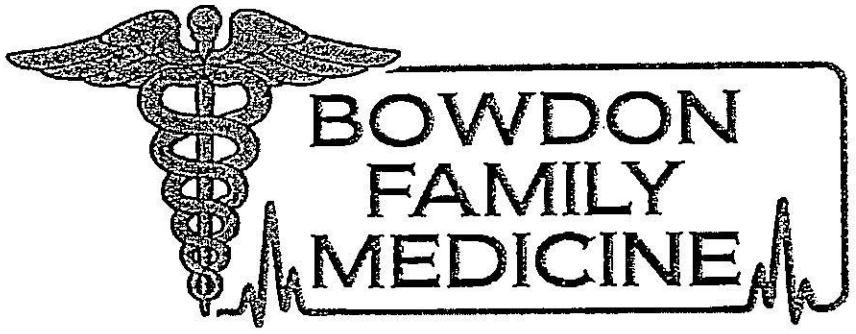


ROBERT C SALTER MSN, CRNP / MICHAEL G GAINES MD

Patient Name: Last_____ First_____ Middle_____

Birthdate:_____ Social Security#:_____ Sex:_____ Race:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: Cell_____ Home_____ Email:_____

Driver's License#:_____ Marital Status:_____

Employer:_____ Phone:_____ Retired:_____ Unemployed:____

Primary Insurance:_____ ID#:_____ Group#:_____

Card Holder Name:_____ Relationship:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Primary Pharmacy:_____ Location:_____

Person to Notify In Case Of Emergency: _____ Relationship_____

Address_____ City_____

State_____ Zip code_____ Phone_____

Consent to Treatment: I consent to necessary treatment, including drug screen, medicine, and performance of operation and conduct of x-ray or other studies that may be used by the attending physician, his nurse or staff.

Authorization for release of information: I authorize BFM LLC. To furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care or my employer who is providing payment of my medical bills due to injury on the job.

Assignments of benefits: I hereby authorize payment directly to BFM LLC. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but do not exceed the BFM LLC. Charges for these services I understand that I am financially responsible to BFM. LLC not by this assignment. I authorize the refund of overpaid insurance benefits where my coverage are subject to coordination of benefits.

Guarantee of account: For services furnished by BFM LLC. I hereby guarantee the payment of all accounts for service rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Georgia and agree to pay, if necessary all costs off collection, including attorney's fees, $25 no show fee for office visits, $150 no show fee for ultrasounds and $35 return check fee that are not covered by insurance.

Patient Signature:_____ Date:_____

BOWDON FAMILY MEDICINE

PATIENT PAST MEDICAL HISTORY FORM

NAME_____DOB_____TODAY'S DATE_____

REASON FOR TODAY'S VISIT_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?

	Asthma		COPD		Heart Disease		Jaundice		Severe Headaches
	Arthritis		Depression		Heart Failure		Kidney Issues		Severe Heartburn
	Anxiety		Diabetes		Hepatitis		Meningitis		Stomach Ulcers
	Blackout spells		Emphysema		Hernia		Poor Circulation		Stroke
	Blood Thinner		Head Injury		Hypertension		Pneumonia		TB
	Cancer		Heart Attack		Hyperlipidemia		Seizures		Thyroid Problems

OTHER PROBLEMS NOT LISTED: _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	ASPIRIN		DEMORAL		PENECILLIN		TETANUS
	CODEINE		"MYCINS"		STEROIDS		OTHER

Allergic Reaction Symptoms :_____ HIVES _____ANAPHYLAXIS_____GI PROBLEMS

CIRCLE THE FOLLOWING THAT APPLY:

SINGLE MARRIED DIVORCED WIDOWED

SMOKE? YES / NO HOW MUCH? _____ **DRINK?** YES / NO HOW MUCH? _____

FAMILY HISTORY—- PLEASE CIRCLE ALL THAT APPLY:

CANCER DIABETES HEART DISEASE HIGH BLOOD PRESSURE STROKE

MOTHER LIVING? _____ FATHER LIVING? _____

PLEASE LIST ANY SURGERIES AND DATE_____

_____

DATE OF LAST COLONOSCOPY: _____

DATE OF LAST MAMMOGRAM: _____

DATE OF LAST EYE EXAM: _____

INTERNAL ACCT# _____

BOWDON FAMILY MEDICINE

Current Medication List

MUST BRING COMPLETED TO YOUR APPOINTMENT

Patient Name:_____ DOB:____/_____/_____
(Please Print)

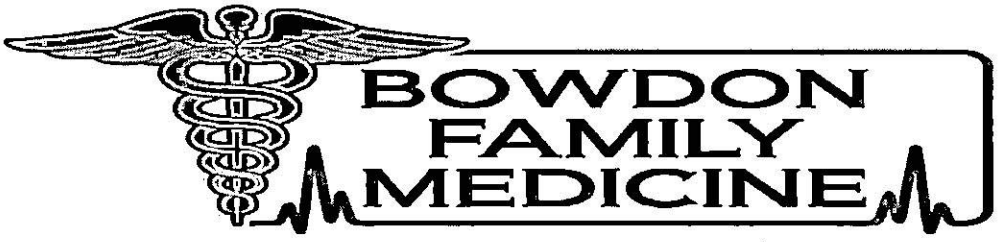
Date this List was completed: ____/_____/_____

Pharmacy Frequently Used: _____

Pharmacy Phone Number: (____)_____-_____

NOTE: LIST PRESCRIPTION AND OVER THE COUNTER

DRUG NAME	MILLIGRAMS PRESCRIBED	DISPENSED (Ex: 1-3x's daily)



307 West College St, Bowdon GA 30108 PH)678-257-5182 **FAX) 678-257-5183**

REQUEST AND AUTHORIZATION TO RETRIEVE/DISCLOSE MEDICAL INFORMATION

(PROTECTED HEALTH INFORMATION)

I, _____ **DOB:** _____

(Parent or legal representative name)

Do hereby authorize_____

To disclose information or copies thereof covered under privacy regulations issued pursuant to the HIPPA ACT of 1996 to: **Bowdon Family Medicine 307 West College St Bowdon Ga 30180**

Care and treatment from (date) _____ through (date)_____

This consent and authorization include, for the period indicated, the care and treatment records designated pertaining to the patient for physical and /or emotional illness including psychological or psychiatric treatment and/or alcohol and drug abuse, and/or AIDS (HIV) related testing or illness, and/or testing for sexually transmitted diseases. The nature and extent of the information to be released is:

	Patient ID Card		Operative Report		Imaging Report		
	Abstract Only		Clinical Notes		Laboratory Report		
	ED Report		Physician orders/notes		EKG: EMG Report		
	History/Physical		Physical Therapy Notes		Cardiac Cath Video		
	Discharge Summary		Respiratory Therapy Notes		Other		Complete Record

The requested use or disclosure of this medical information is:

I hereby acknowledge and understand that this authorization is a waiver of the confidential and privileged nature of the records designated above but only with respect to the specified purpose(s) for which this disclosure is made. I further acknowledge and understand that this authorization will prevent the patient making a claim for a violation of privacy in connection with the release of the medical information as described herein. I understand that BFM, LLC. Cannot require me to sign this authorization to receive treatment unless the provision of healthcare is solely for the purpose of creating phi for disclosure to a third party or for research related treatment, in which BFM LLC will not provide the service unless I sign this authorization. This request and authorization may be revoked at any time by written notice received by BFM, LLC. Health information management department, but any revocation will not apply to records already furnished in reliance upon this request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first.

_____

(Signature of patient or Legal representative) (Relationship) (Date)

ROBERT C SALTER MSN, CRNP/MICHAEL GAINES MD

BOWDON FAMILY MEDICINE
307 WEST COLLEGE STREET
BOWDON, GEORGIA 30108
PHONE: 678-257-5182
FAX: 678-257-5283

CONSENT FORM FOR LABORATORY SERVICES

I, _____. Date of Birth, _____

ACKNOWLEDGE AND AUTHORIZE CHRIS SALTER TO PERFORM THE FOLLOWING LAB (S). I AM AWARE AND AGREE TO ASSUME RESPONSIBILITY FOR PAYMENT OF CHARGES FOR LABORATORY SERVICES THAT ARE NOT COVERED BY MY HEALTHCARE INSURER.

• PROFILE 1(CMP)	• PSA SCREENING
• PROFILE	• PSA DIAGNOSTIC
• PROFILE	• URIC ACID
• PROFILE	• CBC WITH DIFF
• PROFILE	• GLUCOSE
• PROFILE	• PROTIME
• PROFILE	• RPR
• AMYLASE	• VITAMIN D
• B-12	• TESTERONE
• FERRITIN	• AM CORTISOL
• HBGA1C	• TSH
• LIPASE	• OTHER

_____

_____

_____

_____

HIPPA RELEASE FORM

Name:_____ Date of Birth: _____

We are unable to discuss your treatment with anyone unless you give us permission.

_____ I authorize the release of information including the diagnosis, records, images, examination render and claims information. This information may be released to:

_____ Spouse Name: _____

_____ Child(ren) Name(s): _____

_____ Parent Name: _____

_____ Other Name: _____

_____ Information is not to be released to anyone.

This release of information will stay in effect until terminated by me in writing.

Messages

For messages, please call the following number: _____

If unable to reach me:

_____ You may leave a detailed message.

_____ You may leave a message requesting I return you call.

_____ Other: _____

The best time to reach me is at the following time: _____

Phone 678-257-5182 Fax 678-257-5183

POLICIES:

- **THERE IS A $25 CHARGE FOR NO SHOW APPOINTMENTS**
- **CANCELLING YOUR APPOINTMENT WITH LESS THAN A 24 HOUR NOTICE RESULTS IN A $25 SERVICE CHARGE**
- **PAYMENT IS DUE AS SERVICES ARE RENDERED**
- **MEDICAL REQUESTS WILL BE ADDRESSED AT THE END OF EACH BUSINESS DAY**
- **PLEASE CALL IN REFILLS ONE WEEK PRIOR TO PRESCRIPTION EXPIRING**
- **IF IT HAS BEEN 6 MONTHS SINCE YOUR LAST VISIT YOU ARE REQUIRED TO MAKE AN APPOINTMENT FOR FOLLOW UP BEFORE PRESCRIPTIONS ARE REFILLED**
- **NARCOTICS WILL NOT BE PHONED IN**
- **ANXIOLYTICS WILL NOT BE PHONED IN**

Patient Signature:_____

Date:_____