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

In Case of Emergency Contact

Name: _____

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

Insurance

Primary Insurance: _____

Member ID: _____ Group #:_____

Secondary Insurance: _____

Member ID: _____ Group #:_____

Medications:_____

_____

Drug Allergies: _____

_____

Signature: _____ Date: _____

Authorizations and Agreements

NEWNAN
FAMILY MEDICINE ASSOCIATES, P.C.

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.