WAYCROSS
Internal Medicine, P.C.

711 Knight Avenue • Waycross, GA 31501
912-283-9423 • Fax: 912-283-2946

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OFFICE HOURS
BY APPOINTMENT

Welcome New Patient!

The providers and staff of Waycross Internal Medicine want to warmly welcome you to our practice. To ensure a smooth check-in at your initial visit, we ask you to complete the enclosed patient packet and return it before your appointment.

You may fax the forms to 912-283-2946 or email to management@wimdocs.com. If you cannot return the forms, please be sure to bring them with you on the day of your appointment. You will need to arrive 15 minutes before your scheduled appointment time so that we can ensure your chart is ready.

If you have medical insurance, we ask and require you to bring your insurance cards with you to all appointments. Please check to make sure that your cards are not expired. We will also need to make a copy of your driver's license or photo ID.

All insurance co-payments, deductibles, and co-insurances will be collected at check-in. For self-pay patients, payment in full is required at the time of service. For questions regarding self-pay prices please call our billing office at 912-283-2311. We accept cash, checks, and all major credit cards.

Thank you! We look forward to meeting you soon.

WAYCROSS INTERNAL MEDICINE, P.C.
711 Knight Avenue Waycross, GA 31501 912-283-9423

Please Arrive 15 minutes prior to your appointment time.

BRING ALL MEDICATION BOTTLES TO YOUR APPOINTMENT, INSURANCE CARDS, PHOTO ID & PAYMENT

Patient Information

Date: _____ Name_____
(First) (Middle) (Last)

Gender: Male / Female Date of Birth:_____ SSN:_____

Address: _____

City: _____State: _____ Zip: _____

Home:(___)_____Cell:(___)_____ Email:_____

Employer:_____ _____

Employer Phone: _____ Address: City__ _____ State___ __Zip_____

Marital Status: (Circle) Single Married Divorced Widowed Life Partner Other:_____

Spouse: _____ Date of Birth: _____

Spouse Employer: _____Work Phone: _____ _____Cell Phone: _____

Emergency Contact:_____Phone:_____Relationship:_____

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Waycross Internal Medicine may discuss my medical condition/information with the following:

Name of Person/Persons_____Relationship_____

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If you are a student, please list the parent /guardian /responsible party's name, phone number, and address information below. This information is important and must be completed.

Student Status (circle one): Full-Time Part-Time Not a Student Grade:_____

Parent/ Guardian/ Responsible Party Name: _____ Phone: _____

Address: _____ City: _____State:_____ Zip:_____

PATIENT INSURANCE COVERAGE

Driver's License or photo ID, and ALL insurance cards are required.

Primary Insurance:

Subscriber Name: _____ DOB: _____ Age: ____ Gender: M/F _____

Subscriber's Address: _____ City: _____ State_____ Zip: _____

Insurance Name: _____ Phone Number of Ins. Co: _____

Policy Number: _____ Group Number: _____ _____

Subscriber's Employer: _____ Phone: _____ Address: _____

Secondary Insurance:

Subscriber Name: _____ DOB: _____ Age: ____ Gender: M/F _____

Subscriber's Address: _____ City: _____ State_____ Zip: _____

Insurance Name: _____ Phone Number of Ins. Co: _____

Policy Number: _____ Group Number:_____ _____

Subscriber's Employer: _____ Phone: _____ Address: _____

Additional Insurance:

Subscriber Name: _____ DOB: _____ Age: ____ Gender: M/F _____

Subscriber's Address: _____ City: _____ State_____ Zip: _____

Insurance Name: _____ Phone Number of Ins. Co: _____

Policy Number: _____ Group Number:_____ _____

Subscriber's Employer: _____ Phone: _____ Address: _____

Prescription Insurance:

Subscriber Name: _____ DOB: _____ Age: ____ Gender: M/F _____

Subscriber's Address: _____ City: _____ State_____ Zip: _____

Insurance Name: _____ Phone Number of Ins. Co: _____

Policy Number:_____ Group Number:_____

BIN Number: _____ PCN Number:_____ _____

PATIENT MEDICAL HISTORY:

(Please circle illnesses or conditions you have experienced)

Heart Disease	Diabetes	High Blood Pressure	Asthma	Depression/Anxiety
Pneumonia	Cancer	COPD (Emphysema)	Arthritis	Thyroid Disease
Abnormal Bleeding	Stroke	Vein Trouble	Hepatitis	Tuberculosis
Rheumatic Fever	Jaundice	Kidney Disease	Glaucoma	Migraine Headaches

Other: _____

Have you ever experienced any serious injuries or broken bones?" Yes/ No List:_____

Have you received a blood transfusion? (Circle) Yes/No Date:_____

Surgeries: (Circle) Yes/No If yes, please list the procedure, surgeon, date, and location performed:

_____

Last colonoscopy _____ Last bone density _____

Have you traveled outside of the country in the last 30 days? Yes No If Yes, Where_____
Where and when have you lived or traveled outside the U.S.? _____

Women's Health History:
Periods are: Regular / Irregular Abnormal Spotting or Bleeding? Yes No Age of Menopause:____
Are you followed by an OBGYN? Yes No _____
Last Mammogram:_____ Location_____ HPV Vaccine: Date_____

Immunization History:

Covid-Year_____	Flu-Year_____	Pneumonia-Year_____
Shingles- Year_____	Hepatitis-Year_____	MMR- Year_____
Tetanus-Year_____	Other_____	Other_____

Social Medical History:
Do you smoke cigarettes? Yes/ No Current: Packs/day_____ Number of Years_____
Do you use other tobacco)? Type _____ Number of Years_____
Do you vape? Yes / No Number of Years_____
Do you drink alcoholic beverages? (circle) Yes/ No Weekly Amount: _____

FAMILY HISTORY:

			Ages or Age at Death	Present health or cause of death
Father	Living Yes/ No		_____	_____
Mother	Living Yes/ No		_____	_____
Spouse	Living Yes/ No		_____	_____
Brothers	No. Living	____	_____	_____
	No. Deceased	____	_____	_____
Sisters	No. Living	____	_____	_____
	No. Deceased	____	_____	_____
Children	No. Living	____	_____	_____
	No. Deceased	____	_____	_____

Please circle any illness that has occurred in any of your blood relatives.

Heart Disease	Diabetes	High Blood Pressure	Allergies	Nervous Disorder
Cancer	Stroke	Abnormal Bleeding	Stroke	Tuberculosis
Kidney Disease	Other: _____			

Known Allergies:

Medication Allergy:_____Reaction:_____

Medication Allergy:_____Reaction:_____

Medication Allergy:_____Reaction:_____

Other Allergy:_____

Other Allergy:_____

MEDICATION HISTORY:

LOCAL PHARMACY:_____ MAIL ORDER PHARMACY:_____

Have you taken Cortisone-Type Drugs? (Circle) Yes / No Date Taken _____

Please list your current prescription and non-prescription medications (including vitamins, aspirin, nutritional supplements, and oral contraceptives):

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

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Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

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Medication: _____ Dose: _____ Frequency: _____

HIPAA AND HEALTH INFORMATION AUTHORIZATION DISCLOSURE FORM

With my consent, Waycross Internal Medicine, may use and disclose **protected health information (PHI)** about me to carry out **treatment, payment, and healthcare operations (TPO).** Please see Waycross Internal Medicine's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Waycross Internal Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by sending us a written request to the Privacy Officer, Waycross Internal Medicine, 711 Knight Avenue-Waycross, Georgia 31501.
With my consent, Waycross Internal Medicine may call my home or other designated location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other test results.

With my consent, Waycross Internal Medicine may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and Confidential.

With my consent, Waycross Internal Medicine may e-mail to the email address I have on file, any items that assist the practice in carrying out TPO, such as appointment reminders, patient statement information, and other things. I have the right to request that Waycross Internal Medicine restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Waycross Internal Medicine's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Waycross Internal Medicine may decline to provide treatment to me.

Name of entity or person(s) to receive my PHI:

_____ _____

_____ _____

Patient's Name: _____ Date of Birth: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Legal Guardian: _____

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OFFICE HOURS
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____ DOB: _____/_____/_____

Address:_____

INFORMATION REQUESTED FROM

Provider: _____ FAX: _____

I, _____(Patient Name), hereby give permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information to Waycross Internal Medicine.

Signature of Patient/Guardian_____

Date_____

Please Fax records to 912-283-2946
If MORE than 25 pages, please mail to our address.
Please do not send a disk.

ALL FORMS MUSTS BE FULLY COMPLETED

RX Consent

By signing this consent form, you are agreeing that your provider at Waycross Internal Medicine may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for the denial of health services. You also have the right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke the consent. You may revoke this consent at any time in writing but if you do, it will not affect any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Belleview Medical Partners to enroll me in this E-Prescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Name_____ Patient DOB_____

Signature of Patient/Guardian_____ Date_____

Relationship to the Patient_____

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FINANCIAL POLICY

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

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

All co-pays, deductibles, and allowable percent your insurance does not cover are due at the time of service. If you are self-pay, you must pay your entire visit in full at the time of service.
We accept cash, personal checks, MasterCard, Visa, and American Express. You will be charged a service charge of $37.00 for returned payments due to Non-Sufficient Funds. You may also lose your privilege to write checks in our office. If your account has an outstanding balance of $5.00 or less, you will NOT receive a statement in the mail. You will be notified of the balance on your next visit.

WORKER'S COMPENSATION AND AUTOMOBILE ACCIDENTS

We Do Not accept Worker's Compensation or Automobile Accidents Claims. If this is your situation, you will be responsible for your account at the time of service. We will gladly provide you with an itemized bill upon full payment.

CHILDREN OF DIVORCED PARENTS

Payment is due at the time of service- Regardless of who is responsible by order of the Divorce Decree.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and will do our best to answer any questions relating to your insurance. Your insurance is a contract between you, the employer, and the insurance company. We are NOT a party to the contract. Not all services are covered by insurance. Some insurance companies select certain services they will NOT cover.
We must emphasize that as your medical care providers, our relationship and concern are with you and your health-Not your Insurance Company. All charges are your responsibility when services are rendered. On a balance that has been on your account for more than 90 days, including outstanding balances that your insurance has not paid, Collection action may be taken. We realize that emergencies do arise and may affect timely payment on your account. If such an extreme does occur, please contact our billing office promptly for assistance. If it becomes necessary to collect any sum due through an attorney, the patient will be responsible for ALL reasonable costs of collection, including attorney fees. If you have any questions about this information, please do not hesitate to ask us. We will be happy to help in any way we can.

I Have Read and Understand the Financial Policy

_____Phone _____
Signature of Guarantor

_____Date_____
Name of Guarantor

_____ __Witness_____
Social Security Number

Waycross Internal Medicine
Healow-Online Patient Portal User Guide

We are proud to announce that our practice offers **Healow**, your personal online access to all aspects of your health care. Healow is a secure, convenient, and uncomplicated way to access your health information.

To use Healow, first contact us to enable your portal. We will verify your email address and set up your username and password.

To open Healow on your web browser, enter **https://health.healow.com/WayIntMed**

You can also scan this code  to be directed to the link above.

From there you can sign directly into Healow. You will also need to install the Healow App on your phone or tablet by visiting the Apple App Store or Google Play Store. Search for healow Medical by eClinicalWorks LLC. If needed, our practice code is **CAJEAD.**

Sign in using the email address and password you have provided us. Call our office if you need assistance, need to change your username or password or to unlock your account. Please note you will be locked out after several unsuccessful login attempts.

Here is what you can do with our portal-

- **Communicate with your provider.**
- **Get reminders.**
- **Manage your appointments.**
- **Access your test results.**
- **View your medications and request refills.**

Patient Portal URL: **https://health.healow.com/WayIntMed**

Email on file_____

Username_____

Password_____