GEORGIA ARRHYTHMIA CONSULTANTS

☐ Dr Sogade	☐ Kathy NP-C		
☐ Dr Poku	☐ Dr Williams	Patient: _____	DOB: _____
☐ Dr Haithcock	☐ Amy NP-C	Date: _____	Location: _____
☐ Bridget NP-C	☐ Dr.Mezu-Chukwu		

New Patient - Non Mcr Patient		
X	E&M	Office Consult
	99241	Straightforward
	99242	Expanded
	99243	Detailed
	99244	Comprehensive
	99245	Comp Complete
X	CPT	Office Diagnostics
	93000	EKG
	93000A	AICD EKG
	93015	Stress Test
	99024	Post Op Visit
	93272	Event Monitor (MD Review)
	93270	Event Monitor (Hook Up)
	93224	24 Hour Holter MD Review
	93231	24 Hour Holter Connection
	93268	Event Monitor (Global)
	93290	ICM OptiVol
	93306	Echo Cardio
	93320	Echo
	93325	Color Add On
X	CPT	Pacemakers
	93279	Programming Single
	93280	Programming Dual
	93281	Programming Multiple
	93288	Interrogation All
	93293	Transtelephone
X	CPT	AICD
	93282	Programming Single
	93283	Programming Dual
	93284	Programming Multiple
	93289	Interrogation All
	CPT	LOOP Analysis
	93285	Loop Programming MD
	93291	Loop Interrogation MD
X	CPT	Remote Monitoring
	93294	Interrogation PPM MD
	93295	Interrogation ICD MD
	93296	Interrogation PPM/ICD Tech
	93297	ICM OptiVol MD
	93298	Loop Interrogation MD
	93299	Loop Inter/ICM OptiVol Tech
X	CPT	Laboratory
	85610-QW	PT-INR
	36416	Capillary Blood Draw
X	CPT	Office Procedures
	93660	Head Up Tilt

NEW PATIENT			ESTABLISHED PATIENT		
X	E&M	Office Visit	X	E&M	Office Visit
	99201	Straightforward		99211	Nurse Visit
	99202	Expanded		99212	Straightforward
	99203	Detailed		99213	Expanded
	99204	Comprehensive		99214	Detailed
	99205	Comp Complete		99215	Comprehensive

VITALS HT WT

BP HR RR

CHIEF COMPLAINT

HPI

Dx

Physical Exam

EKG

Plan

Provider Signature

Georgia Arrhythmia Consultants
639 HEMLOCK ST. SUITE #100
MACON, GA 31201

REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Email Address:			Race (Circle one) American Indian/Alaska Native / Asian /Hawaiian / Black or African American / White / Hispanic / Other
Pharmacy Name and Location			
Birth Date:	Sex (check one) ☐ F ☐M		Social Security Number:
Street address:		Cell phone : ( )	Home phone ( )
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:		Employer phone ( )
Spouse Name:	Spouse DOB:		Spouse SSN:
Primary MD	Cardiologist		Permission to obtain records(circle one) YES NO

HEALTH INFORMATION DISCLOSURE:

Name/Relation1._____/_____2._____/_____

3._____/_____4._____/_____

INSURANCE INFORMATION

(Please give your insurance card (s) to the receptionist

Name of Primary Insurance:			Subscriber's S.S. no. (if different from patient):
Subscriber's name (if different from patient):			Birth Date:
Group no.:	Policy no.:		
Patient's relationship to subscriber: ☐ Child	☐ Self	☐ Spouse	☐ Other
Name of secondary insurance (if applicable):			Subscriber's S.S. no. (if different from patient)
Subscriber's name (if different from patient):	Birth Date:		Patient's relationship to subscriber(circle one) Self Spouse Child Other
Group no.:	Policy no.:		
OTHER INSURANCE:	Policy no.:		Group no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone	Work phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Macon Electrophysiology Associates or insurance company to release any information required to process my claims.

Patient/Guardian Signature:	***Date:***

Georgia Arrhythmia Consultants and Research Institute

Name_____ Date of Birth _____

Reason for today's visit:_____

How long have you had this problem:_____

LIST ALL DRUG and FOOD ALLERGIES:_____

Please list ALL of your current medications:

Please indicate if you have (or had) any of the following medical problems by placing an "X" next to the problem.

Heart disease		Previous Stroke		Diabetes		Lung Problems	
High Blood Pressure		Digestive Problems		Seasonal Allergies		Kidney Problems	
Seizures		Hepatitis		Arthritis		Depression	
Cancer		Thyroid Problems		Asthma		Tuberculosis	

If you have ever had surgery, please list the year and type of surgery

Year	Surgery

Have you or anyone in your family ever had a reaction to anesthesia? Yes____ No____
If YES please describe what happened:_____

Please Indicate if anyone in your family has any of the following health problems:

Heart Disease		High Blood Pressure		Diabetes		Sudden Cardiac Arrest	
Stroke		Cancer		Seizures			

Have you ever smoked cigarettes or used tobacco? Yes____ No____
If YES, do you still use tobacco products? Yes____ No____
If YES, how much/how often do you use these products?_____

Do you drink alcohol? Yes___ No___ If YES, how would you describe your drinking?
Social_____ Moderate_____ Heavy_____

Do you now or have you ever used illegal drugs? Yes____ No____
If YES, please describe your drug use:_____

Have you had a recent; Stress test_____ Ultrasound of heart_____
Worn a heart monitor_____ Heart Cath_____

Georgia Arrhythmia Consultants
FELIX O. SOGADE, M.D., F.A.C.C., FHRS
JOSEPH W. POKU, M.D., F.A.C.C.
DANIEL B. HAITHCOCK, M.D.
ERIC S. WILLIAMS, M.D.
URE MEZU-CHUKWU, M.D.
KATHY S. FRAZIER, NP-C
BRIDGET J. LEARY, NP-C
AMY GROOVER, NP-C
Board Certified in Internal Medicine, Cardiovascular Diseases, & Clinical Cardiac Electrophysiology
639 Hemlock Street, Su
Macon, Georgia
Telephone: (478) 75
Fax: (478) 75

TO: _____
PHYSICAN'S NAME

_____
ADDRESS

_____
CITY STATE ZIP

I hereby request that my medical records be released to:

_____

Patient's Name: _____
First Middle Last

Patient's Date of Birth: _____

Patient's Authorized Signature: _____

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639 Hemlock Street, Suite 100
Macon, Georgia 31201
Telephone: (478) 755-1560
Fax: (478) 755-1562

PATIENT NAME _____

CONSENT FOR MEDICAL TREATMENT

The Undersigned hereby authorizes Georgia Arrhythmia Consultants to furnish the necessary treatments: laboratory tests, drugs and supplies as may be ordered by the Physician in charge to the above named patient. I acknowledge that no guarantee or assurance has been made to me as the result of treatment or examinations in the Physician's office.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization is hereby granted to Georgia Arrhythmia Consultants and treating Healthcare Professionals to release to my insurance company or companies, their agents, or other third party payors, confidential information (including copies of records) as may be requested or necessary for the completion of claim processing relative to my office visits.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned, and if more than one, jointly and severally, hereby authorize payment directly to Georgia Arrhythmia Consultants of the insurance benefits otherwise payable to him/her or due to become payable to him/her, but not to exceed the balance due of the charges. I understand and agree that I am financially responsible for any charges not covered by the assignment of insurance benefits. I authorize Georgia Arrhythmia Consultants to file appeals on my behalf if required.

GUARANTEE OF ACCOUNT

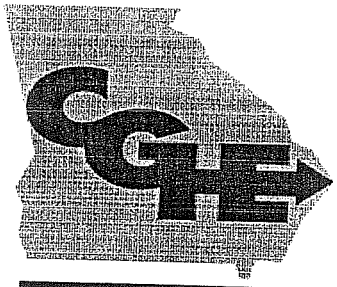
For and in consideration of the goods and services rendered and to be rendered by or through Georgia Arrhythmia and treating Healthcare Providers, the undersigned guarantees payment of all fees and charges incurred by and for the above named patient. Final billing will be rendered upon confirmed determination of all charges incurred, less insurance payments, if any, actually received. The undersigned agrees to make such payment in full immediately upon receipt of such billing. If the undersigned is unable to make full payment, satisfactory payment arrangements can be made. Effective September 1, 2007, our office will assess a $15.00 financial penalty to patients for failing to give at least a 24 hour notice of cancellation. This charge cannot be billed to the insurance company and must be paid along with any additional payments due at time of visit.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, THAT IT HAS BEEN FULLY EXPLAINED, AND THAT HE/SHE UNDERSTANDS ITS CONTENTS AND AGREES TO ALL TERMS AND CONDITIONS SET FORTH ABOVE.

_____ _____
PATIENT DATE

_____ _____
GUARANTOR DATE

_____ _____
WITNESS (GAC REPRESENTATIVE) DATE



CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

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/Representative *Signature of Patient/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):* _____

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

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical 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 information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health 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 redisclosure. 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 and disclosures: 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 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 Heath Exchange, 777 Hemlock Street, Hospital Box 98, 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*.

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