NGOC
NORTHWEST GEORGIA ONCOLOGY CENTERS

TANNER HEALTH SYSTEM
A Service of Tanner Medical Center - Villa Rica

Patient Registration Form

You have been scheduled with Tanner Health Systems. This Patient Registration Form is needed by your physician at the time of your visit. Your physician will need a complete list of medications you are taking, any allergies you may have and other medical history which could have an impact on your healthcare treatment. Complete this form as accurately as possible and bring with you to your appointment. This information will assist us in obtaining a complete picture of medical, surgical and social history.

Your visit will be more efficient if the information is completed before your scheduled appointment and will help you and your physician make the best healthcare decision possible. Also we request that you bring your Insurance / Pharmacy Cards and a Picture ID.

Thank you,
Tanner Health Systems

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TANNER MEDICAL GROUP REGISTRATION: As a member of Tanner Medical Group, we are committed to providing the best and most comprehensive healthcare possible. We encourage you to ask questions.

PATIENT INFORMATION

Patient Last Name | Patient First Name | Alias

Date of Birth | Social Security Number | Gender (M F Other) | Race (Choose One)

Street Address | City | State | Zip Code

Primary Care Provider | Preferred Pharmacy

Primary Language | Interpreter? (Y N)

Email Address | Employer

Home Telephone | Work Telephone | Mobile Number | Preferred Communication (Call Text Email)

Marital Status (Choose One)

RESPONSIBLE PARTY / GUARANTOR

Guarantor Last Name | First Name | Guarantor Date of Birth | Phone

Guarantor Address | Social Security | Relationship (Choose One)

OTHER / EMERGENCY CONTACT INFORMATION

Name | Relationship (Choose One) | Phone

INSURANCE INFORMATION

Primary Insurance Company | Policy Holder Last Name | Policy Holder First Name

Relationship to Patient | Social Security Number | Date of Birth | Policy Number | Group Number

Secondary Insurance Company | Policy Holder Last Name | Policy Holder First Name

Relationship to Patient | Social Security Number | Date of Birth | Policy Number | Group Number

PATIENT AUTHORIZATION AND CONSENT TO TREATMENT

A. Consent to Treat: I consent and/or authorize the employees and agents of Tanner Medical Center, Inc. and affiliates of Tanner Health System (TMC) to perform such diagnostic or screening examinations, tests, procedures, or services and to provide any medications, care, treatment, services or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries as ordered by the treating physician(s).

I also consent to the transportation of the patient (by air or ground) to and from other facilities for such services.
I understand that the treating physician(s) is responsible for informing and explaining to me the nature of my individual condition , the risks and alternatives to the proposed course of treatment, and the possible results of the care, treatment, or services among other things. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees as to any results have been or will be made.

I understand that I retain the right to refuse any particular examination, test procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I understand that TMC will request recent pharmacy history.

I understand that TMC participates in a secure Health Information Exchange (HIE). The HIE supports integrated system patient care initiative by allowing physicians and healthcare providers to share and access patients' health information through an HIE for treatment, payment, and health care operations purposes. I understand that I have a right to opt out of having my information available in the HIE by signing an OPT-Out form.

I understand that as part of the HIE, I have the right to elect to participate in MYTanner Patient Portal to obtain secure access to my personal patient information.

B. TMC healthcare education: At times, care, examination, treatment and service may be delivered by students under the supervision of the attending physician or authorized THS personnel. Students wilt never have primary responsibility for your care; there will always be fully licensed healthcare professionals supervising the students, and available to assist with your care, treatment and service. I consent that these students may be present during my care and treatment, and I further consent that they may perform such examinations, tests, treatment and care as their supervisor directs.

C. Information Privacy: I am automatically included in the Patient Directory and Clergy List which allows TMC to relay my location and general condition if asked for by name, and my religious affiliation to clergy without asking by name. If I do not want to be included in these lists, I will so designate. If I opt out of tile Patient list, I understand that if family members, my clergy, neighbors, or friends inquire about me while I am a patient, my presence here will not be disclosed, and that mail or flowers addressed to me will be returned.

D. Consent to Release Medical Records Information to Patient's Insurance Com an and Other Health Care Providers: Insurance companies, Medicare, Medicaid , Champus, or other health care providers, home health agencies, nursing homes, rehabilitation centers, etc.) may request that TMC provide the patient's admitting diagnosis or other medical information to verify eligibility for payment, to process payment, to ensure appropriate discharge planning needs are met and to provide for continuity of care. I authorize TMC and the patient's physician (s) to release any information acquired in the course of examination and treatment for the purposes stated in th1s paragraph. I understand that Information concerning alcohol, substance abuse, mental health, HIV, AIDS or sexually transmitted diseases may be released. Unless revoked, this consent is valid until the claim is paid.

E. TMC is not a participating provider for all HMO, PPO, POS or independent insurance companies: I understand the TMC facility may be out-of-network or ineligible or payment from the patient's Insurance carrier. The patient or responsible party accepts responsibility for being knowledgeable about the insurance information presented and will notify the patient's insurance company the patient sought treatment at the TMC facility. The fact that TMC Is not a participating provider with the patient's Insurance company does not waive the patient liability for payment for services rendered.

PATIENT AUTHORIZATION AND CONSENT TO TREATMENT continued

F. Guaranty of Payments to TMC: I hereby guarantee payment of all charges to the patient in connection with the patient's hospitalization, care, treatment or services, in accordance any with extension TMC's standard rates and terms of payment. I am aware that I am not released of any liability by any extension of time granted me for the payment of these charges. I also waive homestead and all other exemptions. Payment for services is due at the time of service or at such time agreed upon by TMC in writing. I also agree to pay all expenses incurred or owed collection by TMC in collecting this account, including but not limited to fifteen percent (15%) attorney's fees and collection agency fees of up to fifty percent (50%), in the event this account is not paid as stated above. I hereby authorize the hospital to apply credit balances to reduce other outstanding accounts with the hospital which I am responsible before refund of any remaining balance.

G. Authorization for Insurance Company to Pay TMC and the Physician Directly: I authorize payment directly from the patient's insurance company to TMC and physician(s) who provide goods or services to the patient. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying payment under the Social Security Act is complete and correct and request that payment or authorized benefits is made on the patient's behalf. I authorize TMC to act as attorney-in-fact to collect and endorse payment checks from any payment source. In the event of an Insurance company request for administrative review or denial of any services obtained, I authorize TMC to appeal on my behalf.

H. Privacy Notification: I acknowledge that I have received a copy of the Notice of Privacy Practices for TMC. In receiving this notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

L. Leaving the Hospital Building: Leaving the hospital building (unless to a designated smoking area) while a patient Tanner Medical Center, Inc. is prohibited. If I choose to leave the hospital building, I understand it will be documented in my medical record and that it may affect insurance reimbursement. In addition, if I choose to leave the hospital building, I and my next of kin/family members, absolve Tanner Medical Center, Inc., my physician and any other persons caring for me from any present or future liability related to leaving the hospital building prior to receiving a physician's discharge order.

J. Photography, Video, Digital, and Other Images: I understand that my photograph or that of my child or ward, may be taken while receiving treatment at the hospital for the following purposes: care, treatment, education, patient safety, and as a measure to prevent identity theft.

K. Responsibilities for valuables: TMC is not responsible for valuables, money, personal or other possessions, which are not deposited with TMC at the time of admission. TMC assumes no responsibility for the safety of dentures, eyeglasses or other personal property, documents, cash or other valuables. TMC reserves the right to dispose of checked personal effects if they are not claimed within one (1) month after discharge.

L. Communication: By signing this form, I expressly consent and authorize TMC and its affiliates and agents, including any collection agency or debt collector hired by TMC to communicate with me for any reason, including, but not limited to, past and future medical services, collection of amounts owed for said services, and marketing. This communication may be made using an automatic telephone system or an artificial or prerecorded voice at the telephone number(s) I provided to TMC and also any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service or other radio common carrier service, or any service for which I am charged for the call. In addition, I further expressly consent and authorize TMC to communicate with me at any phone number or email address or other unique electronic identifier or mode that I provided to TMC at any time, or any phone number or email address or other unique electronic identifier or mode Tanner finds or obtains on its own which is not provided by me.

M. Medicare Inpatients and Observation Patients: acknowledge that they have received a copy of "An Important Message from Medicare" and "An Important Notice to Medicare Patients." I understand that I am responsible for any deductibles, co-payments, self administered drugs, and/or non-covered outpatient services as defined by Medicare.

N. Credit Reporting: Our institution operates in accordance with all in this provisions of the Fair Credit Reporting Act and all relevant local, state, and federal laws. Information acquired in this process may be used to verify specific demographic information, and provide specific financial data useful in helping some of our patients become eligible for our financial assistance programs. Credit reports and all other 3rd party data may be accessed only for valid, work related purposes.

PATIENT AUTHORIZATION AND CONSENT TO TREATMENT continued

O. Disclosure: I understand there are circumstances under which information about the patient must be disclosed or reported. Such circumstances may include requirements for disclosure of information to law enforcement agencies, and cases of HIV tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention.

P. Smoking: All Tanner Medical Center, Inc. facilities are non-smoking facilities. If I choose to smoke while hospitalized, I agree to smoke only in the designated smoking areas. I hereby absolve Tanner Medical Center, Inc., my physician and any other persons caring for me from any present and future liability caused by smoking and/or going to/from the designated smoking areas while a patient in the hospital. I understand the risks of smoking to my health, and also understand the benefits of not smoking.

Q. Acknowledgment of Physician /Hospital Relationship: Some or all of the health care professionals performing services in This hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions, and TMC, its affiliates, subsidiaries and this hospital ("TMC") shall not be liable for the acts or omissions of any such independent contractors. _____ (Initial)

R. Complaints: In order to resolve issues promptly, patients and/or their representatives are encouraged to express concerns to TMC staff as soon as possible after the occurrence. Patients are encouraged to report patient safety or quality of care concerns to Risk Management at (770) 836-9842. If the concern cannot be resolved at this level, patients may contact the hospitals accrediting body, The Joint Commission.

Mail to:
The Joint Commission Office of Quality Monitoring
One Renaissance Blvd. Oakbrook Terrace, IL 6018
Phone:(800) 994-6610 Fax: (630) 792-5636

Georgia Department of Human Resources Health)
Office of Regulatory Services
2 Peachtree Street, NE
Atlanta, GA 30309

404-657-5700- 1-800-326-0291 (Home)
1-800-633-4227 (1-800-MEDICARE)

Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
(871) 696-6775

Regional IV, Office for Civil Rights
U.S. Department of Health ana Human Services
Atlanta Federal Center, Suite 3B70,
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Voice phone 404-562-7886
Fax 404-562-7881
TDD 404-331-2867

Patient desires: ○ not to be included in the Patient Directory (initial) _____

○ not to be included in the Patient Directory (initial) _____

Patient / Responsible Party	Date
Responsible Party (if different from patient)	Date
Witness	Date

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NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth | Today's Date

Referring Physician | Other Physicians you see: | Other Physicians you see:

Reason for visit:

		Diagnosis Year			Diagnosis Year
High Blood Pressure	Y N		Kidney Problem	Y N	
Bypass/Valve Replacement	Y N		Stomach Problem	Y N	
Pacemaker or Defibrillator	Y N		HIV	Y N	
Congestive Heart Failure	Y N		Hepatitis	Y N	
Heart Attack / Rhythm Problem	Y N		Osteoporosis	Y N	
Thyroid Problem	Y N		Seizures	Y N	
Diabetes	Y N		Blood Clots	Y N	
Asthma or COPD	Y N		Prior history of Cancer	Y N	
Gout	Y N		Depression	Y N	

Other illness not listed above:

Prior Surgeries:

		Year			Year			Year
Gallbladder	Y		Spleen	Y		Colon	Y	
Uterus	Y		Lumpectomy	Y		Joint Replacement	Y	
Ovaries (one)	Y		Mastectomy	Y		Prostate	Y	
Ovaries (both)	Y		Stomach Bypass	Y				

Health Maintenance: Fill in all that apply.

		Date			Date
Colonoscopy	Y		Prostate Exam	Y	
Mammogram	Y		Pap Smear	Y	

Gynecologic History: Fill in all that apply.

First menstrual period age? Age | Last menstrual period (menopause) age? Age | Number of pregnancies?

Birth control pills Y N | Hormone replacement therapy? Y N

continue >

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NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth

Social History:

Tobacco Use Y Please explain below N No and have never

		Packs per day / How often?	Years of use?			Packs per day / How ofen?	Years of use?
Cigarettes	Y N			Cigar	Y N		
Pipe	Y N			Chewing Tobacco	Y N		

Do you drink alcohol Y N ☐ Occasionally ☐ Daily ☐ Beer / Wine ☐ Hard Liquor

Choose One
Marital Status

Occupation:

Family History:	Alive	Age	List Illnesses or Cause of Death
Mother	Y N		
Father	Y N		
Siblings (brother/sister)	Y N		
Other	Y N		

Are you allergic to any medications? Y N

Please List:

Medications: List all medicines and supplements you take:

Medication	Start Date	Dose	How often?	Reason

continue >

Patient Registration Form

Are you allergic to CT dye? ○ Y ○ N

Are you diabetic? ○ Y ○ N

If diabetic, are you taking medication? ○ Y ○ N

Do you have any metal implants? ○ Y ○ N

If yes, where are they located?

Do you have a personal or family history of:

Kidney Disease	○ Y ○ N	○ Personal and/or	○ Family
Kidney Failure	○ Y ○ N	○ Personal and/or	○ Family
Kidney Transplant	○ Y ○ N	○ Personal and/or	○ Family
Other Transplants	○ Y ○ N	○ Personal and/or	○ Family
None of the Above	○ Y ○ N	○ Personal and/or	○ Family

Patient Registration Form

MEDICATION LOG

Use this form to keep a record of all prescribed medications. Talk to your provider or your pharmacist if you have any questions regarding your medications or if you're experiencing unexpected complications or side effects.

- If medication or treatment prescribed by your physician doesn't seem to help the problem, please let your provider know.
- Please check your medications at the beginning of each week to make sure you will have enough until your next visit.
- Please allow a 24hour notice for prescription refills.
- Pain medications require a written prescription from your physician and cannot be refilled on weekends or after office hours

PATIENT INFORMATION

Patient Last Name | Patient First Name | Date of Birth

Date form completed:

1

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

2

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

MEDICATION LOG

3

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

4

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

5

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

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PRESCRIPTION DRUG MONITORING PROGRAM

Beginning July 1, 2018, the state of Georgia has mandated that all providers utilize the Prescription Drug Monitoring Program that tracks prescription drugs to identify and address inappropriate or unsafe patterns of controlled drug use. For your safety, NGOC will access the Georgia Prescription Drug Monitoring Program (PDMP) as required by law to monitor when you fill controlled substance prescriptions.

The providers and staff at NGOC are committed to make prescriptions safer and to provide you with the treatment you need to reduce side effects. In an effort to safeguard your controlled substance prescriptions, please provide the name and contact information of any caregiver who can request controlled substance prescriptions on your behalf;

Patient Name	Patient Relationship	Phone Number
Patient Name	Patient Relationship	Phone Number

I agree to the following:

- **I will communicate with my provider about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve the pain.**
- **I am responsible for my medicines. I will not share, sell, or trade my medicine.**
- **I will not increase my medicine until I speak with my doctor or nurse.**
- **I will safeguard my medications from loss, theft, or unintentional use by others.**
- **My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.**
- **I will keep all appointments set up by my doctor.**
- **Refills of my controlled substance medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.**

My signature below indicates that:

I understand that my provider will be monitoring my receipt of controlled substance prescriptions through the Georgia Prescription Drug Monitoring Program as required by law throughout my treatment period.

Signature / Date: (date authorization signed by Patient or Legal Guardian / Personal Representative)	Date

Print Patient Name or Name of Legal Guardian / Personal Representative	Signature of Patient or Legal Guardian / Personal Representative