NEWNAN
FAMILY MEDICINE ASSOCIATES, P.C.

Patient Information Sheet

Name:
_____

DOB: ____/_____/_____ Race: _____ Sex at Birth: M or F

Phone #: _(_____)_____-_____ SSN: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____@_____.com

<u>In Case of Emergency Contact</u>

Name:
_____

Phone: _(_____)_____-_____ Relation: _____

<u>Insurance</u>

Primary Insurance: _____

Member ID: _____ Group #:_____

Secondary Insurance:
_____

Member ID: _____ Group #:_____

Medications:_____
_____

Drug Allergies: _____
_____

Signature: _____ Date: _____

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Authorizations and Agreements

Name: _____Mr./Mrs./Ms.

SSN: _____ **Date of Birth**: _____ **Sex at Birth**: ☐Male ☐Female

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Domestic Partner

Race: ☐American Native or Alaska Native ☐Asian ☐Black or African American ☐White

☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Islander

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino **Preferred Language**: _____

I. **Authorization to Release Information:** Newnan Family Medicine Associates, PC (NFM) is authorized to release information contained in my medical record, before, or after date of service, via com, telephone, or fax:

a. To my insurance company(s), their agents, or another third-party payor, and/or government, or social service agencies, which may or will pay for any part of the medical expenses incurred by authorized representatives of NFM

b. As mandated by law.

c. To alternate care providers, including community agencies and services, as ordered by my physician, or as requested by me or my family for post-hospital care or outpatient services.

This information authorized to be released shall include, but is not limited to infectious or contagious disease information, including HIV and AIDs- related evaluations, diagnosis or treatment; information about drug and/ or alcohol abuse or treatment of same; and/or psychiatric or psychological information. I waive any privilege pertaining to such confidential information.

NFM, its agents, and employees are hereby released from any and all liabilities, responsibilities, damages claims, and expenses arising for the release of information as authorized above. I acknowledge that this consent is valid until such time as all bills related to medical care have been paid and/or post-care arrangements have been made. I further understand that I can withdraw this content release of information at any time prior to expiration (noted below) except to the extent action has been taken in reliance hereon.

II. **Financial Agreement And Assignment Of Benefits:** I, the undersigned, hereby authorize payment directly to NFM and treating physician of the insurance benefits otherwise payable or due to become payable. I understand and agree I am financially responsible for any charges not covered by this assignment of insurance benefits. Also, I hereby assign to NFM my rights under Georgia Law to have any insurance claim processed and/or paid within 15 working days of receipt of the claim by the insurance company. It is further agreed that any credit balance resulting from insurance payments or other sources that are refundable to the responsible party will be applied to any other account owned by NFM by family or myself.

III. **Assignment Of Medicare And Medicaid Benefits, Patient Certification And Payment Requests:** I herby certify that the information given by me in applying for payment under Title XVII and XIX of the

Social Security Act is correct. I request that payment is authorized benefits be made and assign the benefits payable for services rendered during this visit to the physician or organization furnishing the

services. The undersigned if other than the patient and the patient are responsible for and agree to pay charges not covered by this assignment. Including any Medicare deductibles.

IV. **Potential Liability:** The health insurance option I have selected may be required prior authorization for coverage of some series. If coverage of services that have been requested in this case are not approved by my insurance company based upon medical information provided by the physician and/or myself, I will be liable for total charges or a portion of the charges in accordance with my insurance program.

V. **Consent For Routine Diagnostic Procedure And Medical Treatment:** I hereby consent to the performance of such procedures and/or treatment as deemed necessary or advisable by my physician at Newnan Family Medicine Associates, PC. I hereby consent to the performance of all nursing and technical procedures and tests directed by my physician. Further, I understand that should any hospital, or emergency medical personnel, physician, or other person be exposed to report an exposure to my blood or body fluids, my blood will be tested for blood-borne infections including Hepatitis B and C as well as HIV/Aids. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments of examination at Newnan Family Medicine Associates, PC.

_____ _____

Patient's Signature or Patient's Representative Date

For Official Use Only

We have made every effort to obtain written acknowledgment of recipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐The patient refused to sign.

☐Due to an emergency, it was not possible to obtain and acknowledgment.

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☐We were not able to communicare with the patient.

☐Other (Please specifiy)_____

AUTHORIZATION TO RELEASE HEALTH RECORDS

I, _____ hereby voluntarily authorize the disclosure of information from my health record.

Patient's Name: _____ Patient's Date of Birth: _____

Patient's SSN: _____

Information requested from: _____

Phone No.: _____ Fax No. _____

Purpose of release: _____

_____

The information is to be provided to:

Name of Person/Organization/Facility: _____

Address: _____

Phone No. _____ Fax No. _____

1. I understand that this authorization will expire on (date): _____
2. I understand that I may revoke this authorization (except the extent that action was already taken in reliance on this signed authorization) at any time notifying Newnan Family Medicine Associates in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's or Patient's Representative's Signature **Date**

_____ _____

Printed Name of Patient or Representative **Relationship to Patient**

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

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Under HIPAA with Patient's written request, records must be provided within 30 days of request.
HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.

MISSED APPOINTMENT / SAME-DAY CANCELLATION POLICY

Newnan Family Medicine Associates is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, that prevents another patient from being seen during that time slot.

If you need to cancel or reschedule your appointment, please call our office at (770) 251-5540 by 5:00PM on the day prior to your scheduled appointment. If prior notification is not given, you will be charged $25.00 for the missed appointment.

Please sign below to consent to these terms:

_____ _____

Patient Signature Date

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Notice of HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses of disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices*, including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. To choose this option, I and/or Patient must notify your Business Office and must pay the bill for that health care service in full.

Patient Name: _____

Relationship to Patient _____

Signature: _____Date: _____

To address any special needs, we may have to confirm your wishes. Please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one: YES NO

If YES, please list names below for our record:

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Reason: _____

Staff Initials:_____ Date: _____

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COMPREHENSIVE HISTORY & PHYSICAL

NAME _____ S M W D INSURANCE _____

ADDRESS _____ PHONE (H) _____ (MOBILE) _____

OCCUPATION _____

FAMILY HISTORY

If any blood relative has suffered any of the following – please indicate which relative

TUBERCULOSIS _____ EPILEPSY _____ ARTHRITIS _____ HYPERENSION _____
STROKE _____ DIABETES _____ GOUT _____
MIGRAINE _____ CANCER _____ KIDNEY DISEASE _____ HEART ATTACK _____
MENTAL ILLNESS _____ ALLERGY _____ GLAUCOMA _____

HOSP ADM

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

IMMUNZ

APPROX. DATE OF LAST INJECTION

☐ SMALLPOX _____ ☐ DIPTHERIA _____
☐ TYPHOID _____ ☐ PERTUSIS _____
☐ MEASLES _____ ☐ POLIO _____
☐ MUMPS _____ ☐ TETANUS _____
☐ RUBELLA _____ ☐ FLU _____

MEDICATIONS CURRENTLY TAKING

_____
_____
_____

DRUG ALLERGIES

_____
_____
_____

MEDICAL HISTORY

Mark "C" for current problems. Tick box and indicate age when you had any of the following.

MAIN PROBLEM (1) _____ (2) _____ (3) _____

☐ Sinus Trouble
☐ Hay fever / Allergies
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic Cough
☐ Asthma / Wheezing
☐ Chest Pain
☐ High Blood Pressure
☐ Heat Murmur
☐ Palpitations
☐ Swollen Ankles
☐ Fainting Spells
☐ Indigestion or Heartburn

☐ Peptic Ulcers
☐ Abdominal Pain – Chronic
☐ Change in Bowel Habits-Recent
☐ Diarrhea _Constipation
☐ Diverticulosis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Gall Bladder Trouble
☐ Hernia
☐ Blood in urine
☐ Kidney Stones
☐ Venereal Disease

☐ Chronic Fatigue
☐ Anemia ☐Bruise easily
☐ Cancer
☐ Diabetes
☐ Thyroid Disease
☐ Convulsions / Seizures
☐ Stroke
☐ Tremor / Hands Shaking
☐ Arthritis / Rheumatism
☐ Back Pain – Recurrent
☐ Gout
☐ Rashes ☐ Hives

☐ Psoriasis ☐ Eczema
☐ Seeping – difficulty
☐ Mental Illness
☐ Smoking ☐ cig. per day

Other Symptoms or Diseases

☐ _____
☐ _____
☐ _____

SUMMARY _____

_____
_____
_____
_____

_____
Patient Signature **Date**