Snellville, GA
678-252-2132 (phone)
619-329-8933 (e-fax)

IntervalCare MEDICAL SERVICES

New Patient Information

Patient's Full Name: _____ Today's Date: _____
Patient's Date of Birth:_____ Sex: _____
Home Address:_____
Home phone number:_____Cell Phone: _____
Email address:_____
Name of your assisted living, personal care home or nursing facility (if you currently reside in one):_____
What is your preferred contact method?

- ❑ Cell
- ❑ Home
- ❑ Phone
- ❑ Email

Text Message Approval?

- ❑ Yes
- ❑ No

Race/Ethnicity

- ❑ American Indian/Alaska
- ❑ Asian
- ❑ Black
- ❑ Caucasian
- ❑ Pacific Islander
- ❑ Other _____
- ❑ Decline

Marital Status

- ❑ Married
- ❑ Single
- ❑ Divorced
- ❑ Widowed
- ❑ Decline

Employment Status

- ☐ Retired
- ☐ Disabled
- ☐ Employed

Primary/secondary language spoken:_____

List your primary care provider and their contact information:_____
_____

Preferred Pharmacy name, address, and phone number:

_____

Permission to Release Medical Information

Authorized persons that my medical information can be shared with:

Name, relationship, and phone number _____
Name, relationship, and phone number _____

I authorize IntervalCare Medical Services Inc, to share the following in person or by telephone, in regards to my treatment.

- ☐ Clinical Information (test results, diagnosis, treatment plan)
- ☐ Demographic Information
- ☐ Financial information

- ☐ ***I DO NOT authorize IntervalCare Medical Services, Inc to share my medical information with any other individual.***

I understand that I may revoke or change this consent by submitting my request in writing to IntervalCare Medical Services, Inc. You may email your written request to our office at info@intervalcaremed.

Power of Attorney (skip if not applicable)

Name:_____
Relationship:_____ Phone Number:_____
*** Please provide a copy of the power of attorney for the chart***

Emergency Contact

- ❑ Same as Power of Attorney

Contact Name: _____
Relationship: _____
Emergency contact phone number: _____
Do you have a living will or advance directive?
Yes No

Primary Insurance Information:

Insurance Company: _____
Member ID #_____ Group #_____
Primary policy holder's Name_____
Primary Policy holder's Birthdate (if not the patient)_____
Patient's relationship to policy holder_____

Secondary Insurance Information (if applicable):
Insurance Company:_____Secondary Member ID:_____

IntervalCare Medical Services, Inc Policies
RELEASE OF MEDICAL INFORMATION - I authorize IntervalCare Medical Services, Inc, to share medical records/information concerning my care to any physician, hospital, pharmacy, or agency involved in my care. IntervalCare Medical Services, Inc may also request medical records from other agencies involved in my care (hospitals, specialist offices, primary care offices, etc).

ASSIGNMENT OF MEDICAL BENEFITS - I authorize my insurance carrier to assign medical benefits, if applicable, to IntervalCare Medical Services, Inc. I also authorize release of medical information necessary to process all medical insurance claims. By signing, you consent to our office contacting your insurance company on your behalf and billing the cost of your visit to the insurance company you provided.

PAYMENT POLICY - Co-payments or cash payments are to be collected prior to my appointment. If it is an initial visit, co-payments may be collected after billing is processed with my insurance. IntervalCare accepts Visa, MasterCard, and Discover. All medical services provided are directly charged to the patient or responsible party. If our provider is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance (typically your deductible) and billed accordingly, if applicable. Payment is expected to be paid in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY - Our office requests that we receive notice no later than 24 hours prior to the appointment. Appointments not canceled 24hrs prior will incur a $50 fee that will need to be paid prior to booking your next appointment.

REFERRAL POLICY - I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so may not allow IntervalCare to bill my insurance and will result in charges being billed directly to myself.

LABORATORY POLICY-I understand that laboratory testing centers may require demographic information about me and a form of identification provided prior to testing. I will need to arrange for lab draws if an order for labs has been placed. I also understand that laboratory cost is not included in my visit with IntervalCare Medical Services providers. However, the laboratory may bill my insurance for payment. It is my responsibility to ensure lab cost will be covered by my insurance prior to testing. Otherwise, lab costs may be billed to me for payment.

CONSENT FOR TREATMENT- I give consent to perform my medical visit in the clinic or via telecommunication as outlined on the telemedicine consent form. I agree to IntervalCare Medical Services' HIPAA policy. A copy of the telemedicine consent and HIPAA policy can be sent to me at my request from IntervalCare Medical Services Inc.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND PAYMENT POLICIES.

Patient's (Responsible Party) Name _____
Signature/Date_____

Medical History

Full Legal Name *_____ Date of Birth*_____

Allergies and reaction (food and medication) *_____

Height (in feet and inches) * _____ Weight *_____

When were your last annual labs drawn and where?_____

What diagnosis have you previously been given for psychiatric/mental health care? *

_____

What is your main concern today?_____

Which provider/clinic managed your mental health care_____

Who is your mental health therapist?

_____

Current Medications (include OTC medication and vitamins)*:

Name of Medication	Dose	Frequency

Social History

Where were you born and raised?_____

What is the highest level of education you've completed?_____

Occupation (currently or prior to retirement)_____

Retirement year_____

Do you require accommodations for your daily living? If yes, explain.

_____

_____

Have you ever or do you currently drink alcohol? *_____

If yes, how often?_____ how many oz per day?_____

When did you quit?_____

Have you ever/do you currently smoke, vape or chew tobacco? *_____

If yes, how much (ex. cigarettes/day)?_____

How long have you been a nicotine user?_____

When did you quit?_____

Any history of drug use*? What type? (include marijuana)_____

Past Surgical History: (list all operations and year performed) *

Hospitalizations*?_____

_____

_____

_____

_____

Have YOU been diagnosed with any of the following*?

	Cancer		Glaucoma		Angina
	Measles		Diarrhea		Dementia
	Chickenpox		Constipation		Eczema
	Bronchitis		Stomach Ulcer		Skin Ulcer
	Diabetes		High Blood Pressure		Heart Attack
	Seizures		Urinary Tract Infection		Frequent Falls
	Asthma/COPD		Hepatitis		Head Injury
	Rheumatic Fever		Irregular heartbeat		Kidney Stones
	Thyroid Disorder		Liver Disorder		Kidney Disorder
	Congestive Heart Failure		Hearing Difficulty		Loss of Consciousness

Other serious illness/diagnosis:

_____

_____

Family History (check if applies to your parent, sibling, grandparent) *

	Hypertension		alcoholism		Diabetes
	Cancer		Heart Disease		Stroke
	Dementia/Alzheimer's		Thyroid Disease		Insomnia
	Seizure		Blood Disorder		Depression
	Anxiety		Bipolar Disorder		Schizophrenia

I have answered the above questions to the best of my knowledge.

Signature & Date *_____