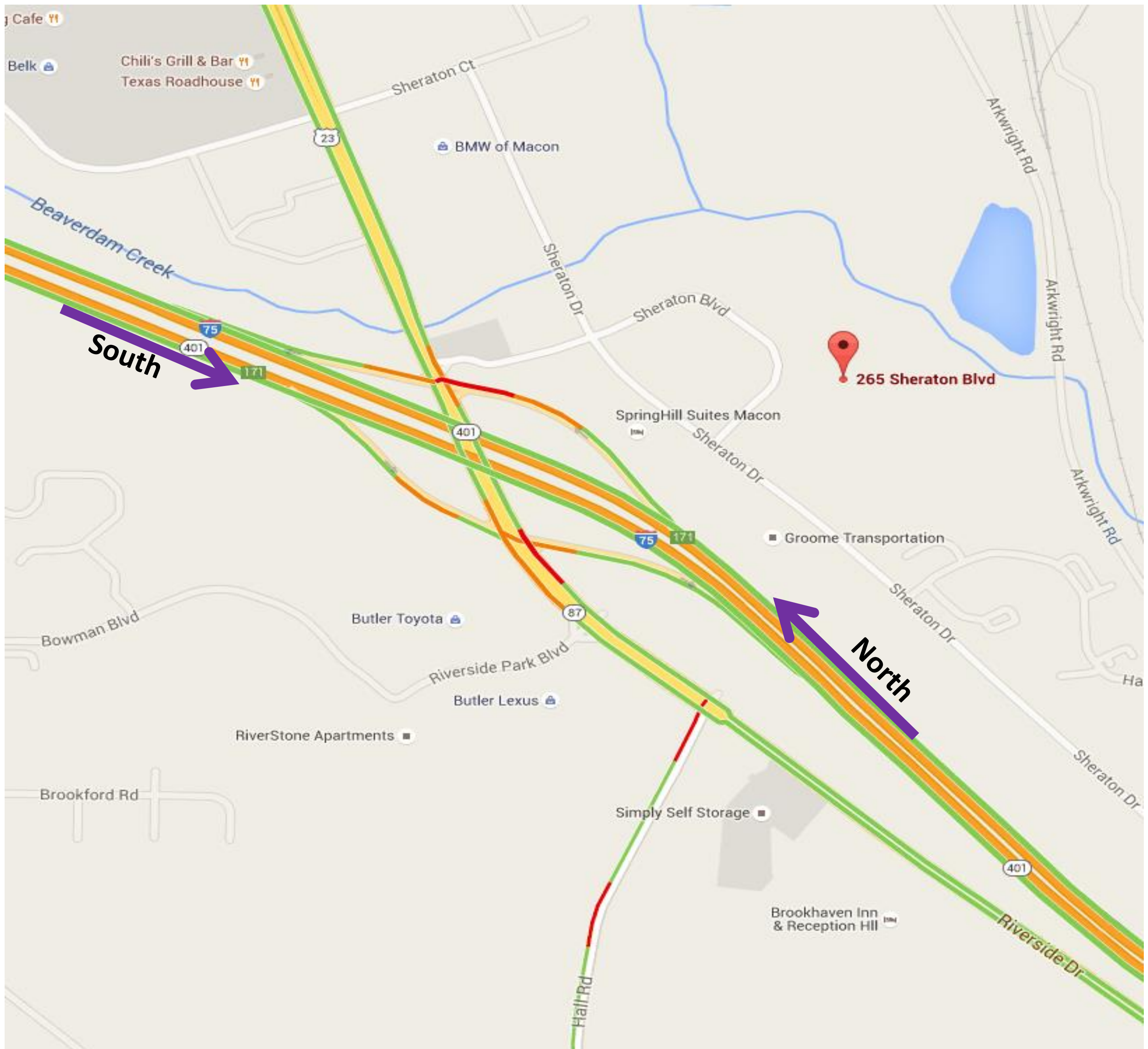
Conditions of participating in the patient portal

Access to the secure web portal is an optional but highly recommended service. We reserve the right to suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold The Jones Center for Diabetes and Endocrine Wellness or any of its staff liable for network infractions beyond their control.

☐ I ACCEPT Patient Portal. ☐ I Decline Patient Portal at this time

Print Name ____________________________ Patient email _______________________________

DOB ______________ Patient Signature ___________________________ Date _______________



Traveling I75 North:

I75 North to Exit 171

Take right off the exit onto Riverside Dr. / 87 and take an immediate right onto Sheraton Blvd.

Follow Sheraton Blvd. and The Jones Center will be on your left

Traveling I75 South:

I75 South to Exit 171

Take left off the exit onto Riverside Dr. / 87 and then turn right onto Sheraton Blvd.

Follow Sheraton Blvd. and The Jones Center will be on your left.