Welcome and thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to take this opportunity to familiarize you with our office policies:

Please bring the following items to your first visit:

- Insurance Card(s), Picture ID and Co-Pay
- The name(s), address, phone/fax numbers to your previous doctors to obtain your medical records.
- **All medications you are currently taking in the bottles.**
- All NEW PATIENT paperwork, health history and required signatures.

Reminders:

- ***It is your responsibility to know the benefits that you receive from your insurance company***. This includes wellness/physical coverage, deductible amounts, and co-payment requirements. If your insurance requires a designated primary care provider (PCP), please sure to have this updated prior to your appointment.
- For your convenience, we provide onsite lab services from Labcorp and Quest Diagnostics. If your insurance requires you to use a specific reference laboratory, it is your responsibility to tell us before labs are drawn so that you may be given an order sheet to go to an outside lab that insurance covers.
- In compliance with HIPAA laws, no information will be given to anyone, including family, without prior written consent.
- New Patients will only be allowed to reschedule or cancel their initial appointment twice. Failure to contact the office to cancel or reschedule new patient appointment will result in dismissal from the practice and unable to return.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for the Providers will be directed to the nurses.
- We provide same day and walk in appointments for our established patients.

Our goal is to provide you with the most efficient and up to date health care available. We are always open to suggestions. We look forward to seeing you!
Sincerely,
Dr. Mary Bell Vaughn and Vineville Internal Medicine Staff

www.vinevilleintermalmedicine.com

Be sure to like us on Facebook AND Instagram @vinevilleinternalmedicine

Your Appointment is scheduled for _____/_____/_____ at _____:_____			
3448 Vineville Avenue, MACON, GA 31204			
Bldg A - Blue	**Bldg B - Green**	**Bldg C - Purple**	**Acute Care Clinic-Bldg D - Yellow**
( ) Mary Bell Vaughn, MD	( ) Mary Bell Vaughn, MD	( ) Krista Keen, NP	( ) Jenna Franz, NP
( ) Daryl Remick, MD	( ) Melissa Belflowers, NP	( ) Sarah Purser, NP	( ) Daryl Remick, MD
( ) Erin Caves, NP	( ) Shandora Hayman- Jones, NP		
( ) Jarrett Mitchell, NP	( ) Shannon Ethridge, NP		
( ) Katie Aldridge, NP			
( ) Tammy Hughes, NP			
1024 Keith Drive, PERRY, 31069			
( ) Kim Johnson, N	( ) Regina Wiley, NP	( ) Tammy Hughes, NP	
147 James Street, GRAY, GA 31032			
( ) Jen Woodall, NP	( ) Mary Bell Vaughn, MD	( ) Erin Caves, NP	
506 Osigian Blvd, Warner Robins, GA 31088			
( ) Ashley Dykes, NP	( ) Krista Keen, NP		

Vineville Internal Medicine

Thank you for choosing Vineville Internal Medicine (VIM) for your healthcare needs. We are committed to providing quality and affordable health care to you and your family. Because some of our patients have questions regarding general practice guidelines and patient financial responsibility for services rendered, we have developed these policies for your information and future reference. Please read them, ask any questions you may have and sign in the space provided. You may keep all pages other than the signature page (the last page).

General Practice Policies

Telephone Calls: If you have a medical emergency, please call 911.

Due to heavy call volumes, some calls will be transferred to a voice mail box. The voice mails are monitored continuously throughout the day. All calls received before 4pm will be returned within the same business day.

The following options are available:

#1- Refills
#2- Billing Questions related to billing or insurance claims
#3- Appointments
#4- Nurse Calls
#5- Provider Calls (Copay/Visit charges applied to Provider calls)

Medication Refills: All refills and prescription renewals should be initiated through your pharmacy. Please notify your pharmacy when you need a refill, and they will contact our office for approval. If there aren't any authorized refills remaining, you will need to contact our office to make an appointment for evaluation to ensure there are no issues with your medications. To schedule an appointment, you may contact us directly at 478-405-0045, option #3, or use the Patient Portal Healow App to schedule an appointment. We request 72 hours to process all prescription refills.

Missed Appointments: To ensure the best outcome for every patient, we feel strongly that every appointment is medically necessary. Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Our system is set to call and/or text reminders of your scheduled appointments. Please ensure that your preferred method of contact and contact information are up to date in our system and respond to these calls accordingly. Although we understand that emergency situations may arise, a quick call to cancel your appointment would be appreciated. Due to high demand and limited availability of same day appointments we have instituted a "missed appointment" fee. You must give at least a 24hr advance notice to cancel or reschedule appointments. Failure to do so will result in a "missed appointment" fee charge of $25.00-$50.00 to your account, depending on the service scheduled. These fees are patient responsibility, will be billed directly to you and should be paid before scheduling another appointment.

Dismissal: As a last resort, repeated failure to keep your scheduled appointments or failure to comply with practice treatment policies may result in dismissal from the practice. Dismissal may also occur if your account has carried an unpaid balance after the 3rd billing statement without making payment arrangements. If for any reason you have been dismissed from VIM, you will be notified by regular and/or certified mail that you have 30 days to seek alternative care. During that 30-day period, your provider will only be able to provide treatment on an emergent basis.

Financial Policies

Identification and Proof of Insurance: At each visit you will be asked to provide driver's license/picture ID and current insurance card. Please be sure to bring these to each appointment so we can ensure accurate information in your patient account. If your insurance plan requires a designated Primary Care Provider (PCP), please have this updated PRIOR to your visit. Failure to update your PCP could result in denial of your claim and your visit will be considered a self-pay. We have made prior arrangements with many insurers and health plans to accept assignment of benefits and participate in most insurance plans, including Medicare and Medicare Advantage plans. We are happy to file insurance to your primary and secondary insurance as a courtesy. Your insurance will be verified prior to each visit or procedure. If we are unable to verify your coverage prior to your visit, you will be considered a self-pay patient and payment in full will be expected until your coverage can be re-established.

Minor Patients:
Patients under the age of 18 will not be seen without a parent/guardian present or without signed consent form. For all services Rendered to minor patients, we will look to the adult accompanying the patient for payment.

Self-Pay Patients:
For all services rendered to patients without insurance or proper proof of insurance, a self-pay discount will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Should any test performed result with any abnormalities, additional testing may be required and will fall under the patients' responsibility for those charges.

Insurance Coverage: If your insurance changes, please notify our office prior to your visit so that the necessary updates can be made to ensure you receive the maximum benefits. We will submit your primary and secondary insurance claims; however, resolving any claims issues that require additional information from you are your responsibility. If additional information is requested, failure to respond to VIM or your insurance company will result in the unpaid balance being moved to your financial responsibility. If your insurance company does not respond to our claim with payment or denial within 45 days, unpaid charges may be billed directly to you. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any specific questions you may have regarding your benefits, deductible, and coverage limitations.

Co-payments, Co-Insurance and Deductibles: Payment of co-pays, co-insurance and deductibles are part of your contract with your insurance company and are required per our agreement to accept your plan. Please help us in upholding the terms of these contracts by paying your co-payment at each visit. We will attempt to verify your out-of-pocket expense prior to any procedures being performed but pre-certification does not guarantee payment by your insurance company and therefore could become patient responsibility after the claim has paid. If we cannot determine this amount at the time of your visit, patient responsibility will be assigned after your insurance company has processed the claim and submitted payment to VIM. This balance is due upon receipt of your statement.

Non-covered services: Some recommended services may be ordered by your provider but may be deemed as not reasonably necessary by Medicare or your insurance company based on plan limitations and/or your benefit structure.When possible, you will be advised in advance if we believe the service may not be covered, the reason it may not be covered and the anticipated charges for these services. Services that are never covered or services that exceed your limits of coverage will be billed directly to you. For example, Medicare only covers a well-woman exam every two years. If you have scheduled these visits annually, you will be charged for the service that exceeds frequency limitations. For traditional insurance, annual physicals are typically scheduled at least 366 days apart. If you are having cosmetic procedures, payment in full is expected at the time of service and no claim will be filed to your insurance. We will try our best to notify you of these circumstances; however, understanding the benefits of your insurance is ultimately your responsibility.

Preventive Services/Sick Visit on the Same Day: Preventive services are traditionally scheduled at regular intervals to collect or update basic patient information related to history, physical status, and to make plans for additional servicesthat may be required to ensure patient wellness. In some cases, a patient may request or require additional services outside of what is traditionally provided in a preventive/wellness visit. If your provider feels that the sick portion of the visit requires significant additional work and/or follow-up, you may be assessed an office visit charge or co-pay for the separate sick visit.

Multiple Statements: VIM bills for services provided by the physicians and providers in the practice. Ancillary services such as laboratory, pathology, or radiology services, etc., may be billed by an outside medical vendor. Therefore, you may receive separate statements from those offices. Please pay each statement separately.

Non-payment: If any balance is over 90 days past due, your final statement will notify you that you have **20 days** to pay your account in full to avoid being turned over to an outside collection agency. Partial payments will not be accepted unless a payment agreement has been established and followed as scheduled. If at any point a payment is missed, the collection process will pick up where it left off and the account will be referred immediately to an outside agency. In the event your account balance is referred to a collection agency, your account will be made inactive and you will be dismissed from Vineville Internal Medicine. Additionally, because of the high expense related to using an outside collection agency, additional fees will be added to your account to help cover that additional expense.

Credit Balances: In the event that a credit balance is created for any VIM service date, we will verify that there are no outstanding balances on any other date of service and no upcoming appointments before initiating a refund. Because of the administrative expense of processing a refund, any credit balance of $20.00 or less will remain on the account for use at a future visit unless the refund is specifically requested by the patient or guarantor

PLEASE RETURN THIS SHEET TO THE FRONT DESK

(Form Version 05/17/2024)

Our practice is committed to providing the best treatment to our patients. In return, your adherence to these office and financial policies is requested and expected. Please let us know if you have any questions or concerns.

I have read and understand the Vineville Internal Medicine policies dated and agree to comply with these terms as outlined above. **(Initial Here _____)**

Patient Information:

Name (Last, First): _____ Email: _____

Date of Birth _____ Marital Status_____ Race _____ Sex (Select One): Male / Female

Mailing Address: _____ City _____ State_____ Zip Code_____

Social Security#_____ Employer: _____

****Emergency Contact Name/Relationship: _____**

****Emergency Contact Phone#: _____**

Please tell us how to contact you:

I authorize Vineville Internal Medicine to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Home telephone # _____ Yes ____ No ____ Home Answering Machine Yes ___ No ___

Cell Phone # _____ Yes ____ No ____ Cell Phone Text/Voice Mail Yes ___ No ___

Work telephone #_____ Yes ____ No ____ Work Voice Mail Yes ___ No ___

VIM Patient Portal:

We comply with the Hitech Act of 2009 by communicating with our patients via patient portal.

Are you signed up for the portal? Yes ____ No ____ I don't want to sign up _____

I acknowledge that I will receive electronic billing statements upon enrolling in the patient portal. **(Initial here _____)**

Health Information Disclosure (HID):

List anyone that may call on your behalf to discuss your health information:

Spouse/Partner Name: _____ Phone # _____

Parent Name: _____ Phone # _____

Other Name/Relationship: _____/_____ Phone # _____

Other Name/Relationship: _____/_____ Phone # _____

( ) Check if you DO NOT want your emergency contact or anyone else to have HID access

Patient Signature: _____ Date: _____

Please return this signature sheet to the front desk with your other patient information (Central Georgia Health Exchange Consent Form and Medical Records Release form). You may keep all the other printed information for your use.

We look forward to creating a long-lasting medical partnership.

Good Health!

Vineville Internal Medicine

Vineville Internal Medicine

Mary Bell H. Vaughn, MD

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: _____ DOB: ___/___/____

Records being requested from:

Dr. _____ Phone Number: _____ Fax Number: _____
Dr. _____ Phone Number: _____ Fax Number: _____
Dr. _____ Phone Number: _____ Fax Number: _____
Dr. _____ Phone Number: _____ Fax Number: _____

The information you may release subject to this signed release form is as follows:

(**X**) Complete Records (**last 2 years**)
( ) Progress Notes
( ) H&P
( ) Other (Please specify below)
( ) Lab Reports
( ) Radiology Report
( ) Rx Records
( ) Pathology Reports
( ) Immunization Records
( ) Hospital Reports

_____
_____
_____

(ONLY if this applies to you)

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies, Please initial and date this form. Initial: _____ Date: __/__/___

Release my protected health information to the following physician/facility:

Dr. Mary Bell Vaughn
Vineville Internal Medicine
3448 Vineville Ave
Macon, Ga 31204

Phone: 478-405-0045
Fax: 478-405-0054

Patient Name (Please Print) _____ Date: ___/___/_____

Signature: _____ 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 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 wish to participate in the Central Georgia Health Exchange electronic medical record at this time

_____	/ /	_____	/ /
Printed Name of Patient/Representative	***DOB***	**Signature**	***Date***

AUTHORITY OF REPRESENTATIVE: POA

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 you're 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* v II 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 re-disclosure. 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 healthcare provider s office.

I understand that I may withdraw this permission by giving written notice to Administrator. Central Georgia Health Exchange, 111 Perimeter Parkway Macon. GA 31210. 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 my other healthcare providers {including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) ll1roughthe *Central Georgia Health Exchange.*

Patient Name: _____ Date ____/____/_____

Age _____ DOB ___/_____/_____ Date of Last Physical _____

Reason for your visit today_____

Conditions & Symptoms (Check the conditions or symptoms you currently have or have had in the past year

General

Specialists:_____

- □ Appendicitis
- □ Chills
- □ Chicken Pox
- □ Dizziness
- □ Fainting
- □ Fever
- □ Hernia
- □ Loss of sleep
- □ Loss of weight
- □ Organ Transplant
- □ Ulcers
- □ Sweats
- □ Measles
- □ Mononucleosis
- □ Mumps
- □ Polio

Muscle/Joint/Bone

Specialist:_____

Pain, weakness or numbness in:

- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Arthritis
- □ Hips
- □ Legs
- □ Neck
- □ Shoulders

Infectious Diseases

Specialist:_____

- □ AIDS
- □ HIV Positive
- □ Typhoid Fever
- □ Venereal Disease

Pulmonary

Specialist:_____

- □ Bronchitis
- □ Emphysema
- □ Tuberculosis
- □ Pneumonia
- □ Asthma

Endocrinology

Specialists:_____

- □ Diabetes
- □ Goiter
- □ Thyroid Problems

Gastrointestinal

Specialists:_____

- □ Appetite poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Hepatitis
- □ Liver Disease
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

Psychiatric

Specialists:_____

- □ Alcoholism
- □ Anorexia
- □ Bulimia
- □ Chemical Dependency
- □ Depression
- □ Nervousness
- □ Psychiatric Care
- □ Suicide Attempt

Hematology/Oncology

Specialists:_____

- □ Anemia
- □ Bleeding disorders
- □ Cancer

Rheumatology

Specialists:_____

- □ Gout
- □ Rheumatic Fever
- □ Scarlet Fever

Nephrology

Specialists:_____

- □ Kidney Disease
- □ Dialysis Treatment

Ophthalmology

Specialists:_____

- □ Cataracts
- □ Crossed eyes
- □ Blurred vision
- □ Double vision
- □ Glaucoma
- □ Vision-Flashes
- □ Vision-Halos

Cardiovascular

Specialists:_____

- □ Chest pain
- □ Heart Disease
- □ High blood pressure
- □ High Cholesterol
- □ Irregular heart beat
- □ Low blood pressure
- □ Pacemaker
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

Neurological

Specialists:_____

- □ Forgetfulness
- □ Headache
- □ Numbness
- □ Epilepsy
- □ Migraine Headaches
- □ Multiple Sclerosis
- □ Stroke

Ear, Nose & Throat

Specialists:_____

- □ Allergies
- □ Bleeding gums
- □ Difficulty swallowing
- □ Earache
- □ Ear discharge
- □ Hay fever
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Tonsillitis

Skin

Specialists:_____

- □ Acne
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Redness
- □ Scars
- □ Sores that will not heal

Genito-Urinary

Specialists:_____

- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination
- □ Gonorrhea
- □ Herpes

MEN only

- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Prostate Problems
- □ Sore on penis
- □ Other

WOMEN only

- □ Abnormal Pap smear
- □ Bleeding between periods
- □ Breast lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Miscarriage
- □ Nipple discharge
- □ Painful Intercourse
- □ Vaginal discharge
- □ Vaginal Infections
- □ Other

Date of Last:

Menstrual period _____

Pap smear _____

Mammogram _____

Chest x-ray _____

Echo _____

Colonoscopy _____

Patient Name: _____ DOB: ____/____/____

Patient History (fill in health information about yourself)

Current Prescriptions Medications

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

Current OTC Medication (this includes vitamins and Herbal treatments)

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)

Name of Drug/Food	Reaction	Type	Status

Previous Medications Taken (i.e. blood pressure-nontherapeutic/cannot tolerate satins)

Name of Drug	Dosage in Milligrams	Reason No Longer Taking

Patient Name: _____ DOB: ____/____/____

Family History (fill in health information about your family)

Relation	Age	State of health	Age of Death	Cause of Death	Check if, your blood relative had any of the following Disease	Relationship to you
Father					☐ Arthritis, Gout	
Mother					☐ Asthma, Hay Fever	
Brothers					☐ Cancer	
					☐ Chemical Dependency	
					☐ Diabetes	
					☐ Heart Disease	
Sisters					☐ High Blood Pressure	
					☐ Kidney Disease	
					☐ Tuberculosis	
					☐ Stroke	

Hospitalizations/Operations

Year	Hospital	Reason for hospitalization and outcome

Have you ever had a blood transfusion? ( ) yes ( ) no

If yes, please give approximate date_____

Serious illness/injuries	Date	Outcome

Pregnancies

Year of birth	Sex of birth	Complications?

Health Habits

(check which you use or do and describe how much you use)

( ) Caffeine	
( ) Tobacco	
( ) Regular Exercise	
( ) Soda	
( ) Raw Fruit	
( ) Vegetables	
( ) Alcohol	
( ) Fiber	

Immunizations

Vaccine	Date Given
Tetanus/Tdap	
Pneumovax (pneumonia)	
Flu	
Gardasil (HPV)	
Varicella (chicken pox)	
Meningococcal	
Hepatitis A	
Hepatitis B	
Zostavax (shingles)	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her practice responsible for any errors or omissions that I may have made in the completion of this form

Signature: _____ Date: ____/ ____/_____

Rooming Nurse: _____ Date: ____/____/_____