

Patient Registration

Patient Information					
First Name	MI	Last Name	Gender	Last 4 digits of SS#	Date of Birth
Address		City		State	Zip
Home Phone	Cell Phone	Work Phone	E-mail Address		
Preferred Method of Contact:		Preferred Pharmacy:			
Emergency Contact #1 Full Name and Number:				Relationship to Patient:	
Emergency Contact #2 Full Name and Number:				Relationship to Patient:	
Allergies and Reactions:					
Current Medications					
Name/Strength/Instructions:					
Social History					
Occupation		Marital Status		Sexually Active YES NO	
Tobacco Use: If yes, how long?		Alcohol: If yes, drinks per day/week.		Caffiene: If yes, drinks per day.	
Recreational Drugs: If yes, describe.		Special Diet: If yes, describe.		Regular Exercise: If yes, describe.	
Health Maintenance					
Bone Density	Y	N	Date:	Physical Exam	Y N Date:
Colonoscopy	Y	N	Date:	Mammogram	Y N Date:
Eye Exam	Y	N	Date:	Pap Smear	Y N Date:
Family Medical History					
Father/Paternal Grandparents:					
Mother/Maternal Grandparents:					
Siblings:					
Children:					
Immunization History					
Tetanus in the last 10 years	Yes	No	Shingles vaccine	Yes	No
Pneumonia vaccine	Yes	No	Hepatitis B series	Yes	No
Flu shot in last 1 year	Yes	No			

Direct Primary Care Patient Agreement

Georgia Wellness Solutions, Inc.

This is an Agreement between Georgia Wellness Solutions, Inc.(Practice), a Georgia corporation, located at 100 Pecan Point, Griffin, GA 30224. John Vu, MD (Physician) in his capacity as an agent of Georgia Wellness Solutions, Inc. and you (Patient).

Background

The Physician, practices family medicine, delivers care on behalf of Practice in Georgia. In exchange for certain fees paid by You. Practice through its Physician(s), agrees to provide patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The Practice website is www.vudomedicine.com

Definitions

1. Patient. A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to, or listed on the documents attached as Appendix 1, and incorporated by reference, to this agreement.
2. Services. As used in this Agreement, the term Services, shall mean a package of ongoing primary care services, both medical and non-Medical, and certain amenities(collectively "Services"), which are offered by Practice, and set forth in Appendix 1 and 2. The Patient will be provided with methods to contact the physician via phone, email, and other methods of electronic communication. Physician will make every effort to address the needs of the Patient in a timely manner, but cannot guarantee availability, and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.
3. Fees. In exchange for the services described herein, Patient agrees to pay Practice, the amount as set forth in Appendix 1 and 2, attached. Applicable enrollment fees are payable upon execution of this agreement. If this Agreement is terminated by either party before the end of an applicable monthly period, then the Practice shall seek only partial payment for the final month of service based on the number of days of membership provided to the patient and the itemized charges, set forth in appendix 2, for services rendered to Patient up to the date of termination.
4. Non-Participation in Insurance. Patient acknowledges that neither Practice, nor the Physician participate in any health insurance or HMO plans. Physician has opted out of Medicare. Patient acknowledges that federal regulations REQUIRE that Physician opts out of Medicare so that Medicare patients may be seen by the Practice pursuant to this

private direct primary care contract. Neither the Practice nor Physician make any representations regarding third party insurance reimbursement of fees paid under this Agreement. The Patient shall retain full and complete responsibility for any such determination. If the Patient is eligible for Medicare, or during the term of this Agreement becomes eligible for Medicare, the Patient will sign the agreement attached as Appendix 3, and incorporated by reference. This agreement acknowledges your understanding that the Physician has opted out of Medicare, and as a result, Medicare cannot be billed for any services performed for you by the Physician. You agree not to bill Medicare or attempt Medicare reimbursement for any such services.

5. Insurance or Other Medical Coverage. Patient acknowledges and understands that this Agreement is not an insurance plan, not a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by Practice, or its Physicians. Patient acknowledges that Practice has advised that patient obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs. Patient acknowledges that THIS AGREEMENT IS **NOT A CONTRACT THAT PROVIDES HEALTH INSURANCE**, in isolation does NOT meet the insurance requirements of the Affordable Care Act, and is not intended to replace any existing or future health insurance or health plan coverage that Patient may carry. This Agreement is for ongoing primary care, and the Patient may need to visit the emergency room or urgent care from time to time. Physician will make every effort to be available at all times via phone, email, other methods such as "after hours" appointments when appropriate, but Physician cannot guarantee 24/7 availability.
6. Term. This Agreement will commence on the date it is signed by the Patient and Physician below and will extend monthly thereafter. Notwithstanding the above, both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination. The Patient may terminate the agreement with twenty-four hours prior notice, but the Practice shall give thirty days prior written notice to the Patient and shall provide the patient with a list of other Practices in the community in a manner consistent with local patient abandonment laws. Unless previously terminated as set forth above, at the expiration of the initial one-month term (and each succeeding monthly term), the Agreement will automatically renew for successive monthly terms upon the payment of the monthly fee at the end of the contract month. Examples of reasons the Practice may wish to terminate the agreement with the Patient may include but are not limited to:
 - The Patient fails to pay applicable fees owed pursuant to Appendix 1 and 2 per this Agreement;
 - The Patient has performed an act that constitutes fraud;

- The Patient repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances;
 - The Patient is abusive, or presents an emotional or physical danger to the staff or other patients of Practice;
 - Practice discontinues operations; and
 - Practice has a right to determine whom to accept as a patient, just as a patient has the right to choose his or her physician. Practice may also terminate a patient without cause as long as the termination is handled appropriately (without violating patient abandonment laws).
7. **Privacy & Communications.** You acknowledge that communications with the Physician using email, facsimile, video chat, instant messaging and cell phone are not guaranteed to be secure or confidential methods of communications. The practice will make an effort to secure all communications via passwords and other protective means and these will be discussed in an annually updated Health Insurance Portability and Accountability Act (HIPAA) "Risk Assessment." The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to the patient. If the Patient initiates a conversation in which the Patient discloses "Protected health Information (PHI)" on one or more of these communication platforms then the Patient has authorized the Practice to communicate with the patient regarding PHI in the same format.
8. **Severability.** If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.
9. **Reimbursement for Services if Agreement is Invalidated.** If this Agreement is held to be invalid for any reason, and if Practice is therefore required to refund all or any portion of the monthly fees paid by the Patient, Patient agrees to pay Practice an amount equal to the fair market value of the Services actually rendered to Patient during the period of time for which the refunded fees were paid.
10. **Assignment.** This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.

11. Jurisdiction. This Agreement shall be governed and construed under the laws of the State of Georgia and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Griffin, Georgia.

12. Patient Understandings (initial each):

_____ This Agreement is for ongoing primary care and is **NOT** a medical insurance agreement.

_____ I do **NOT** have an emergent medical problem at this time.

_____ In the event of a medical emergency, I agree to call 911 first.

_____ I do **NOT** expect the practice to file or fight any third party insurance claims on my behalf.

_____ I do **NOT** expect the practice to prescribe chronic controlled substances on my behalf. (These include commonly abused opioid medications, benzodiazepines, and stimulants.)

_____ In the event I have a complaint about the Practice I will first notify the Practice directly.

_____ This Agreement (without a "wrap around" compliant insurance policy) does not meet the individual insurance requirement of the Affordable care Act.

_____ I am enrolling (myself and my family if applicable) in the practice voluntarily.

_____ I may receive a copy of this document upon request.

_____ This Agreement is non-transferable.

Patient Name: _____

Patient (or Guardian) Signature: _____

Physician Name: _____

Physician Signature: _____

Date: _____

Appendix 1: Georgia Wellness Solutions Periodic and Enrollment Fees

This Agreement is for ongoing primary care. This Agreement is **NOT HEALTH INSURANCE** and is **NOT A HEALTH MAINTENANCE ORGANIZATION**. The patient may need to use the care of specialists, emergency room, and urgent care centers that are outside the scope of this Agreement. Each Physician within the Practice will make an appropriate determination about the scope of primary care services offered by the Physician. Examples of common conditions we treat, procedures we perform, and medications we prescribe are listed on our website and are subject to change.

Fee Schedule

Enrollment Fee: This is charged when the Patient enrolls with the Practice and is nonrefundable. This fee is subject to change. If a patient discontinues membership and wishes to re-enroll in the practice, we reserve the right to decline re-enrollment or to require that the re-enrollment fee reflect an amount equivalent to the months of absent payments when dis-enrolled from the Practice.

Your enrollment fee is \$100.00

Monthly Periodic Fee (billed at the end of the service period) - This fee is for ongoing primary care services. Your number of virtual visits (e-mail, electronic, phone) are not capped. We prefer that you schedule visits more than 24 hours in advance when possible. Many services in our office (such as EKGs, laboratory tests and generic medications) are available to you at low cost to you. These items will be listed on our website and are subject to change.

The monthly periodic fee is \$ _____ per month (due at the end of the month of service).

The periodic fee will be billed at the end of the month (after the ongoing primary care has been provided) and the patient is entitled to leave the practice at any time and be assigned a prorated final bill based upon the date of withdrawal from the practice.

After-Hours visits

There is no guarantee of after-hours availability. This agreement is for ongoing primary care, not emergency or urgent care. Your physician will make reasonable efforts to see you as needed after hours if your physician is available.

Acceptance of Patients

We reserve the right to accept or decline patients based upon our capability to appropriately handle the patient's primary care needs. We may decline new patients pursuant to the guidelines proffered in Section 6 (Term), because the Physician's panel of patients is full (capped at 600 patients or fewer), or because the patient requires medical care not within the Physician's scope of services.

Appendix 2: Georgia Wellness Solutions Itemized Fees

Ongoing Primary Care is included with the Periodic Fee described in Appendix 1. Please see a list of some of the chronic conditions we routinely treat on the Practice website (subject to change). There are no itemized fees for office visits.

In Office Procedures we are generally comfortable performing the listed procedures on the website. These are typically available at no additional cost unless otherwise designated, and these are also subject to change.

Laboratory Studies will be drawn in the office at no additional charge and the Patient will be charged according to the direct price rate we have negotiated with the lab. An example of common laboratory studies and their prices (subject to change) are listed on the practice website.

Medications will be ordered in the most cost effective manner possible for the Patient. When we dispense medications in the office these medications will be made available to the patient at low cost. Examples of commonly dispensed medications and their prices (subject to change) are listed on the practice website.

Pathology studies (most commonly skin biopsies and PAP smear) will be ordered in the most economical manner possible. Anticipated prices for these studies (subject to change) are listed on the website.

Radiology studies will be ordered in the most cost effective manner possible for the Patient. Commonly ordered radiologic studies and prices (subject to change) are listed on the website.

Surgery and specialist consults will be ordered in the most cost effective manner possible for the Patient.

Vaccinations are **NOT** offered in our office at this time due to the cost prohibitive nature of stocking a limited supply. We will make an effort to help you obtain needed vaccinations elsewhere in the most cost effective manner possible.

Hospital Services are **NOT** covered by our membership plan, and due to mandatory "on call" duties required at local institutions we have elected **NOT** to obtain formal hospital admission privileges at this time.

Obstetric and Gynecologic Services are **NOT** covered by our membership plan. Due to our small size, we are unable to offer these services at this time.



AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

Patient Name:

Date of Birth:

Address:

City/State/Zip:

Home/Cell#:

I authorize the named healthcare provider to disclose the health information as directed below in person, by email, or by mail to the address specified at the time of the request.

Provider Name:

Phone Number:

RECORDS AUTHORIZED TO BE RELEASE: **LAST 2 YEARS ONLY**

- Office Notes (complete medical record)
- Lab Reports
- Radiological images/reports (xrays, mammograms, MRI, CT, DEXA, Ultrasound)
- Other: _____

PLEASE FAX MY RECORDS TO : **IF MORE THAN 30 PAGES-PLEASE MAIL**

Georgia Wellness Solutions
100 Pecan Point, Suite A
Griffin, Ga. 30224

Phone: (678) 326-9934
Fax: (678) 805-5564

Patient or Representative Signature

Date

Name of Representative (please print)

Witness