Russell G. O'Neal, MD, LLC

1760 Bass Road, Suite 200A Macon, GA 31210
Phone: 478-309-1212 Fax: 866-493-2791

Patient Information Form

Last Name _____ First Name_____ M.I. _____

Address _____Apt # _____

City _____ State_____ Zip_____ Sex (M) _____ (F) _____

Home Phone_____ Cell Phone_____

SSN _____ Date of Birth_____ Martial Status (Circle) S M W D

Email _____

Patient's Employer _____

Occupation _____ Work Phone _____

Race (Circle) Asian African American Hispanic White Other_____

Preferred Language _____ Ethnicity (Circle) Hispanic Not Hispanic

In Case of an Emergency

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number Home _____Cell _____

Insurance Information

Primary Ins. Co _____

ID Number _____Group Number_____

Subscriber's Name _____DOB_____Relationship_____

Secondary Ins. Co _____

ID Number _____Group Number_____

Subscriber's Name _____DOB_____Relationship_____

Third Ins. Co _____

ID Number _____Group Number_____

Subscriber's Name _____DOB_____Relationship_____

I authorize any holder of medical or other information about me to be released to my insurance company or the Social Security Administration needed for this or any related medical claim. I request payment of medical insurance benefits to Dr. Russell O'Neal. I understand that the charges are my responsibility. I understand that it is my responsibility to know if my physician is in network with my plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill.

Signature _____ Date_____

Patient Representative _____Relationship_____

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Missed Appointment Policy

In order to take preventative measures and to help reduce misunderstanding between our patients and practice, we have adopted the following fee schedule. If you have any questions regarding this policy please discuss with our office manager.

Each time a patient misses an appointment without providing a proper notice, another patient is prevented from receiving care. Our system is set to call and/or text your reminders of your scheduled appointment. Due to high patient demand and limited availability of appointments we have instituted a "no show" fee.

You must give 24 hour notice to cancel or reschedule appointments. Failure to do so will result in a "no show" charge of $50.00. This fee is billed directly to the patient and is not covered by insurance.

Patient Agreement: I have read and fully understand the no show policy of this practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Printed Patient Name Patient DOB

_____ _____

Patient Signature Today's Date

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Notice of Privacy Practices Acknowledgement

My physician's office has provided me with the "**Notice of Privacy Practices**" that contains information about the policies and practices protecting patient privacy (HIPPA). I understand that these policies may be updated at any time. I understand that I am entitled to the most current version and will have the ability to ask questions regarding matters I may not understand. By signing below, I acknowledge that I have read and reviewed the **Notice of Privacy Practices** and give consent to this office for the following:

- Use and disclose my personal health information to carry out treatment, health care operations, and receive payment for her services.
- Share my medical information, as permitted under Federal Law (HIPPA) and Georgia State Law, with my healthcare providers through Health Information Exchange.
- Use electronic health services to communicate with Pharmacies in order to collect date regarding current and past prescriptions.
- Leave messages on my answering machine and/or email regarding appointments and test results that do not require immediate attention.

Approved Phone Number _____

Approved Email address_____

I hereby authorize release of medical information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Printed Patient Name Patient DOB

_____ _____

Patient Signature Today's Date

Patient Name _____ Today's Date _____

Hospitalizations/Operations

Year	Hospital	Reason

Personal Health Habits

Habit	What type?	How Often?
Regular Exercise		
Alcohol Consumption		
Tobacco Use		
Recreational Drug Use		

Immunizations

Vaccine	Appoximate Date
Tetanus/Tdap	
Pneumonia	
Flu	
Shingrix	Both Doses? Y / N
Covid 19	Both Doses? Y / N

Serious Injuries/Illness

Date	Type	Outcome

Children

Sex	Health History

Family History

Relation	Age	Still Living?	Health Conditions (Ex: Arthritis, Asthma, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease)
Father		Y / N	
Mother		Y / N	
Brothers		Y / N	
		Y / N	
		Y / N	
Sisters		Y / N	
		Y / N	
		Y / N	

Patient Name _____ Today's Date _____

CURRENT PRESCRIPTIONS AND OTC MEDICATIONS

NAME OF DRUG	DOSAGE	HOW OFTEN

ALLERGIES

NAME OF DRUG/FOOD	REACTION

Patient Name _____ Today's Date _____

Conditions and Symptoms Checklist

General Health
- □ Chills
- □ Fatigue
- □ Fever
- □ Change in Weight
- □ Night Sweats

Gastrointestinal
- □ Bowel Changes
- □ Constipation
- □ Frequent Diarrhea
- □ Loss of Appetite
- □ Indigestion
- □ Nausea/Vomiting
- □ Rectal Bleeding
- □ Stomach Pain

Ear, Nose, & Throat
- □ Allergies
- □ Dentures
- □ Difficulty Swallowing
- □ Earache/Discharge
- □ Loss of Hearing
- □ Ringing in Ears
- □ Nose Bleeds
- □ Sinus Problems

Cardiovascular
- □ Chest Pain
- □ Heart Disease
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Irregular Heart Beat
- □ High Cholesterol
- □ Swelling of Feet/Hands

Muscle/Joint/Bone

Pain, Weakness, or Numbness in:
- □ Arms/Hands
- □ Legs/Feet
- □ Neck/Shoulders
- □ Back/Hips

Psychiatric
- □ Alcoholism
- □ Anorexia
- □ Bulimia
- □ Anxiety/Depression
- □ Memory Loss/Confusion
- □ Suicide Attempt

Skin
- □ Bruise Easily
- □ Rash/Itching
- □ Change in Moles
- □ Varicose Veins
- □ Change in Hair or Nails
- □ Change in Skin Color

Neurological
- □ Stroke
- □ Headache
- □ Numbness/Tingling
- □ Epilepsy
- □ Dizziness
- □ Head Injury

Genito-Urinary
- □ Blood In Urine
- □ Frequent Urination
- □ Painful Urination
- □ Lack of Bladder Control
- □ Kidney Stones

Pulmonary
- □ Asthma/Wheezing
- □ Pneumonia
- □ Bronchitis
- □ Persistent Cough
- □ Tuberculosis

Ophthalmology
- □ Cataracts
- □ Blurred/Double Vision
- □ Glaucoma
- □ Eye Disease or Injury

WOMEN ONLY
- □ Abnormal Pap smear
- □ Bleeding Between Periods
- □ Breast Lump
- □ Hot Flashes
- □ Miscarriage
- □ Nipple Discharge
- □ Vaginal Discharge
- □ Painful Intercourse

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

Endocrinology
- □ Diabetes
- □ Excessive Thirst
- □ Thyroid Problems

Hematology/Oncology
- □ Anemia
- □ Enlarged Lymph Nodes
- □ Cancer

MEN ONLY
- □ Breast Lump
- □ Erection Difficulties
- □ Lump in Testicles
- □ Prostate Issues

Other: _____

	Date of Last:	**Physicians or Facility:**
Bone Density:	_____	_____
EKG:	_____	_____
Pap Smear:	_____	_____
Mammogram:	_____	_____
Colonoscopy:	_____	_____
Eye Exam:	_____	_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records. The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization. - Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise. We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants. We may use electronic services available to check your medications along with data collected from your pharmacy regarding your prescriptions. - Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise. - Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs. - We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement. Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing you have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request. - You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider. - You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment. - We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan. - You have the right to request

confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you. - Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request. - You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information. - You have the right to receive a copy of this notice, either electronic or paper or both. - You have the right to opt out of fund raising communications. - You have the right to revoke consent at any time. You must request revocation in writing and you will be provided with a "Revocation of consent for use and disclosure of health information form that must be signed." If you revoke this consent Dr. Russell G O'Neal and Nurse Practitioner Morgan Ennis have the right to no longer provide further healthcare services. If you have any questions about our privacy practices, please contact our Privacy Officer at the number below. You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party: Privacy Officer: Megan Stuart Phone number: 478-309-1212. To file a complaint online use the below link: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on: 1-1-2024