DR. RANA MUNNA

INTERNAL MEDICINE

Dr. Munna and her staff are delighted to welcome you to our practice! We are pleased that you chose us for your medical needs. Let me introduce you to our office:

Dr. Munna is a graduate of Mercer University School of Medicine and completed her internal medicine residency in Atlanta. She returned to Macon to begin her practice in 2004. She is dedicated to providing superior care to her patients. Dr. Munna's focus is health, wellness, and fitness. She specializes in weight loss, so be sure to ask us about that program. We also offer Botox, Juvederm and Latisse for your cosmetic needs. Be sure and check out her website: www.Drmunna.com.

Jennifer Burt is a family nurse practitioner (FNP), board certified. She graduated from Troy University with her Doctor of Nursing Practice. Also, Jennifer has a Bachelor of Science in Biology from the University of Pittsburgh and a Bachelor of Nursing from Duquesne University, both located in Pittsburgh, Pennsylvania. Jennifer's prior experience was in the intensive care unit, where she worked for five years at Piedmont Macon Medical Center. Originally from Pennsylvania, Jennifer and her husband reside in Macon, Georgia. She completed the majority of her FNP training with Dr. Munna. Jennifer's goal is to educate patients on their plan of care to promote overall good health.

Michelle/Corrie is our front desk receptionists who will answer your phone calls and check you in at the time of your visit. Please be sure to bring your insurance card, driver's license and new patient paperwork, as we enter this into out computer system.

Sandy/Corrie is our check out receptionist who will also answer your phone calls, check you out at the end of your appointment, schedule any follow up appointments, give you orders for labs, x-rays or mammograms and send your referrals

Lisa, April, and Chelsea are our nurses who will meet you once you are checked in and prepare you for your visit with Dr. Rana Munna or Jennifer Burt NP. You are encouraged to bring any medications you take with you so that this can be discussed at the time of your first visit. Please feel free to bring your own house robe for comfort.

Cecily is the office manager who will be glad to discuss any issues you may have with our office.

Our in-house lab is Labcorp. Labcorp is able to provide labs on all insurance plans we accept.

Our office hours are**: Monday- Thursday 7:45 am- 5pm and Friday 7:45 am- 12pm.**
We are closed for lunch from 12:30 pm-1:30pm

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The following is a list of what is necessary to bring to your first visit:

- Insurance cards and picture ID
- Names and numbers of previous doctors to obtain your medical records
- All new patient paperwork completely filled out
- A list of **ALL** medications you are currently taking and how you are taking them

We look forward to meeting you at your upcoming visit on _____. If you are unable to make your appointment, please notify us with 24 hours or you may be subject to a $50.00 “No-Show” fee.

It is a pleasure to have you as a patient. If our staff can help you in any way, please do not hesitate to call our office.

Sincerely,

Dr. Rana Munna, and Staff

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OFFICE POLICIES

- It is your responsibility to know your benefits from your insurance company. This includes wellness/physical coverage, deductible amounts, co-payment requirements and prescription drug coverage. **(See enclosed Patient Consent Form)**
- We use Labcorp laboratory for all lab work. If you insurance requires a different company to be used, it is your responsibility to tell us before your labs are drawn. In this case we will give you a lab order to take to the preferred lab company.
- In compliance with HIPAA laws no information will be given to anyone, including family members without your written consent.
- We require a 24 hour cancellation notice for all appointments. If this notice is not given you are subject to a $50 "no-show" fee.
- While in the waiting room and exam room please turn off cell phones
- Payment is expected at time of service
- Arriving to an appointment late could result in a rescheduled appointment
- Return check charge of $40
- Patient may be subject to a charge between $45-75 if being treated by Dr.Munna via telephone or email encounter when the patient has been offered an appointment but chooses not to come in to the office. Insurance will not pay for this charge; it will be patient's responsibility. (Note: This does not include requesting refill on maintenance medications).
- Appointment reminders will be sent via patient portal unless staff is notified otherwise.
- Telephone call will be made for reminders if patient is not web enabled for patient portal
- NOTE: Normal prescription refills will be handled Monday-Friday.
- During all TELEHEALTH visits, patients should be fully dressed and in a well-lit area free of distractions (i.e. television, music, etc.). Please inform us if it is necessary for a family member or friend to be present during your visit for the sake of providing additional information about your health status, medications or other information pertinent to the visit. Otherwise, for the privacy of yourself, family and friends, we recommend other individuals not be present during the time of the visits.

_____
Print Name

_____
Patient Signature

_____
Date

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PATIENT CREDIT CARD CONSENT FORM

To Our Patients:

Effective immediately, we are implementing a new policy. You will be asked for a credit card number at the bottom of this form and the information will be held securely until your insurances have paid their portion and notified us of the amount paid. Be sure and review your Explanation of Benefits from your insurances which will also tell you of any amount you may owe. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed or can be emailed to you. This policy is in keeping with the same process that you experience when checking into a hotel.

The advantage of this new policy to you is you will no longer have to send us a check via mail. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate, send out, and follow up on. The combination will benefit everyone in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Of course, co pays will still be due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask.

Sincerely,
Rana Munna, MD.

I authorize Rana Munna MD to charge outstanding balances on my account to the following credit card:

( ) VISA ( ) MASTERCARD

Card number: _____ Expiration Date: _____ CVV: _____

Name on Card (please print) _____

Signature: _____ Date: _____

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HIPAA Patient Information Consent Form

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, the office of Rana K. Munna M.D. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Munna's Office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office of Rana K. Munna M.D. has already taken action in reliance thereon.

_____ _____
Signature Date

The following people are allowed to receive and discuss my health information and/or pick up medication or prescriptions on my behalf:

1) _____ Relation:_____ Phone#_____

2) _____ Relation:_____ Phone#_____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient: _____

Date of Birth: _____

REQUESTING MEDICAL RECORDS FROM:

Physician: _____

Address: _____

Office Phone #: _____ Fax: _____

TO WHOM IT MAY CONCERN:

Please send all medical records, including office visit, laboratory studies, radiologic studies, EKG reports and hospital admission records on the above patient for the purpose of treatment.

If more information is needed, please contact our office. Thank you.

PATIENT SIGNATURE: _____

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PATIENT INFORMATION

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Date: _____

Name: _____
(As it appears on insurance card)

Age: _____ Date of Birth: _____ Male/Female

SS#: _____ Race: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Email Address: _____

How would you like to be reminded of your appointments?

☐ Text Message OR ☐ Phone Call/Recorded Message

Emergency Contact Person: _____ Contact Number: _____

Relationship to Patient: _____

Pharmacy Name: _____

Pharmacy Phone number: _____

Pharmacy Address: _____

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Primary Insurance:

Primary Card Holder Name: _____

Relationship to Patient: _____ Birthdate: _____ SS#:_____

Insurance Company: _____

Contact#:_____ Group#:_____

Subscriber #:_____

Is patient covered by additional insurance? Yes No

Secondary Insurance:

Primary Card Holder Name: _____

Relationship to Patient: _____ Birth date: _____SS#:_____

Insurance Company: _____

Contact#:_____ Group#:_____

Subscriber #:_____

ASSIGNMENT AND RELEASE

By signing below I _____ certify that I have submitted true and accurate cards/information, and I understand I can be prosecuted to the full extent of the law for providing false information.

I certify that I (or my dependent) have insurance coverage with

_____

I also assign directly to Dr. Rana Munna 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 use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relation: _____ Date: _____

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MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE:(ORAL, DROPS, INJECTION)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ALLERGIES

MEDICATION	REACTION

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PAST SURGERIES AND DATES

DATE	SURGERY TYPE

PAST HOSPITALIZATONS

DATE	REASON	HOSPITAL

Please list current problems that need medical attention

1.

2.

3.

4.

5.

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SOCIAL HISTORY

Marital Status:

____ Single _____ Married ____ Divorced _____Widowed ____Separated

Children:

Boy(s)_____ Girl(s)_____

Health Habits

Check which you use or do and describe how much you use and how often

	Caffeine	
	Tobacco	
	Regular Exercise	
	Alcohol	
	Recreational Drugs	
	Other:	

Immunization

Vaccine	Date Given
Tdap/Tetanus	
Pneumovax	
Flu	
Zostavax	
Prevnar 13	

Most Recent (Estimated Dates and Where)

Physical Exam	
Mammogram	
Pap Smear	
PSA	
EKG	
Colonoscopy	
Chest X-Ray	
Eye Exam	

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer(type:_____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:_____)			
Emphysema (COPD)			
Heart Disease			
High Blood Pressure (Hypertension)			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal (kidney) Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

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Family

Relation	Living	Year of Birth	Deceased	Age of Death
Father				
Mother				
Brother				
Sister				

Check if any blood relative had/have any of the following Diseases

	Disease	Relationship to you
	Cancer (Type)	
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Stroke	
	Dementia	
	Diabetes	
	Thyroid Issues	

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Please circle if you have, or have had on more than one occasion, any of the following:

CONSTITUTIONAL
Good general health
Recent weight change (loss or gain)
Fever
Fatigue
Night sweats

EYES
Eye disease or injury
Wear glasses/contacts
Blurred or double vision
Previous cataract surgery
Glaucoma

ENT
Hearing loss
Ear ringing
Earaches
Chronic sinus problems
Nosebleeds
Wax impaction
Difficulty swallowing
Dentures

CARDIOVASCULAR
Chest pain
Irregular heart rhythm
Palpitations heart fluttering
Shortness of breath with exertion
Shortness of breath while lying flat
Swelling of feet or hands

RESPIRATORY
Chronic cough
Pneumonia
Tuberculosis (TB)
Spitting up blood
Shortness of breath
Chronic bronchitis
Asthma or wheezing

GASTROINTESTINAL
Loss of appetite
Change in bowel movement
Nausea or vomiting
Frequent diarrhea
Constipation
Rectal bleeding
Abdominal pain
Heartburn
Peptic ulcer

GENITOURINARY
Frequent urination
Burning or painful urination
Blood in urine
Incontinence or dribbling
Kidney stones
Male-decrease in urinary stream

GYNECOLOGIC
Female- abdominal pain with periods
Female- irregular periods
Female- vaginal discharge
Female - # pregnancies____# miscarriages_____
Female- date of last period_____

MUSCULOSKELETAL
Joint pain, stiffens or swelling
Muscle weakness
Muscle pain or cramps
Back pain
Cold extremities

SKIN/BREAST
Rash or itching
Change in skin color
Change in hair or nails
varicose veins
Breast pain, lumps, or discharge

NEUROLOGICAL
Headaches
Dizziness
Convulsions or seizures
Numbness or tingling
Tremors
Paralysis
Stroke
Head injury
Loss of consciousness (frequent)

PSYCHIATRIC
Memory loss or confusion
Anxiety
Depression
Insomnia
Eating disorder

ENDOCRINE
Diabetes
Excessive thirst or urination
Heat or Cold intolerance
Dry skin

HEMATOLOGIC
Bleeding or bruising tendency
Anemia
Phlebitis
Previous blood transfusion
Enlarged lymph nodes

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