JUBILEE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-___-_____

RESPONSIBLE PARTY INFORMATION (*If not self*)

(Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)_____(First)_____(MI) _____

Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:___-___-_____Phone number: _____

Address:_____

City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____

Phone number:_____ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:_____ ☐ Guardian

Address_____

City, State:_____ZIP: _____

Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

1415 Alice St. Waycross, GA 31501 Katherine Varnadore, NP-C P 912-387-2186 F 912-387-4328

JUBILEE

FAMILY PRACTICE LLC

Insurance Information

Bring insurance cards and photo ID to all appointments

Primary Ins: _____

Subcriber ID/Policy #:_____Group ID#_____

Policy Holder Name: _____ SS#_____

DOB:_____ Provider/ Claims #_____

Claims Mailing address:_____

Secondary Insurance:_____

Subcriber ID/Policy #: _____Group ID#_____

Policy Holder Name: _____ SS#_____

DOB:_____ Provider/ Claims #_____

Claims Mailing address:_____

1415 Alice St. Waycross, GA 31501 Katherine Varnadore, NP-C P 912-387-2186 F 912-387-4328

JUBILEE

FAMILY PRACTICE LLC

FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT IS DUE AT TIME OF SERVICE

All co-pays, deductibles and the percentage you are responsible for, is due at time of service. If you are Self Pay, you MUST pay the Self Pay price in full at time of visit, Unless other arrangements have been made with the Practice Manager, prior to your visit.

We accept Cash, Master card, Visa and American Express. We DO NOT accept personal checks?

No show appointments

Patients who do not cancel and NO SHOW for your appointment could be charged a $25.00 NO SHOW Fee.

WORKERS COMPENSATION AND AUTOMOBILE ACCIDENTS

We DO NOT accept workers compensation or automobile accident claims. If this is the case, you are responsible for your account at the time of service.

My signature below indicates that I have read and understand the Financial policy and appointment policy.

Signature:_____ Date:_____

Printed Name:_____

1415 Alice St. Waycross, GA 31501 Katherine Varnadore, NP-C P 912-387-2186 F 912-387-4328

JUBILEE FAMILY PRACTICE
PATIENT CONSENT/REFUSAL TO TREATMENT FROM

Consent to Treatment:

I recognize that I need medical services. I consent to care by physicians and mid-levels at Jubilee Family Practice. I understand that the practice of medicine is not an exact science and that any treatment and/or prescribed medication may involve risk and side effects. I understand that I will be informed about the availability of alternate modes of treatment or procedures and their benefits and risks, including no treatment at all, except in emergencies.

Use of Medical Information:

I understand, consistent with Georgia and federal law, Jubilee Family Practice will share all medical information as necessary for continuation of care and with any other institution or person as allowed by law. As an example, I understand that Jubilee Family Practice does not have an in-house lab and uses an out-sourced medical laboratory and my lab work and personal information is shared to accomplish testing I may desire. Privacy and confidentiality of personal health information is important at Jubilee Family Practice. There are policies in place to ensure that your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves this office either electronically, by fax, or paper record without specific authorization by the patient.

I have read and fully understand to my satisfaction, this entire document consisting of consent to treat, use of medical information, and financial information. I have had an opportunity to ask questions and received answers. I also authorize release of any necessary medical record information by and to any referrals on my behalf.

_____ **Consent to medical treatment**

_____ **Refusal of medical treatment**

Signature:_____ **Date:**_____

Printed name of person **(if not patient)** and please indicate relationship **(if signing for someone else):** _____

JUBILEE

FAMILY PRACTICE LLC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record		☐ Physician Orders		☐ Demographics	
☐ History and Physical		☐ Laboratory		☐ Rehabilitation Services	
☐ Consult Report		☐ Imaging/Radiology		☐ Special Test/Therapy	
☐ Operative Report		☐ Nursing Notes		☐ Itemized Bill/Claims	
☐ Progress Notes		☐ Medication Record		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

1415 Alice St. Waycross, GA 31501 Katherine Varnadore, NP-C P 912-387-2186 F 912-387-4328

MEDICAL RELEASE

Many of our patients allow family members such as their spouse, parents, or others to call and request medical/billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/billing information released to family members, you must sign this form. Signing this form will give consent to release this information to the family members indicated below. This consent will not allow Jubilee Family Practice to release any other information to these family members.

You have the right to revoke this consent in writing.

I understand that I have the right to revoke this authorization at any time, and that I must do so in writing and present my written revocation to the health information management department at Jubilee Family Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I authorize Jubilee Family Practice to release my medical information to these individual(s):

1. _____ Relationship to patient:_____

2. _____ Relationship to patient:_____

3. _____ Relationship to patient:_____

Patient Name:_____

Patient Signature:_____ Date:_____

Patient Lab Responsibility Form

(Out of Network)

Patients are to be aware that our Laboratory services are provided by LabCorp Laboratory. Patients are responsible for the payments of co-pays, co-insurance, deductibles, out-of-network fees and all other procedures or treatments not covered by their insurance plan. If lab work is performed and considered out of network there may be an additional charge if your insurance coverage does not include this laboratory. Please check with your insurance company. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.

I acknowledge that I assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover lab work performed.

_____ _____

Patient Date

_____ _____

Representative Date

JUBILEE

FAMILY PRACTICE LLC

At Jubilee Family Practice LLC, we welcome patients of every age from newborn to older adults regardless of gender, race, color, religion, sexual orientation, or national origin and assigns providers regardless of racial preference. JFP, LLC is committed to the patient-centered medical home model for delivering safe high-quality healthcare. Care is delivered in accordance with evidence-based medicine along with clinical support tools.

Your Rights

- Receive assistance in understanding rights, including an interpreter if required
- Know the names, credentials, and functions of staff involved in your care
- Receive considerate, respectful care in a clean and safe environment
- Receive complete information about your diagnosis, treatment, and prognosis
- Given the opportunity to participate in decisions involving your healthcare
- Given the opportunity to discontinue care or refuse treatment
- Given the opportunity to discontinue care with your current provider & transfer to another provider
- Receive an explanation as to what can be expected if care is refused
- Review and obtain a copy of medical records
- Receive all information necessary to make informed consent for any procedure
- Expect privacy and confidentiality for the care you receive, including your medical records
- Formulate advance directives
- Receive complete information on how to file a complaint or grievance
- Receive complete information on a reasonable estimate of charges for medical care upon request prior to treatment.
- Receive a copy of an itemized bill that is clear and understandable upon request

Your Responsibilities

- Ask questions about your healthcare, symptoms, illness etc.
- Be honest about health history, habits and symptoms
- Update your provider with important changes regarding your health
- Take medications as prescribed
- Call your doctor first with any non-emergent healthcare issues or symptoms
- Keep your provider informed of any information from other healthcare professionals
- Keep your appointments or reschedule in a timely manner
- Follow medical recommendations and your agreed upon treatment plan
- Call your doctor's office if you did not hear from us as agreed upon
- Learn about your health insurance benefits and coverage
- Give honest feedback about our healthcare approach and your plan of care
- Be responsible for your health, habits and lifestyle choices

Updated 03/05/24