D. CONRAD HARPER, M.D. L.L.C.

WESTSIDE OFFICE
102 NW Bowens Mill Road
Douglas, GA 31533
912-384-3838 (P)
912-384-8847(F)

To: Patients of Dr. Harper

As you all know, I feel screening techniques are very important and enable physicians to detect disease early with the intent to hopefully treat the disease in a successful manner. Therefore, I am going to recommend a very simple test for the early detection of colon cancer, i.e. "fecal occult blood". This test involves the collection of a stool sample followed by testing for very small amounts of blood. Current recommendations suggest this test be performed on an annual basis if you are over age 50. This test is also not intended to replace the need for a colonoscopy. Therefore, my staff will be reminding you of the need for this test if you are over age 50.

Thank you.

Dr. Harper

Patient's Rights and Responsibilities

As a patient you have certain rights and responsibilities. We recognize a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care.

Patients have the right to:

- Receive humane care and treatment with respect and consideration
- Privacy and confidentiality when seeking and receiving care except for life threatening conditions or situations
- Confidentiality of your health records
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved, and prognosis of an illness or health related condition.
- Ask about reasonable alternatives to care
- A second professional opinion regarding one's health care and treatment
- Participate actively in decisions regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or care

Patients have the responsibility to:

- Provide complete information about one's illness/problem to enable proper evaluation and treatment
- Ask questions so that an understanding of the condition or problem is ensured
- Show respect to health personnel and other patients
- Reschedule/cancel an appointment to allow another person to be given the time slot...three(3) "no shows" may results in your dismissal from the practice
- Arrive for their scheduled appointments on time. Patients arriving 30 minutes late for their scheduled appointments will have to reschedule for another day.
- Pay bills or file health claims in a timely manner
- Use prescription or medical devises for oneself only
- Inform the practitioner(s) if one's condition worsens or an unexpected reaction occurs from a medication

24 HOUR CANCELLATION & NO-SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Dr. Harper reserves the right to charge a fee of $25.00 for all missed appointments (no-shows) and appointments which, without compelling reason, are not cancelled with a 24-hour advanced notice.

No-show fees will be billed directly to the patient. This fee is not covered by insurance. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

____ DATE ____________________

PRINTED NAME

____

SIGNATURE

ATTENTION

Please bring the following with you to your appointment.

1. All medication including over the counter medicine
2. Insurance cards
3. Payment

Your appointment may be rescheduled if you do not bring the items listed above.

If you need to reschedule your appointment, please call 24 hours ahead.

Thank you for your cooperation.

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Patient Information

First & Last Name: ______________________________ Middle Initial: ________

Male or Female   Date of Birth: ______________ Home Phone: ____________ Cell Phone: ______________

Marital Status: S M D W   Social Security Number: ______________ Pharmacy Preferred: ______________

Mailing Address: ____

Physical Address: ____

City: ____________________ State: ____________________ Zip Code: __________

Employer: ______________________ Work Phone Number: ______________________

Spouse Name: ______________________ Phone Number: ______________________

Emergency Contact: ______________________ Phone Number: ______________________

Email Address: ____

Is This Visit A Hospital Follow Up? Yes or No   Dates in Hospital: ______________________

Assignment & Release

Attention Medicare Patients: We are required by law to collect a Co-Payment that is not covered by Medicare. Please let us know if you have a supplemental policy that might cover this co-payment. Under the Federal law governing Medicare, you are mandated by law to pay your deductible and a 20% co-payment.

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________, and assign directly to Dr. Conrad Harper all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the release of any/ all of my medical records to any insurance company and to any referred doctor(s).

If you have an unpaid balance 90 days after the Insurance payments have been received, we will put you on a monthly payment plan. Our billing office will contact you to make those arrangements or you can pay your balance on a credit card. By signing below you acknowledge that you understand this policy.

X____

(Responsible Party Signature)   (Relationship)   (Date)

Insurance Policy Holder Name: ______________________________ Date of Birth: ________

FINANCIAL POLICY

1. Payment is due at the time of service. You may also be asked to pay old balances in full before an appointment can be scheduled.
2. If you have insurance, please provide us with your card and verify your current address and phone number.
3. We will bill your insurance company as a courtesy, however, if your insurance company does not provide us with a payment in a reasonable amount of time, a request for the account balance will be sent to you.
4. If you have insurance coverage with a company that we do not have a contract with for payment claims, you will be asked to cover the full cost of today's visit. We will be glad to file your claim and proceeds will be paid directly to you as the "insured".
5. Not all procedures are covered by your insurance. Payment for these procedures will be your responsibility. Therefore, you may wish to check with your insurance company or obtain verification before these procedures are scheduled.
6. If you do not have insurance, you will be considered a "self-pay". The fee or charge will be adjusted to reflect a discount for services rendered.
7. Medicare patients are required by Federal Law to pay their co-payments and annual deductible. Co-payments and your annual deductible amount are not covered by Medicare.
8. NONPAYMENT- balances over 90 days will be brought to the attention of Dr. Harper and the Office Administrator. Efforts will be made to establish a payment plan to meet your budget and needs. However, continued non-payment for services rendered may result in your dismissal from our practice. Your cooperation regarding this matter would be greatly appreciated.
9. MISSED APPOINTMENTS- An excessive number of missed appointments not cancelled within a reasonable time frame may result in your dismissal from this practice. Please call in advance to cancel your appointment to allow us to offer this time slot to someone else in need of medical services.
10. Please direct any questions you have regarding your account balance to our billing coordinator. Again, efforts will be made to accommodate your specific needs and circumstances.
11. Otherwise, we sincerely appreciate you choosing our office as the provider of your healthcare service and will make every effort to provide high quality and individualized service.

Thank You.
Dr. Harper, Mallory O'Brien, FNP-C, Justin Fender, FNP-C, and staff

I have read and understood the payment policy and agree to abide by its guidelines.

_______________________________ _______________________

Patient or Responsible Party Signature Date

This agreement will be scanned and made a permanent part of your healthcare record.

D. Conrad Harper, M.D., L.L.C.

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Medical Records Release Form

Date: ________________

Doctor's Name & Address: ____

____

____

Please fax last 3 most recent office notes, labs, testing etc.

On Patient: ___________________________ **DOB:** ________________ **to 912-384-8847**

D. Conrad Harper, M.D., L.L.C.

Patient Name: ____ **DOB:** _________________________

Patient Signature: ____

Patient Address: ____

____

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Consent for Use or Disclosure of Protected Health Information for Payment, Treatment, and Health Care Options

By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for which you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations, You may refuse to sign this form; however, your diagnosis and treatment may be conditioned upon your consent as evidenced by your signature on this form.

You should read the Notice of Privacy Practices for Protected Health Information (PHI) attached to this form before signing the consent. The terms of the notice may change from time to time, and you may always get a revised copy by asking the Privacy Officer of this practice.

You have the right to request that the practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to requested restrictions; however, if the practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under Federal Law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under Federal Law.

You may communicate with the following individuals regarding my condition or course of treatment: ______________________________

You may communicate confidential information to me, including invoices for services, to the following address and phone numbers:

____

____

____

______________________________ ______________________________

Individual Signature Date

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is a condensed version of our notice of Privacy Practices. Our full length notice follows this summary.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medical information is personal to you, and we are committed to protecting your privacy. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

Here are a few examples of uses for your medical information. For more details, please refer to the notice of Privacy Practices that follows this summary.

*For medical treatment
*To obtain payment
*In emergency situations
*Appointment recall reminders
*To run practice efficiently/effectively
*For research
*To avert a serious threat to health & safety
*For organ and tissue donation
*For worker's compensation programs
*In response to certain request arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the practice of the Secretary of the Department of Health and Human Services. To file a complaint you may contact our privacy officer, Steve Bailey at (912) 384-4000 EXT: 202. All complaints must be submitted in writing and you will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:
*The right to inspect and copy
*The right to amend
*The right to an accounting of disclosures
*The right to request restrictions
*The right to a paper copy of this notice
*The right to request confidential communications

For more information about these rights, please review the detailed Notice of Privacy Practice that follows this summary.

Medical History Form

Fill in the information below as completely as possible.

Name: ______________________________ **Age:** ____________ **Date:** ______________

YOUR CURRENT MEDICATIONS:

Name of Medication	Dosage	How Many Times Per Day
____________	__________	______________
____________	__________	______________
____________	__________	______________
____________	__________	______________
____________	__________	______________
____________	__________	______________
____________	__________	______________

LIST ANY ALLERGIES TO MEDICATIONS:

Name of Medication	What reaction did you have?
______________________________	________________________
______________________________	________________________
______________________________	________________________
______________________________	________________________
______________________________	________________________

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Medical Problem	Circle One	Give Details
Heart Disease	Yes/No	______________
Diabetes	Yes/No	______________
High Blood Pressure	Yes/No	______________
Lung Disease	Yes/No	______________
Asthma	Yes/No	______________
Cancer	Yes/No	______________
Thyroid Problems	Yes/No	______________
Ulcers	Yes/No	______________
Blood Transfusions	Yes/No	______________
Kidney Problems	Yes/No	______________
Arthritis	Yes/No	______________
Seizures	Yes/No	______________
Breast Problems	Yes/No	______________
Sexually Transmitted Disease	Yes/No	______________
Any Other	Yes/No	______________

RECENT SYMPTOMS:
(List any symptoms you are having or had recently.)

GENERAL	
Hay Fever	YES/NO
Sneezing	YES/NO
Sinus Problems	YES/NO
Prolonged Fevers	YES/NO
Weight Loss/Gain	YES/NO
EYES	
Recent change in Vision	YES/NO
Drainage from Eyes	YES/NO
CARDIOVASCULAR	
Chest Pain or Tightness	YES/NO
Irregular Heart Beat	YES/NO
Episodes of Heart Fluttering	YES/NO
Fainting or Dizziness	YES/NO
Increasing Shortness of Breath	YES/NO
Short of Breath when laying flat	YES/NO
Wake up at night short of breath	YES/NO
Swelling of legs	YES/NO
Excessive Fatigue	YES/NO
LUNG HISTORY	
Wheezing or asthma attacks	YES/NO
Chronic Cough	YES/NO
Cough up blood	YES/NO
Painful breathing	YES/NO
Excessive Snoring	YES/NO
Difficulty staying awake during the day	YES/NO
Episodes of Stopping breathing at night	YES/NO
GASTROINTESTINAL	
Frequent Heartburn or Indigestion	YES/NO
Pain or difficulty when swallowing	YES/NO
Vomiting Blood	YES/NO
Red blood in stool	YES/NO
Black, tarry stools	YES/NO
Chronic Diarrhea	YES/NO
Chronic Constipation	YES/NO
Abdominal Pain	YES/NO
URINARY	
Blood in urine	YES/NO
Difficult passing urine	YES/NO
Urge to urinate too frequent	YES/NO
Frequent urination at night	YES/NO
Painful urination	YES/NO
SKIN	
Skin lesions or moles that concern you	YES/NO
NEUROLOGICAL	
Seizures or Epilepsy	YES/NO
Stroke or stroke-like symptoms	YES/NO
PSYCHIATRIC	
Anxiety	YES/NO
Depression	YES/NO
MUSCULOSKELETAL	
History of joint pain or arthritis	YES/NO
Low Back Pain	YES/NO
Neck Pain	YES/NO

PAST SURGICAL HISTORY:
(Please list previous surgeries and the year the surgeries were performed.)

____

____

____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies __________
Number of live births __________
Stillbirths/Miscarriages/Abortions __________

Date of your last Pap smear __________
Date of your last mammogram __________
Date of your last menstrual period __________

FAMILY MEDICAL HISTORY:
(List medical problems of any relatives.)

Medical Problem	Which Relative	Give Details
Heart Disease	____________________	____________________
Diabetes	____________________	____________________
Stroke	____________________	____________________
Cancer	____________________	____________________
High Cholesterol	____________________	____________________
High Blood Pressure	____________________	____________________
Other Problems	____________________	____________________

Father: __________ Living, His Age__________

__________ Died, at age__________ from what cause____

Mother:__________ Living, Her Age__________

__________ Died, at age__________ from what cause____

Number of brothers: __________ Number of sisters: __________

SOCIAL HISTORY:

Circle one: Single/Married/Divorced/Widowed

Number of children:__________ Your Occupation:__________________________

Smoking (check one): __________I have never smoked
__________I smoked previously but quit.
How much: __________ for how long: __________ Quit when: __________
__________I currently smoke
How much: __________ for how long: __________

Do you drink alcoholic beverages: YES/NO If yes, how much/how often:__________________

BALANCE SELF TEST

ARE YOU AT RISK FOR FALLS?

*Have you fallen in the past year?	YES	NO
*Do you lose your balance when standing?	YES	NO
*Do you lose your balance when you initially get up after sitting?	YES	NO
*Do you get dizzy, faint or have seizures?	YES	NO
*Does it take you more than one try to get up out of a chair or out of bed?	YES	NO
*Do you trip over your own feet or objects on the floor?	YES	NO
*Do you take corners too sharp; bump into corners or door frames?	YES	NO
*Do you use a walker, cane or need assistance to get around?	YES	NO
*Do you lose your balance, feel unsteady or stagger when walking?	YES	NO
*Have you had a recent loss of or decrease in vision or hearing?	YES	NO
*Do you have numbness or loss of sensation in your feet or legs?	YES	NO
*Have you experienced a stroke, accident or any other health problems that may have affected your balance?	YES	NO

If you have answered yes to one or more questions, you may have a balance problem. If you are concerned about falling, you should speak with your physician.

Patient Name (Printed): ____________________ SSN: __________

Patient Signature: _________________________ Date: __________

This survey asks questions about you, your breathing and what you are able to do. To complete the survey, mark an X in the box that best describes your answer for each question below.

1. **During the past 4 weeks, how much of the time did you feel short of breath?**

None of the time	A little of the time	Some of the time	Most of the time	All of the time
☐ 0	☐ 0	☐ 1	☐ 2	☐ 2

2. **Do you ever cough up any "stuff" such as mucus or phlegm?**

No, never	Only occasional colds or chest infections	Yes, a few days a month	Yes, most days a week	Yes, everyday
☐ 0	☐ 0	☐ 1	☐ 1	☐ 2

3. **Please select the answer that best describes you in the past 12 months. I do less than I used to because of my breathing problems**

Strongly disagree	Disagree	Unsure	Agree	Strongly agree
☐ 0	☐ 0	☐ 0	☐ 1	☐ 2

4. **Have you smoked at least 100 cigarettes in your ENTIRE LIFE?**

No	Yes	Don't Know
☐ 0	☐ 2	☐ 0

5. **How old are you?**

35-49	50-59	60-69	70+
☐ 0	☐ 1	☐ 2	☐ 2

How to score the survey: In the spaces below, write the number that is next to your answer for each of the questions. Add the numbers to get the total score. The total score can range from 0 to 10.

______ + ______ + ______ + ______ + ______ = ______

#1 #2 #3 #4 #5 Total:

FATIGUE SEVERITY SCALE (FSS) OF SLEEP DISORDERS

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g.,7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS QUESTIONNAIRE							
During the past week, I have found that:	Disagree ←→ Agree						
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
Exercise brings on my fatigue.	1	2	3	4	5	6	7
I am easily fatigued.	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
	TOTAL SCORE:						

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Scoring your results.

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

THE FATIGUE SEVERITY SCALE KEY

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.

Berlin Questionnaire Sleep Evaluation

Patient Name:________________________ Date: _______________

1. Do you snore?
   - Yes
   - No
   - Not Sure

   If you snore….
2. Is your snoring
   - Slightly louder than breathing
   - As loud as talking
   - Louder than talking
   - Very loud. Can be heard in adjacent rooms.
3. How often do you snore?
   - Nearly everyday
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
4. Has your snoring ever bothered other people?
   - Yes
   - No
5. Has anyone noticed that you quit breathing during your sleep?
   - Nearly everyday
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
6. How often do you feel tired or fatigued after you sleep?
   - Nearly everyday
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
7. Do you feel tired or fatigued during your wake time?
   - Nearly everyday
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - Yes
   - No

   If yes, how often does it occur?
   - Nearly everyday
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
9. Do you have high blood pressure?
   - Yes
   - No

EPWORTH SLEEPINESS SCALE

You can use the form below to determine your sleepiness level. For each situation, choose a number based on the scale below. When you finish entering all responses, add the total of your score and enter it at the bottom. It is important to select one answer (0 to 3) for each of the 8 situations below.

PLEASE US THE FOLLOWING SCALE:

0=Would never doze off
1=Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

Situation	Chance of dozing (0 to 3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place-for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
	Total Score:			

THE EPWORTH SLEEPINESS SCALE KEY:

- A total score of less than 10 suggest that you are not suffering from excessive daytime sleepiness.
- A total score of 10 or more suggest that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder.

YOUR NEXT STEPS:

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true EDS is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.