Welcome to
EFFINGHAM MEDICAL PARTNERS, LLC

Joseph Ratchford, MD | Prakash Patel, MD | Ryan Ratchford, MD

Hello New Patient!

We, at Effingham Medical Partners, would like to take a moment and welcome you to our practice!

We want you to know that we appreciate the opportunity to take care of your healthcare needs and we look forward to serving you. Your health is our primary care.

In order to expedite the new patient registration process, we ask that you complete the enclosed patient information forms and bring the forms with you at the time of your appointment. Please do not send them back in the mail.

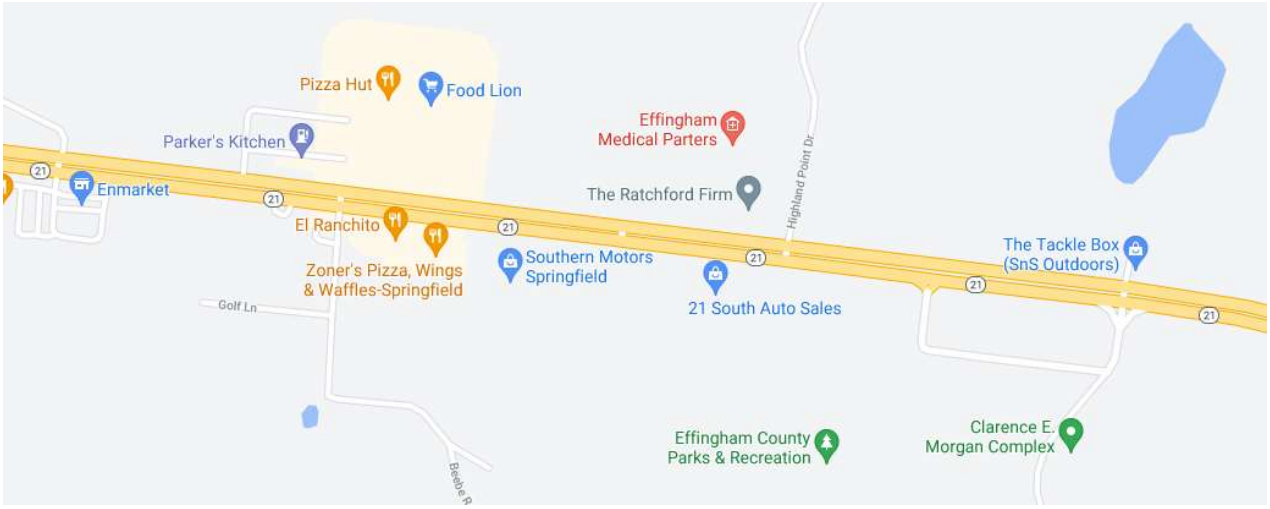
Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office and ensures we have the information necessary to fully address your healthcare needs.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card(s)
- Your copayment/deductible amounts
- A list of current medications

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance to allow us the courtesy of offering your spot to another patient. Our phone number is 912-754-7500 and fax is 912-754-7505.

Thank you for choosing Effingham Medical Partners, LLC for your healthcare needs.



We are located at 1571 Highway 21 South in Springfield behind the Ratchford Law Firm in the red brick building.

PATIENT INFORMATION			
LAST NAME	FIRST NAME M.I.		PREVIOUS NAME
MAILING ADDRESS		CITY/STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY NUMBER	( ) MALE ( ) FEMALE	( ) SINGLE ( ) MARRIED ( ) WIDOW ( ) DIVORCED
HOME PHONE	CELL PHONE	EMPLOYER	WORK PHONE
RACE ( ) BLACK OR AFRICAN AMERICAN ( ) WHITE ( ) AMERICAN INDIAN OR ALASKA NATIVE ( ) ASIAN ( ) OTHER: _____ ( ) DECLINE		ETHNICITY ( ) HISPANIC OR LATINO ( ) NOT HISPANIC OR LATINO ( ) DECLINE	PREFERRED LANGUAGE
PRIMARY PHARMACY AND LOCATION		EMAIL ADDRESS	

SPOUSE/GUARANTOR INFORMATION (List Guarantor if the patient is a minor, under the age of 18)			
LAST NAME	FIRST NAME M.I.		RELATIONSHIP TO PATIENT
ADDRESS (IF DIFFERENT FROM PATIENT)			
DATE OF BIRTH	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE COMPANY NAME		INSURANCE COMPANY NAME	
ID/POLICY NUMBER		ID/POLICY NUMBER	
SUBSCRIBER/INSURED NAME		SUBSCRIBER/INSURED NAME	
SUBSCRIBER/INSURED ADDRESS		SUBSCRIBER/INSURED ADDRESS	
DATE OF BIRTH	RELATIONSHIP TO PATIENT	DATE OF BIRTH	RELATIONSHIP TO PATIENT

CONSENT TO TREAT

I authorize Effingham Medical Partners, LLC to provide medical treatment to the patient named above. I have received a copy of the "Notice of Privacy Practices" which details how my personal health information may be used and disclosed as permitted under federal and state laws, including Substance Use Disorder records protected by 42 CFR Part 2. I have read and understand the contents of this notice. I understand this release will be valid unless I revoke it in writing.

SIGNATURE OF PATIENT/GUARANTOR _____ DATE _____

EFFINGHAM MEDICAL PARTNERS, LLC
FINANCIAL POLICY

PATIENT NAME _____ DATE OF BIRTH _____ DATE _____

We are dedicated to providing you with the best possible care and to maintain this relationship we find it necessary to implement the following financial policy.

- Your insurance cards and picture id will need to be presented each time you visit our practice to assure we have current information on file. If the insurance card is not provided, the appointment will be handled as self-pay and payment for services will be collected prior to being seen.

- Your insurance company requires that you use in-network physicians, labs, hospitals and services in order to receive maximum benefits. It is your responsibility to notify us of which providers/facilities are in-network with your insurance and to notify us if this information changes at any time in the future.

- All co-payments and estimated deductible amounts must be paid prior to seeing the physician on the date service is rendered. Patients are responsible for their deductibles and all charges not reimbursed by insurance. We file your insurance as a courtesy to you; therefore it is your responsibility to provide our office with up to date billing information.

- Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your physician, you are expected to contact your insurance company for an explanation as to why payment has been delayed.

- Self-pay patients are required to pay the fee for the office visit prior to being seen and will be balance billed for any additional fees at the time of charge posting.

- Checks returned by the bank for insufficient funds, stop payments, or for any other reason will be assessed a $35.00 NSF fee for which the patient will be held responsible.

- Account balances turned over to a third party collection agency for non-payment will have a collection fee of 33.25% added to the total amount due. This is pursuant to Georgia Statutory Law “O.C.G.A.-13-1-11.” The entire balance plus any collection fees must be paid in full prior to any future visits at Effingham Medical Partners, LLC. By signing this financial policy, I understand and agree to pay any collection fees that may arise if my account is turned over to a third party collection agency.

- If you do not show up or if you do not cancel your appointment within 24 hours of your scheduled appointment time, a $15.00 No Show fee will be added to your account balance.

I have read and understand the financial policy of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice. I authorize the release of any medical information necessary to process my insurance claims.

SIGNATURE OF PATIENT/GUARANTOR _____ DATE _____

EFFINGHAM MEDICAL PARTNERS, LLC
CONSENT FORMS

PATIENT NAME _____ DATE OF BIRTH _____ DATE _____

PATIENT'S CONTACT LIST – HIPAA & EMERGENCY CONTACTS

You have the option to select different types of contacts. You can designate one person to be both a HIPAA and Emergency Contact, but you also can designate separate people as either a HIPAA Contact or Emergency Contact.

A HIPAA contact is a person who you authorize Effingham Medical Partners to release information to about your medical condition, including but not limited to prescription pickup, laboratory, radiology, or test results.

It is important for you to name an Emergency Contact. This is a person that you authorize our staff to contact in the event you have a medical emergency while being treated in our office. This person may be contacted in the event we are unable to reach you regarding an urgent matter.

	Type of Contact:
Contact Name:	( ) HIPAA ( ) Emergency
Phone:	Relationship:

	Type of Contact:
Contact Name:	( ) HIPAA ( ) Emergency
Phone:	Relationship:

NOTIFICATION OF IN-NETWORK FACILITIES

Please indicate below your insurance carrier's preferred lab, hospital and radiology services. Inaccurate information provided below may result in your being held responsible for all charges.

HOSPITAL	LAB	RADIOLOGY
( ) MEMORIAL UNIVERSITY MEDICAL CENTER ( ) ST. JOSEPH'S/CANDLER HEALTH SYSTEM ( ) EFFINGHAM HEALTH SYSTEM	( ) LABCORP ( ) QUEST ( ) ST. JOSEPH'S/CANDLER ( ) EFFINGHAM (EHS) LAB	( ) MEMORIAL UNIVERSITY MEDICAL CENTER ( ) ST. JOSEPH'S/CANDLER HEALTH SYSTEM ( ) EFFINGHAM HEALTH SYSTEM

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Effingham Medical Partners, LLC to view my external prescription history via the RxHub service. I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and staff and Effingham Medical Partners and it may include prescriptions from several years prior.

My signature below certifies that I read and understand the scope of my consent and that I authorize access:

SIGNATURE OF PATIENT/GUARANTOR _____ DATE _____

EFFINGHAM MEDICAL PARTNERS, LLC
PATIENT HISTORY

PATIENT NAME _____ DATE OF BIRTH _____ DATE _____

PERSONAL MEDICAL HISTORY
(Circle all that apply)

ALLERGIES
ANEMIA
ANXIETY
ARRHYTHMIA (IRREGULAR HEART BEAT)
ARTHRITIS
ASTHMA
BIPOLAR DISORDER
BLADDER PROBLEMS
BLEEDING PROBLEMS
CANCER (SPECIFY TYPE):
_____
_____
COPD
CROHN'S DISEASE
DEMENTIA
DEPRESSION
DIABETES 1 OR 2
DIVERTICULITIS
DVT (BLOOD CLOT)
GERD (ACID REFLUX)
HEADACHES
HEART ATTACK
HEART DISEASE
HIGH CHOLESTEROL
HIV
LIVER DISEASE
LUPUS
PARKINSON'S DISEASE
PERIPHERAL VASCULAR DISEASE
PULMONARY EMBOLISM
RHEUMATOID ARTHRITIS
SEIZURE DISORDER
SLEEP APNEA
STROKE
THYROID DISEASE

OTHER (PLEASE LIST):
_____
_____
_____
_____

HOSPITALIZATIONS/SURGERIES

APPENDECTOMY ( ) Y ( ) N
CHOLECYSTECTOMY ( ) Y ( ) N
HYSTERECTOMY ( ) Y ( ) N

OTHER (PLEASE LIST PROCEDURE/DATE):
_____
_____

EXAM HISTORY

LAST PAPSMEAR (DATE/LOCATION):

LAST MAMMOGRAM (DATE/LOCATION):

LAST COLONOSCOPY (DATE/LOCATION):

LAST EYE EXAM (DATE/LOCATION):

ALLERGIES
(List all known allergies)

SOCIAL HISTORY

ALCOHOL ( ) Y ( ) N
TOBACCO ( ) Y ( ) N
CAFFEINE ( ) Y ( ) N

FAMILY HISTORY

		RELATIVE:
DIABETES	( ) Y ( ) N	_____
HEART DISEASE	( ) Y ( ) N	_____
HIGH CHOLESTEROL	( ) Y ( ) N	_____
HYPERTENSION	( ) Y ( ) N	_____
LUNG DISEASE	( ) Y ( ) N	_____
STROKE	( ) Y ( ) N	_____
THYROID DISEASE	( ) Y ( ) N	_____
ULCERS	( ) Y ( ) N	_____
CANCER	( ) Y ( ) N	_____

CURRENT MEDICATIONS
(List all current prescription and OTC medications)