PATIENT REGISTRATION FORM

LAST NAME **FIRST NAME** **M.I.**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

SOCIAL SECURITY # **DATE OF BIRTH** **SEX**

MARITAL STATUS:
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

RACE:
☐ Black ☐ White ☐ Hispanic ☐ Other

HOME PHONE **CELL PHONE** **WORK PHONE**

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME **FIRST NAME** **M.I.**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

SOCIAL SECURITY # **DATE OF BIRTH** **RELATIONSHIP TO PATIENT**

HOME PHONE **CELL PHONE** **WORK PHONE**

EMERGENCY CONTACTS

NAME & RELATIONSHIP TO PATIENT **WORK PHONE** **CELL PHONE** **HOME PHONE**

NAME & RELATIONSHIP TO PATIENT **WORK PHONE** **CELL PHONE** **HOME PHONE**

INSURANCE /MEDICATIONS

PARIMARY INSURANCE INFORMATION:

Insurance Company: ______________________________ Plan # ______________ Group # ________________

Subscriber Name: ________________________________ Subscriber Insurance ID# ______________________

Subscriber Date of Birth _____/__/_____ Sex: ☐ Male ☐ Female

Insurance Effective Date: (from) ____/_____/_____ (To) ____/_____/______ Co Pay $ __________________

SECONDARY INSURANCE INFORMATION:

Insurance Company: ______________________________ Plan # ______________ Group # ________________

Subscriber Name: ________________________________ Subscriber Insurance ID# ______________________

Subscriber Date of Birth _____/__/_____ Sex: ☐ Male ☐ Female

Insurance Effective Date: (from) ____/_____/_____ (To) ____/_____/______ Co Pay $ __________________

CURRENT MEDICATIONS **DRUG ALLERGIES**

I authorize the release of any medical information necessary to process health insurance claims. I request payment of the benefits be made to Atlanta Primary Care Peachtree, PC, or Newnan Family Medicine Associates, PC. Any balance is due within 30 days of notification by this office. This authorization is valid unless rescinded in writing. A photocopy is as valid as the original.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE AND HAVE GIVEN TRUTHFUL INFORMATION TO THE BEST OF MY ABILITY.

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

PATIENT INFORMATION

Name: ____ Mr. / Mrs. / Ms.

SSN:_________________________ Date of Birth_________________ Sex: ☐ Male ☐ Female

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

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

☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Preferred Language:_____________

I. **AUTHORIZATION TO REALEASE INFORAMTION**: Newnan Family Medicine Associates, PC (NFM) is authorized to release information contained in my medical record, before, during, or after date of service, via copy, telephone, or fax:

a. To my insurance company(s), their agents, or other 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 re hereby released from any and all liabilities, responsibilities, damages, claims, and expenses arising from 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 consent for 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 that 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 owed by NFM by family or myself.

III. **ASSIGNMENT OF MEDICARE AND MEDICAID BENEFITS, PATIENT CERTFICATION AND PAYMENT REQUESTS:** I hereby 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 of this 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 tan 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 required prior authorization for coverage of some services. 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 or 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 acknowledgement of receipt 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 an acknowledgement.
- ☐ We were not able to communicate with the patient.
- ☐ Other (Please provide specific details)________________________________

____
____
____
____

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. <u>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.</u>

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:__________________

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: __________________

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

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

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.

NEWNAN
FAMILY MEDICINE ASSOCIATES, P.C.

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**