Primary Care
Internal Medicine
in Evans

Zhenrong Zhang, MD

Thank you for choosing Primary Care Internal Medicine in Evans (PCIM). We are delighted to welcome you and will make every effort to serve you in a manner that will meet your expectations. (The form is available online at pcimevans.com)

Please assist us by completing the attached forms and bringing them with you for your initial visit.

Please also bring the following items with you to assist with your examination.
• Any medical records from your referring or previous physician.
• Picture ID
• Insurance Card(s)
• A list of or in the original bottle all of your medications that you are currently taking.
• Co-payment or co-insurance if applicable.

We are located conveniently at 465 N Belair Road, Suite 3E, Evans, GA 30809.

You may reach us by calling (706)-364-4775.

On behalf of our entire medical team, we would like to thank you for choosing Primary Care Internal Medicine in Evans for your health-care needs.

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Office Information and Policies

Office Hours:
8:00 AM - 5:00 PM Monday through Friday with lunch hour 12:00 PM - 1:00 PM, except for Wednesday form 8:00 AM - 12:00 PM.

Contact Information:
Phone number: 706-364-4775
Fax number: 706-364-6992

We appreciate the opportunity to provide your health care needs. These policies are intended to allow us to provide better health care services to patients in a timely manner. Thank you for understanding and cooperating.

Scheduled Appointments
We do our best to see you in a timely manner when you come in for your appointment. Please arrive 15 minutes before your appointment time to register. if you are more than 15 minutes late, we reserve the right to reschedule you for another time. If no show for 3 times, you will be discharged from the practice.

No-show/late cancellation policy

- We understand that you may need to cancel an appointment occasionally. In such circumstances, please contact us no later than 24 hours before your scheduled appointment time. You may do so by calling 706-364-4775, or using the patient portal to cancel online.
- If you do not show up for your appointment, or cancel or reschedule within 24 hours of your appointment time, we will consider that a no-show. No-show appointments may be subject to a $50 fee. No-show fees are the patient's sole responsibility and must be paid in full before your next appointment.
- We know that unexpected situations sometimes arise. In the case of emergencies or extenuating circumstances, we may waive the no-show fee. Waivers are determined on a case-by-case basis at the practice management's sole discretion.

Prescription Refills
Our clinic MAY NOT manage or prescribe chronic pain and/or pain and/or Benzodiazepines.

- Please contact your pharmacy 3 business days before you need a medication refill. Usually the pharmacist can refill the medication if there are fills or they will submit a refill request to our office electronically. It is your responsibility to notify the pharmacy in a timely manner when refills are needed.
- Approval of your refill may take up to three business days so please be courteous and request early. If you use a mail order pharmacy, please contact mail order pharmacy fourteen (14) days before your medication is due to run out.
- If you need a refill on a controlled substance medication that your current provider is already prescribing for you, please contact the clinic at least 3 days before you are out and allow 3 days to refill the medication. You have to keep regular follow up appointment to get medication refilled.

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- Medication refills will only be addressed during regular office hours. No prescriptions will be refilled on weekends, Holidays, nights or after hours. Please call your pharmacy to verify if you are out of a medication before calling your provider.
- Some medications require prior authorization by your insurance. Depending on your insurance this process may involve several steps by both your pharmacy and our staff. The staff and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Sometimes, only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates. This may take up to 2 weeks.
- It is important to keep scheduled appointment to ensure that you receive timely refills.
- Repeated no show or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months or per provider discretion.
- If you have questions regarding medications, please discuss these during your appointment.
- If you feel your medication needs to be adjusted or changed, please contact us immediately to set up a follow up appointment.
- New symptoms or events require a clinic appointment. Your provider will not diagnosis or treat over the phone.
- We advise that you use prudent judgement and account for unexpected delays. Thank you for your patience as we work hard to provide the best care for you.

Referrals

We refer patient to subspecialists per patient's reference. If patient doesn't know who you want us to be referred, we will choose the physician who we believe can provide the best care for you.

Hospitalization for patients and after hour coverage

We offer quick sick visit throughout the day as much as possible if you can call us or book online before you come in. You can go to Urgent Care for minor issues or ER if you are severely sick after office hour or weekends and need immediate attention.

Laboratory Services

We have Quest Diagnostics laboratory on site. Our staff will attempt to determine the lab or facility that your insurance covers, but it is ultimately your responsibility as the patient/insured to confirm the correct lab or facility.

Letter or Forms

Physicians will complete forms and letters as time permits. We ask that you give the physician 7 business days for this. If forms or letters are needed prior to 7 business days, an appointment will need to be made.

Signature _____Date ___

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HIPAA PATIENT QUESTIONNAIRE

Privacy Notice (HIPAA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Primary Care Internal Medicine in Evan. I hereby authorize PCIM to disclose information about myself that is protected under federal law for the purposes of treatment, payment, and healthcare operations, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will also include but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

Patient Name: _____ D.O.B.: _____

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____
Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____

2. Please print the telephone number where you want to receive calls and text messages about your appointments, lab and x-ray results, and other health care information if other than your home phone number:
Phone :(_____) _____-_____

3. I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from PCIM, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

4. I am fully aware my health information will/may be transmitted by electronic transmission, by secure fax transmittal, by internet or by email for continued health care needs.

Patient Signature (Guardian if under 18 years) _____

Date _____

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Financial Policy

Thank you for choosing Primary Care Internal Medicine in Evans (PCIM). We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing quality healthcare services to our patients. Our financial policy is as follows:

1. Payment Guarantee: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through PCIM from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a PCIM billing statement (A text and or email notification) whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with PCIM's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by AdvancedMD, a third-party business associate. I hereby consent to have my payment information collected and stored securely by AdvancedMD. you will receive an email/text message with your account statement. You are highly encouraged to pay the balance using the security portal provided, or you can mail a check to the office or contact the office for your payment. If you need assistance or have any questions, please contact the office at **706-364-4775**.

2. Insurance: Please provide updated insurance card on each visit. We will file Insurance for you under most circumstances as long as you provide us with current information. You are ultimately responsible for understanding the details of your coverage and what charges you may incur. If your insurance company does not respond to us within 60 days of a filed insurance claim, the charges will be sent to you to follow up on and you will be responsible for payment.

3. Minor Children Patients: Minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the parent who seeks treatment for the child and are due at the time of service regardless of court-ordered responsibility.

4. Self-Pay patients: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I responsible for all charges occurred at time of service.

5. Missed Appointment Charge - Please notify our office at least 24 hours in advance if you are unable to keep a scheduled appointment or you may be charged a $50 fee.
6. Additional Service Charges - A service charge of up to $35-50 may be added for each of the following: a). Returned Checks; b). Additional forms (FLMA, school physical form etc.).
I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my Insurance Company, as well as applicable co-pays and deductibles, are my responsibility.

Patient Printed Name_____DOB_____

Patient Signature (Guardian if under 18 years) _____Date _____

Relationship to Patient_____

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Consent

SECTION I. CONSENT TO TREATMENT: I hereby request, authorize, and consent to the rendering of such care at Primary Care Internal Medicine in Evans (PCIM) as may include treatments and diagnostic procedures considered necessary or advisable by Dr. Zhenrong Zhang in charge of this case and her assistants, designees, or consultants and all other acts appropriately related to the procedures described above as may be necessary, appropriate, or helpful. I understand the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury; or even death. I acknowledge that no guarantees have been made to me concerning the results of examination or treatment.

SECTION II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION;
ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient present for care to assure safety, quality and to coordinate patient care across the provider network. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries may be sent to referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. PCIM can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record. I hereby authorize PCIME to share my electronic medical record among my healthcare providers and obtain medication, medical history through a Provider Health Information Exchange (HIE). PCIM will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

CONSENT FOR VIRTURAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that “virtual health” or “telemedicine services” includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of PCIM’s Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.
I have read or have had read to me the above Sections I, II and understand them. I certify that the information I have given during this processing is true, accurate, and complete as evidenced by my signature:

_____ _____
(Signature of patient or surrogate decision maker) (Date)

_____
(Witness)

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Patient Information

Patients Name (First, Middle, Last): _____

D.O.B.: _____/_____/_____ Age: _____ Marital Status: _____ SSN#: _____-_____-_____

Address: _____ City: _____ State: _____Zip: _____

Primary Number I wish to have used for contact: Home Work Mobile

Home Phone: (_____)-_____-_____Work: (_____)-_____-_____

Mobile: (_____)-_____-_____

Patient Email Address: _____ Male Female

Race: Caucasian African American Hispanic Asian Other _____

Emergency Contact: _____ Phone:(_____)-_____-_____Relationship:_____

Preferred Pharmacy: _____

Preferred Lab: _____

Employment Status: Full time Part time Retired Unemployed

Employer: _____

Guarantor of Account: Self Other: _____ D.O.B.: _____/_____/_____Relationship: _____

Primary Insurance: _____ID No.:_____ Group No.:_____

Subscriber: Self Other: _____ Relationship: _____

D.O.B.: _____/_____/_____ SSN#:_____-_____-_____ Phone Number:(_____)-_____-_____

Secondary Insurance: _____ID No.:_____ Group No.:_____

Subscriber: Self Other: _____ Relationship: _____

D.O.B.: _____/_____/_____ SSN#:_____-_____-_____ Phone Number:(_____)-_____-_____

All information given is accurate. I give permission for this practice to contact me regarding practice information by the above methods.

Print Name: _____ Signature: _____

Date: _____/_____/_____

Reason for visit today: _____

_____

_____

_____

465 N. Belair Road, Suite 2C
(706)-364-4775