Name: _____DOB: _____

Hartwell Family Practice

229 Athens Street
Hartwell, Georgia 30643
(706) 376-3957
Fax (706) 376-1356

E. Wade Walker, M.D. • JoDon Garringer, M.D. • B. Jamison White, D.O.
Brad Jones, FNP • MacKenzie Cheek, NP-C • Austin Darbyshire, FNP

Thank you for your interest in becoming a new patient of Hartwell Family Practice. This packet is designed to allow for a head-start at providing you with the excellent care that our office and providers are known for. It is very important that you read through and understand the contents of this packet and fill out the requested information completely before returning it to us. We cannot process your request to become a new patient until the attached forms have been completed and any previous medical records have been received.

How does the New Patient Application Process Work?
Complete and return the attached forms to Hartwell Family Practice (HFP). Forms can be returned by mail, fax, or dropped off in person at our front office.

Hartwell Family Practice
229 Athens Street
Hartwell, GA 30643
706-377-2814 (fax)

HFP staff will then fax your medical release form to your previous provider(s). Once we receive your medical records, we will forward them on to the appropriate provider to review. Please note due to the extremely high volume of new patient requests, we are unable to follow up with your previous provider if your records are not sent to us in a timely manner. It is your responsibility to reach out to your previous provider to verify they are working on sending your records.

Please be advised that completing the attached forms does not establish a provider-patient relationship with HFP. HFP will verify that your insurance is active and review your forms for completeness. Please note we can only accept a set number of new patients per month based on appointment availability. You will be contacted by our office once this process is complete to let you know if we are able to accept you.

Due to the high demand for our providers, it may be several months before a New Patient appointment can be scheduled. If for some reason, your medical needs require more immediate attention, we suggest that you either maintain your current medical provider or seek out another option for care such as urgent care or the nearest emergency room.

By completing and returning these forms, you agree to and understand the terms of this process.

Name: _____DOB: _____

Please Print

Have you ever been a patient at Hartwell Family Practice?

Will a family member also be submitting a request to become a patient of HFP? If so, please list their name and date of birth:

Please list any family members who are currently patients at HFP and their relationship to you:

Who was your primary care provider and what is the reason(s) you are leaving that provider?

Are you under the care of any *other* health care provider/specialist for any medical problems? Yes / No
If yes, list whom and for what medical condition.

_____

_____

_____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD – FRONT AND BACK

Primary Insurance Information

Policy Holder *Information*

Insurance Name: _____

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Information

Policy Holder *Information*

Insurance Name: _____

Name: _____
Last *First* *Middle*

Date of Birth: _____ Relationship to Patient: _____

Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance carriers. I hereby give my permission and grant authorization to the providers of Hartwell Family Practice to use any and all information gathered to verify benefits under these insurers for myself and my dependents.

Primary **Policy Holder** Signature _____Relationship _____Date _____

Secondary **Policy Holder** Signature _____Relationship _____Date _____

Name: _____DOB: _____

Medical History

Please indicate each of your chronic medical problems by marking the appropriate box below: ☐ None

☐	High Blood Pressure	☐	Asthma
☐	Heart Disease (Describe Type Below)	☐	Emphysema
☐	Diabetes	☐	Kidney Problems
☐	Stroke	☐	Anemia
☐	Cancer Type: _____	☐	High Cholesterol
☐	Thyroid	☐	Depression/Anxiety

List any other medical conditions / problems:

List ALL medications that you are now taking, including OTC. Indicate in left column with an "X" if you wish to have our providers manage the medication. You may use the back of this page or attach a list if needed. No Medications ☐

X	Medication	Strength (mg.)	Directions (ex. Once per day)

Are you allergic to any medications? If so, please list medication and reaction:

Please list any other allergies and their reaction (such as food or environmental allergies):

Name: _____DOB: _____

Please list any surgeries/hospitalizations (including the year): ☐ None

Immediate Family History

If any blood relative has suffered the following conditions, check the box and **indicate which relative.**

☐	Heart Disease_____	☐	Asthma_____
☐	Diabetes_____	☐	Emphysema_____
☐	Thyroid_____	☐	Cancer (Type)_____
☐	Stroke_____	☐	Glaucoma_____
☐	High Blood Pressure_____	☐	Mental Health_____
☐	High Cholesterol_____	☐	Substance Abuse_____

Social History

Tobacco _____ packs a day

# of years _____ Year Quit _____

Exercise _____

Times per week (min/session) _____

Street Drugs _____

Alcohol _____drinks per week

Caffeine _____cups per day

Water _____cups per day

Low fat diet (circle one) Yes / No

Women Only *If Applicable otherwise write N/A

*Age at first menstrual cycle:_____

*Date of first day of last menstrual period:_____

*Number of pregnancies: _____

*Number of live births: _____

*Date of last Colonoscopy: _____

*Date of last PAP? _____

*Date of last Mammogram: _____

*Date of last Bone Density Scan: _____

Men Only *If Applicable otherwise write N/A

*Date of last Prostate Exam: _____

*Date of last PSA: _____

*Date of last Colonoscopy: _____

Vaccines

Refuse ALL Vaccines? (Circle one): YES NO

If vaccines were received outside of Georgia, please list name of practice(s) where received: _____

Name: _____DOB: _____

Summary of Office Policies and Procedures for New Patients:

Hartwell Family Practice (HFP) has established policies and procedures to create and maintain a partnership with patients for the care we provide. We make every effort to ensure that the health care we provide includes preventive care as well as acute and chronic disease management and we put you at the center of that care.

This is not an exhaustive list of all of the office policies and procedures. Visit ***www.hartwellfamilypractice.com*** or our front office for the full text of our policies. Feel free to contact our office to clarify any of the information prior to submitting your new patient forms.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with HFP.

- Newly accepted applicants are not considered patients until they have been seen by a provider for the new patient appointment.
- Any patient that has had a three year absence and has not had an appointment by a provider in our office will not be considered a patient. Former patients that would like to be reestablished as patients will need to go through our New Patient process and be reaccepted.
- While HFP verifies your insurance, patients are responsible for understanding the terms of their medical insurance contracts and if a service that we provide is a covered contract benefit. Patients are responsible for payment if a service is rendered and the medical insurance denies payment.
- We keep same day appointments available for our patient's acute care needs. However, you may need to see a provider other than your regular provider for these appointments depending on schedules.
- All patients must have an account guarantor. Any time an account balance is more than 30 days overdue there will be a monthly $3 service charge.
- Co-pays and any outstanding balance MUST be paid at the time services are rendered. HFP reserves the right to reschedule your appointment if you do not have payment for co-pays, co-ins, deductible amounts, or balances on the day of your appointment.
- We will accept refill requests via telephone, fax, or online but it may take up to 72 hours for processing. It may also be required for you to have an office visit with your provider in order to process a refill request.
- All refill requests for controlled substances must be made with your primary prescribing physician at the time of your regularly scheduled appointment. No other requests for refills of controlled substance medications will be processed.
- **HARTWELL FAMILY PRACTICE WILL NOT MANAGE CHRONIC PAIN MEDICATIONS FOR NEW PATIENTS.**
- Some prescriptions require regular checkup appointments. We do not call-in prescriptions for new medications over the phone and will not make any changes to medications without an appointment.
- **HARTWELL FAMILY PRACTICE HAS A NO SHOW POLICY.** Any time you fail to give us a 24-hour notice of a cancellation, the missed appointment will be considered a No-Show and your account will be charged a $25 no-show fee. More than three (3) No-Show appointments in a one-year period may result in termination of our relationship. Reminder notifications of your appointments are considered a courtesy. It is ultimately the patient's responsibility to maintain all appointments. HFP does not have a cancellation line when the phone lines are closed. **A MISSED NEW PATIENT APPOINTMENT WILL NOT BE RESCHEDULED.**

Please sign below stating that you have read, understand and agree to abide by all Hartwell Family Practice policies and procedures.

Signature of Patient or Legal Guardian_____ Date _____

Print Name of Patient or Legal Guardian _____Relationship _____

Best Contact Number: _____

229 Athens Street
Hartwell, Georgia 30643
Telephone (706) 376-3957
Facsimile (706) 377-2814

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Patient's name Social Security Date of Birth

Which physician at Hartwell Family Practice would you like to receive your records?

_____ E. Wade Walker, M.D. _____ MacKenzie Cheek, NP-C

_____ B. Jamison White, D.O. _____ Any Provider

_____ JoDon Garringer, M.D.

From whom do you wish to forward your medical records to Hartwell Family Practice, P.C.?
Name of person/Facility, Address, Phone or fax number as applicable

_____

_____

_____

Please forward the following information to Hartwell Family Practice, P.C.
(X) NEW PATIENT REQUEST: H&P, medication list, & last 3 office notes and labs

( ) complete medical record ( ) partial record ( ) specific date _____

Including information in reference to: (check all that apply)

( ) drugs and/or alcohol abuse ( ) Psychiatric
( ) venereal disease ( ) Social services
( ) Hepatitis B testing/treatment ( ) HIV testing/treatment
( ) Other _____

Why are you requesting that your records be sent to Hartwell Family Practice?

_____

_____

_____

This authorization is valid for 90 days and may be revoked in writing at any time, except to the extent that action has already been taken in response to this authorization. I also release Hartwell Family Practice, P.C. from any liability or legal responsibility in connection with the release of the above information. I do not give permission for any other use or re-disclosure of this information.
I also accept the risk and consequence of faxing medical records.

_____ _____ _____ _____
Patient Signature Guardian Signature (if under 18) Telephone Date

**PLEASE MAIL/FAX RECORDS TO THE ADDRESS ABOVE **

Below is for HFP Use Only
Date Sent:_____ Initial:_____