- Family Practice
- Nutritional Medicine
- Preventative Care

Lora Fulp Efaw, M.D.
Certified by the
American Board of Family Practice

Registration Information

Please Print

Welcome to our Practice

Date:_________________

Patient Name: ____

Last Name First Name Initial

Responsible Party (if minor): ____ Relationship: ___________________

Responsible Party of this account: _____________________________________ Relationship: __________________

Home Phone: _____________________ Cell Phone: _____________________ Work Phone: _____________________

Address: ____ City: _______________ ST: ______ Zip: ___________

Email Address: ____ ☐ Single ☐ Married ☐ Divorced

Sex: ☐ M ☐ F Age: _________ Birth Date: __________________ Social Security Number: ________________________

Patient Employed by: ____ Occupation: ___________________________

Spouse Employed by: ____ Occupation: ___________________________

Business Address: ____ Business Phone: _______________________

Purpose of Initial Visit: ____

Do you have medical insurance? ☐ Yes ☐ No Name of Insurance Company: ___________________________________

Name of Policy Holder: ____ Policy Number: _______________________

Group #: _______________________________________ Subscriber #: _____________________________________

Name of Secondary Insurance (if any): ____

Policy #: __________________________ Group #: _______________________ Subscriber #: ______________________

☐ Medicare #: ____________________________________ ☐ Medicaid #: ___________________________________

How were you referred to our office: ☐ Yellow Pages ☐ Physician, if so, name: ___________________________________

☐ Newspaper ☐ Hospital Referral ☐ Other: ____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. It is ultimately your responsibility to pay the portions of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have made the insurer).

IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST PAYMENT BE MADE FOR ALL SERVICES AT THE CONCLUSION OF YOUR VISIT.

I authorize any holder of medical or other information about me to release to the Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this car related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment regulations pertaining to Medicare assignment of benefits apply.

Signature: ____ Date: ____________________________

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URINARY

Frequent Urination……………………	no	yes
Burning or painful urination………....	no	yes
Blood in urine………………………..	no	yes
Incontinence or dribbling……………..	no	yes
Urination Difficulty…………………...	no	yes
Male – testicle pain…………………...	no	yes
Female – pain with periods…………...	no	yes
Female – irregular periods……………	no	yes
Female – vaginal discharge…………...	no	yes

SKIN

Rash or itching…………………………	no	yes
Breast pain…………………………….	no	yes
Breast lump…………………………….	no	yes
Breast discharge……………………….	no	yes

CONSTITUTIONAL

Good general health lately……………	no	yes
Recent weight changes………………..	no	yes
Headaches……………………………..	no	yes

EYES

Wear glasses/contact lenses……………	no	yes

ENT

Sinus problems…………………………	no	yes
Sore throat or voice change……………	no	yes
Swollen gland in neck…………………	no	yes

CARDIOVASCULAR

Heart trouble…………………………….	no	yes
Chest pain……………………………….	no	yes
Sudden heart beat changes……………...	no	yes
Swelling of feet, ankles or hands……….	no	yes

RESPIRATORY

Frequent coughing………………………	no	yes
Shortness of breath……………………...	no	yes
Asthma or wheezing……………………..	no	yes

GASTROINTENSTINAL

Loss of appetite………………………….	no	yes
Change in bowel movement…………….	no	yes
Nausea or vomiting………………………	no	yes
Frequent diarrhea………………………...	no	yes
Painful bowel movements or constipation	no	yes
Blood in stool…………………………….	no	yes
Stomach pain…………………………….	no	yes

.

ENDOCRINE

Excessive thirst or urination…………….	no	yes
Heat or cold intolerance…………………	no	yes
Dry skin…………………………………..	no	yes

____

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MUSCULOSKELETAL

Joint pain…………………………..	no	yes
Muscle pain or cramps…………….	no	yes
Back pain…………………………..	no	yes

NEUROLOGICAL

Frequent or recurring headaches……	no	yes
Light headed or dizzy………………	no	yes
Numbness or tingling sensations…...	no	yes

PSYCHIATRIC

Nervousness………………………..	no	yes
Depression…………………………..	no	yes
Sleep problems………………………	no	yes

HEMATOLOGICAL/LYMPHATIC

Easily bruise or bleed………………..	no	yes
Anemia……………………………….	no	yes
Phlebitis………………………………	no	yes
Past transfusions……………………..	no	yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reactions to:

Penicillin or other antibiotics………….	no	yes
Morphine, Demerol, or other narcotics..	no	yes
Novocaine or other anesthetics………...	no	yes
Aspirin or other pain remedies…………	no	yes
Tetanus antitoxin or other serums………	no	yes
Iodine, methiolate, or other antiseptic….	no	yes

other drugs/medication:_________________________

Known food allergies:__________________________

Provider Signature: ____________________________

Date: _____________________________________

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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 CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.
We are required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you and when this notice is changed, we will post a copy in a prominent location. We will also provide you with a copy of the revised Notice on your request made to our Privacy Officer.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would include a physical examination, office visit, and sharing information required to maximize the continuum of care.
- PAYMENT means such activities as obtaining reimbursement for services, confirming insurance coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company or payer for payment of services rendered.
- HEALTH CARE OPERATIONS includes the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, training programs, and customer service. An example of this would be our quarterly medical record/compliance review.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, changes or information about treatment alternatives or health-related benefits and services that may be of interest to you. We may release PHI for Workers' Compensation and public health purposes.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. We may also use and disclose your PHI, without written authorization, in circumstances required by law, public health activities such as preventative control of diseases, to report disease, birth, injury or death, report of child abuse, report reactions to medication of problems with product services regulated by federal FDA.

You have the following rights with respect to your personal health information, which you can exercise by presenting a written request to our Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and receive a copy of your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosure of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal and privacy practices with respect to protected health information.

We have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to
Privacy Office or for written inquiries,
Note "Attention: Privacy Officer"
Paige Pollock, Practice Manager

For more information about HIPPA or to file a complaint
The US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave, SW, Washington, DC 20201

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Medical History Intake Sheet

Name: ____ Birth Date: _______________

Describe your main problem: _____________________________________

Where is your problem located: ___________________________________

How severe is your problem: _____________________________________

How long have you had this problem: ______________________________

When does this problem occur: ___________________________________

Where were you when this problem started: _________________________

What other things happen with this problem: _______________________

____

Any previous hospitalizations/surgeries/serious injuries When?

____ ____________

____ ____________

____ ____________

Monthly self-breast exam:	No	Yes	
Form of regular exercise:	No	Yes	______________________
Seat belt use:	No	Yes	

Have you ever had the following?

Thyroid Disease…………	yes	no
Diabetes…………………	yes	no
Hypertension……………	yes	no
Cancer…………………..	yes	no
Stroke…………………...	yes	no
Heart Trouble……………	yes	no
Arthritis/Gout……………	yes	no
Convulsions……………..	yes	no
Bleeding Tendency……...	yes	no
Acute Infections…………	yes	no
Venereal Disease…………	yes	no
Hereditary Defects………	yes	no

List Medications you are currently taking, nonprescription and herbal:

1) ________________________________
2) ________________________________
3) ________________________________
4) ________________________________
5) ________________________________
6) ________________________________
7) ________________________________
8) ________________________________
9) ________________________________
10) ________________________________
11) ________________________________
12) ________________________________
13) ________________________________

Patient Social History

Marital Status: Single Married Separated Divorced Widowed
Use of alcohol: Never Rarely Moderate Daily __________________
Use of tobacco: Never Previously but quit Current packs/Day _______
Use of drugs: Never Type/Frequency: ___________________________
Excessive exposure at home/work: Fumes Dust Solvents Noise

Family Medical History

	Age	Disease	If deceased, cause of death
Mother	____	______________________________________	____________________
Father	____	______________________________________	____________________
Siblings	____	______________________________________	____________________
	____	______________________________________	____________________
Spouse	____	______________________________________	____________________
Children	____	______________________________________	____________________
	____	______________________________________	____________________

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone: ________________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Work telephone: ________________________
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Written communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number: _______________

☐ Other: ______________________________
____

Patient Signature: ____ Date: ____________________

Print Name: ____ Date of Birth: ______________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosure of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type Key: T = treatment records P = payment information O = healthcare operations
(3) Enter how disclosure was made: F = fax P = phone E = email M = mail O = other

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Patient Name: ____DOB: _______________________

PATIENT ACCOUNT POLICY

Thank you for choosing our Medical Practice to be involved in your health care needs. It is our mission for you to receive the highest quality care a health provider can give. To ensure we do our job effectively, please review the following policy. Should you have any questions or concerns regarding this policy, please ask for the Practice Manager.

As a courtesy to our patients, our Medical Office will file the patient's insurance company/workers compensation for payment. It is the patient's responsibility to ensure our medical office has received the correct billing information for the insurance company and for worker's compensation. In the event the incorrect information is given, the balance for the office visit will be the patient's responsibility.

PATIENTS WITH INSURANCE COVERAGE

- Insurance coverage with co-payments will be collected at the time service is rendered.
- Any amount remaining after insurance company has paid will be the responsibility of the patient.
- Accounts with non-payment due to incorrect information of any kind will be the responsibility of the patient.
- Monthly billing statements will be issued for remaining balances of accounts. Full payment will be due upon receipt.
- Patients with a previous balance will be required to make a payment on the balance in addition to the regular co-payment at the time service is rendered.

PATIENTS WITH NO INSURANCE COVERAGE

- The patient will be required to pay at least $25.00 at the time of service is rendered to be applied toward the balance of the patient's account.
- Monthly billing statements will be issued for remaining balance of accounts. Full payment will be due upon receipt.
- Patients with a previous balance will be required to make a payment on the balance in addition to the regular co-payment at the time service is rendered.

PAYMENT POLICY ON ALL ACCOUNTS

- Our medical office accepts: cash, VISA, MasterCard and Discover credit cards. We also accept personal checks ($25 return fee on all checks).
- Monthly billing statements will be issued for the remaining balances of accounts. Payment is due upon receipt of the billing statement.
- Payment arrangements may be set up on an individual basis. Should arrangements be necessary for your accounts, please ask for the Practice Manager.

____ ________________________________

Signature of Patient or Legal Representative Date

39 Kent Rd • Suite #2, Tifton, GA 31794 • 229.388.9393 • fax: 229.388.9855 • healingandwellness.com

Patient Name: ____ DOB: __________________________

PATIENT PRIVACY AND ACCESS TO MEDICAL INFORMATION

It is the policy of the Center for Healing and Wellness not to disclose ANY private information to any party or organization not actively involved in the medical treatment of that patient without specific written authorization from the patient/guardian. Only patients may provide this authorization. For unmarried patients under the age of 18, patient's guardians may provide authorization. We consider ALL patient information private, whether verbal or written, even if it is not specific to a patient's medical treatment. This includes information about patient addresses and phone numbers. If we feel that we cannot adequately provide care or receive reimbursement based on patient/guardian's privacy requests, the Center for Healing and Wellness reserves the right to refuse treatment. If information is requested by a source not authorized in advance, written permission must be provided. Please consider day-to-day activities that may be affected by this policy. This includes sending notes to a patient's school or place of employment, or allowing any other person besides the guardian to bring a patient to an appointment.

THE CENTER FOR HEALING AND WELLNESS MAY SHARE MEDICAL INFORMATION WITH:
(Please choose the persons/groups below that you allow access to the patient's medical information. Indicate your approval by PUTTING YOUR INITIALS on the line next to that selection).

_______ The patient's referring physician and/or any primary care physicians.

_______ Any medical professional, laboratory, test facility, or medical facility who assistance is necessary to provide medical treatment to the patient.

_______ Any information required by the guardian's health insurance company in order to process and pay insurance claims. This includes primary insurance, secondary insurance, Medicare or Medicaid.

_______ Any psychiatrists/psychologists/counselors who are actively involved in the patient's care.

_______ Any social worker or probation officer actively involved in the patient's care.

_______ The patient's school or place of employment.

_______ Conducting or arranging for medical review, legal services and audits.

_______ Any nursing home or facility involved in caring for the patient.

_______ Any specific person, group or organization not listed above that you allow access to the patient's medical information? (Day care centers, sports teams, summer camp, DMV, workers comp, etc.) If so, please name: _____________________________________

_______ Any person, group or organization that you DO NOT want us to release information to?
If so, please name: ____
Please note: We cannot deny medical information to any parent regarding their child – even if they are non-custodial, unless we are provided with court documents restricting a parent's access.

We are committed to the privacy and security of your protected health information. Our patients have the right to determine who may have access to this information and how this information is used. I understand that my provider may change its Notice of Privacy Practices from time to time and that notice of such changes will be posted at the receptionist's desk. I understand that I may revoke this Consent by notifying my Provider in writing that I revoke this Consent unless my Provider has used or disclosed my Health information in reliance on this Consent.

I HAVE READ THE INFORMATION ABOVE AND AUTHORIZE THE CENTER FOR HEALTH AND WELLNESS TO RELEASE MEDICAL INFORMATION AS INDICATED HERE.

____ ________________________________
Signature of Patient or Legal Representative Date

INFORMED CONSENT FOR MEDICAL OFFICE PROCEDURES AND TREATMENT

The physicians and medical staff of the Center of Health and Wellness thank you for selecting us to assist you with your health concerns. The information that you provide to us, as well as the examinations and test that are performed are all used to determine the most likely diagnosis and most appropriate course of treatment for your problem. The diagnosis may be difficult to determine at first, as many problems present in a similar manner. Tests that are more difficult to perform and have the possibility of complications are generally not recommended until they are necessary to help you determine the cause of your problems.

The treatments are selected to help you cure or improve your health problems. No treatment is 100% effective for all patients and all treatments have some potential for complications. We try to select the best treatment with the least potential for complications. Many of the treatments are selected from successful experience in using them. Others are recent improvements that have been found successful in medical trials. It is not uncommon for physicians to prescribe different therapies for the same condition and get essentially identical results.

It is important to understand that complications can occur with even the simplest treatment. Anything that enters the body has the potential of a very serious reaction. Some people will die from a bee sting or just eating a peanut if they have a serious allergy to either of these. Unfortunately, no one knows if they have allergies to any food, drug or other chemical until they have a reaction. If these reactions are severe, they will cause rash, swelling, and sometimes difficulty breathing. Therefore, it is important to inform the physician of any and all adverse medication reactions that you may have experienced in the past. It is also very important to tell your physician and pharmacist all medications that you are currently taking because some medications may react with other medications in a bad way.

If medication reactions occur, seek medical help. If severe swelling or shortness of breath or wheezing should occur, one should go to the nearest medical facility and even call 911 if necessary. Do not take any more of the medication and be sure to tell the prescribing physician and the pharmacy that filled the prescription about the reaction. Any type of medication (pills, liquids, creams, suppositories or injections) can cause reactions. You should also ready information provided by your pharmacist about medications you have been prescribed.

Examples of some precautions needed for medications are:

1. Do not stay in the sun for very long while taking these prescriptions.
2. Many prescriptions should not be taken if you are pregnant or possibly pregnant. It is very important to advise anyone prescribing a medication or performing a rest or treatment for you that you are pregnant or might possibly be pregnant.
3. Many medications may cause mild nausea or upset stomach. Serious nausea, vomiting, or diarrhea needs attention and you should advise prescribing physician about this problem. If you develop diarrhea while taking an antibiotic, discontinue and notify your physician immediately.
4. Immunizations are made from the virus or bacteria that cause the illness you are trying to avoid. You may notice “flu like” symptoms that may be very uncomfortable for a few days. Rarely an unpredictable, severe reaction may occur and cause a significant medical condition or even lead to death.
5. Some medications can affect blood counts, kidney functions, live functions, or other organ functions, which may not show up early in the course of treatment. Laboratory or other tests may be ordered from time to time to monitor for these possible toxicities. It is very important that you follow through and complete all tests are recommended.

Anything that penetrates the skin such as a shot, injection, puncture, biopsy, or surgical incision may have complications such as:

1. An infection under the skin first noticed as redness and tenderness that spreads.
2. Bleeding that may cause a bruise or blood clot under the skin. This will absorb and go away with time. If the blood clot becomes infected it will become increasingly tender and warm and redness will spread.
3. Continuous bleeding may seep from the incision or it may begin to swell within a couple of hours following the procedure. Apply pressure on the bleeding or swelling.

4. An injury that could cause a loss in sensation or decreased muscle tone. It is likely that nothing can be done to remedy this complication.

The Center of Health and Wellness phone number is 229-388-9393. If the prescribing provider is not available, another member of the medical staff will be able to assist you when you call, indicate that this is a medical problem from a treatment or procedure.

This information is provided to help you decide if you wish to receive the treatment or test results recommended with the knowledge of these potential complications. By signing this form, you are giving your consent and permission for our physician and medical staff to prescribe and perform treatments and tests they recommend for your health needs. The informed consent will be kept on record and considered active for all treatment following the date of your signature. This will apply to any treatments and recommended tests should they occur in the office, as a result of a telephone call from you, at the hospital, or in the hospital emergency room when a physician or medical staff member of this practice provides a service. A copy will be provided for you at any time upon request.

You always have the right to not take any prescription or refuse any procedure or test even if you have previously consented to it. The alternative for not accepting the treatment prescribed and doing nothing is that the condition may get worse, stay the same or possibly get better on its own. As mentioned before, there usually are alternative treatments available for your particular problems.
I have read or have had read to me this informed consent form. I have had an opportunity to ask questions regarding this consent and any potential benefits or complications that can result from treatments or tests ordered by my physician. I understand the information in this informed consent.

Signature of Patient: ______________________________ Date: ____________________

Signature of Parent or Guardian: ______________________________ Date: ____________________

Print Name: ______________________________

Witness: ______________________________ Date: ____________________

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AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, ____, authorize the use and disclosure of my individually identifiable health information, ie: appointments, test results, and scheduled procedures. The persons authorized to receive this information are:

Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

The following persons are not authorized to receive any type of information regarding my individually identifiable health information:

Name	Relationship
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________
Signature of Patient or patient's legal representative Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ____ Date of Birth: ________________________

Social Security Number: ____

1. I authorize the use of disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure.

3. The type and amount of information to be used or disclosed is as follows. (Include dates where appropriate)

A. _____ problem list	E. _____ recent history/physical	I. _____ x-rays
B. _____ medication list	F. _____entire record	J. _____ consult report
C. _____ list of allergies	G. _____ lab results	K. _____ other
D. _____ immunization records	H. _____ labs	

Doctor's Name and Address: ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

   Center for Healing and Wellness
   39 Kent Rd Suite #2
   Tifton, GA 31794

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carriers with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

____ _______________________________________

Signature of Patient or patient's legal representative Date

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INFORMED MEDICATION CONSENT

I grant authorization for any medications needed for my treatment to be shipped and delivered to the office of Lora Fulp Efaw M.D., DBA the Center for Healing and Wellness P.C., located at 38 Kent Rd, Ste. 2, Tifton, GA 31794.

Patient's Name ____ Date of Birth: _____/_____/_____
(please print)

Patient's Signature: ____ Date: _______________________

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INFORMED CONSENT
AND
LIABILITY RELEASE FOR ALL IV THERAPIES

I, ____, understand and acknowledge that ____________________________________ treatment is not approved by any governmental instrumentality for the condition for which I have requested treatment. Additionally, I understand and acknowledge that the treatment I have requested is a non-conventional treatment modality which has been reported to further understand and acknowledge that there may be treatments available for my condition, which are approved by the Federal Food and Drug Administration (FDA), I have considered my options and choose to have the above treatment. In addition to the above, I grant permission for any purchase of my medication for my treatment, to be directly delivered to the office of Lora Fulp Efaw M.D., DBA Center for Healing and Wellness P.C.

Under the provisions of the Georgia Access to Medical Treatment Act, I also give immunity to the Center of Health and Wellness, its practitioners, and staff from prosecution resulting from any adverse reactions that may occur by administration of ____________________________________ treatment to me.

Patient's Name (Please Print): ____

Patient's Signature: ____ Date: __________________________

Witness: ____ Date: __________________________

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Patient's Name: ______________________________________ Insurance: _________________________________

ADVANCE BENEFICIARY NOTICE (ABN)

The purpose of this form is to notify you that medicare, Medicaid, and other insurance companies do not typically pay for the following therapeutic procedures.

Non-covered procedures

1. Chelation IV Therapy
2. Meyers Cocktail Therapy
3. Vitamin C Therapy
4. DMPS Therapy
5. Calcium EDTA Therapy
6. Hydrogen Peroxide
7. Therapeutic Massage
8. Nerve Conduction Study
9. Hormone Therapy
10. Laboratory/Pathology Test
11. Injections

I understand that I will be personally responsible for payment in full for the Non-covered therapeutic procedures listed above. I further understand and agree that payment is due and will be paid in full when service is rendered for the above listed non-covered therapeutic procedures.

________________________________ ____
Date Signature of patient or person acting on patients behalf

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MISSED, RESCHEDULED OR CANCELLATION APPOINTMENT POLICY

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.

Unless there are extenuating circumstances, a 24-hour notice of cancellation is required for all scheduled appointments. **Failure to give a 24-hour notice will result in a $25.00 fee for a standard office visit or $50.00 fee for a new patient visit, physical exam or procedure.**

____
Patient’s Signature

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- Nutritional Medicine
- Preventative Care

Lora Fulp Efaw, M.D.
Certified by the
American Board of Family Practice

APPOINTMENT POLICY

Dear Patient,

Due to the new mandatory EMR and Medicare regulations that we have implemented in our office, it has become more difficult for us to see our patients in a timely manner. We have tried to accommodate each patient and address concerns that you were not scheduled for. In doing this, we realize that we have over extended ourselves and that this is also unfair to the other patients. We have received patient complaints about the wait time. We value your time and our desire is to see each patient in a timely manner.

In an effort to be compliant with the new regulations and in order to better serve each of our patients, we will now have to limit your visit time to the time assigned to you on the schedule. We will only be able to see you for the medical problems that you are scheduled for. If you have additional medical problems, we will need to schedule another appointment to address these. In addition to this, we will not be able to discuss other family member's medical problems at your appointment.

We realize this may be an inconvenience to you and we regret that we have to implement this new policy in our office. But, due to the number of patients that need to be seen each day and to stay on schedule, we will now be limiting our time with you according to the time allotted to you on the schedule. Also, if you are more than fifteen minutes late for your appointment, you will be rescheduled for a later date.

Thank you for understanding and willingness to comply with this new policy.

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Patient's Signature

39 Kent Rd • Suite #2, Tifton, GA 31794 • 229.388.9393 • fax: 229.388.9855 • healingandwellness.com

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Center for Healing and Wellness Payment Policy

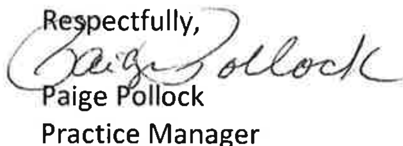
Dear Patient,

We don't exist to profit, but must profit to exist or at least break even. Due to the rising cost of business expenses and decreasing reimbursements, we have had to establish a new payment policy:

1. All co-pays will be collected at the front window on the day of your appointment and if you can't pay your co-pay on the day of your visit, you will be asked to reschedule your appointment. If you know ahead of time that you can't pay your copay or pay on your outstanding balance, we ask that you call in advance to reschedule your appointment.
2. If you have not met your deductible, we are requesting that you pay the allowable amount of your visit upon checking out and if you can't pay your allowable amount you will not be allowed to schedule another appointment until this balance is paid in full.
3. Balances must be paid within thirty days. You may be eligible to receive a 30% discount on your outstanding balance. Please call our office today to see if you meet the criteria.
4. We will not be able to schedule an appointment for you if your balance is $100 or more. This balance must be paid in full before another appointment can be made.
5. If you owe a balance of $100 or more and you call the office for a refill on your medication, according to what the medication is, you will only receive a refill for thirty days and if your balance is not paid within those thirty days, you will receive a letter of discharge.
6. Once your account has been turned over to collections you will receive a discharge from practice letter.

If you are unable to meet the above payment policy, we will have to refer you to another clinic and discharge you from our practice or you will be given thirty days to find another physician.

Respectfully,



Paige Pollock
Practice Manager

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