**Patient Information Sheet**

Name:

DOB: Click or tap to enter a date. Race: Choose an item. Sex at Birth: Choose an item.

Phone #: Enter phone number SSN: last 4 of SSN

Address: Enter Street Address

City: Enter City State: State Abbreviation Zip Code: Enter Zip

Email: Enter Email Address

In Case of Emergency Contact

Name: Name of Emergency Contact

Phone: ­­­­ Emergency Contact Phone Number Relation: Relationship of Emergency Contact

Insurance

Primary Insurance: Enter Company Name

Member ID: Enter Member ID Group #: Enter Group #

Secondary Insurance: Enter Company Name

Member ID: Enter Member ID Group #: Enter Group #

Medications: Enter Medications

Drug Allergies: Enter All Allergies

Signature: Electronic Signature Date: Click or tap to enter today’s date.

**Authorizations and Agreements**

**Name**: Click or tap here to enter text. Choose a prefix

**SSN**: Enter last 4 of your SSN **Date of Birth**: Click or tap to enter a date. **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**: Enter language

1. **Authorization to Release Information:** Newnan Family Medicine Associates, PC (NFM) is authorized to release information contained in my medical record, before, or after the date of service, via com, telephone, or fax:
2. 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
3. As mandated by law.
4. 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 thereon.

1. **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.
2. **Assignment Of Medicare And Medicaid Benefits, Patient Certification 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 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.

1. **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.
2. **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 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 acknowledgment.

□We were not able to communicate 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 to 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 the 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 5:00 PM 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:

Click or tap here to enter text. \_\_\_\_\_\_\_

Patient Signature Date

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 a claim submitted to a health plan. To choose this option, I and/or the 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 acknowledgment of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:

Staff Initials: Date:

**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 \_\_\_\_\_\_\_\_

Stroke \_\_\_\_\_\_\_\_\_\_\_\_

Migraine \_\_\_\_\_\_\_\_\_\_

Mental Illness \_\_\_\_\_\_\_

Epilepsy \_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy \_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis \_\_\_\_\_\_\_\_\_\_\_\_

Gout \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease \_\_\_\_\_\_\_

Glaucoma \_\_\_\_\_\_\_\_\_\_\_

Hypertension \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Attack \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hosp Adm: Please list Year and Illness or Operation**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations:** Approx. Date of Last Injection

Smallpox \_\_\_\_\_\_\_\_\_\_\_ Typhoid \_\_\_\_\_\_\_\_\_\_\_\_ Measles \_\_\_\_\_\_\_\_\_\_\_\_ Mumps\_\_\_\_\_\_\_\_\_\_\_ Rubella \_\_\_\_\_\_\_\_\_

Diptheria \_\_\_\_\_\_\_\_\_\_\_ Pertusis \_\_\_\_\_\_\_\_\_\_\_\_ Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tetanus \_\_\_\_\_\_\_\_\_\_\_ Flu \_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Problems** (1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

Sinus Trouble

Hay fever/ Allergies

Pneumonia/ Pleurisy

Bronchitis/ Chronic Cough

Asthma/Wheezing

Chest Pain

High Blood Pressure

Heart Murmur

Palpitations

Swollen Ankles

Fainting Spells

Indigestion or Heartburn

Peptic Ulcers

Abdominal Pain- Chronic

Change in Bowel Habits- Recent

Diarrhea- Consumption

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

Sleeping Difficulty

Mental Illness

Smoking \_\_\_ cig./ day

**Other Symptoms or Diseases**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Summery

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Signature Date**