COMPREHENSIVE PRIMARY AND URGENT CARE

6131 S. Norcross Tucker Road, Suite 6, Norcross, GA 360093
Phone: (678)205-1959, Fax: (770) 710-0721

PATIENTS REGISTRATION

Last Name: ______________________________ First Name: ______________________________

DOB: ___/___/___ Social #: ___-___-____ Sex (F/M) Marital Status (S, M, D, W)

Address: __________________________ City: _______________ State: ____ Zip Code: _______

Cell Phone: __________________ Home #: ___________________ Work#: _________________

EMERGENCY CONTACT

Name: ____

Phone#: __________________________ Relation to patient: _____________________________

INSURANCE INFORMATION

Primary Insurance Name: ___________________________ Policy ID: ______________________

Insured's Name: __________________________________ DOB: ___/___/___

Secondary Insurance Name: _________________________ Policy ID: ______________________

Insured's Name: __________________________________ DOB: ___/___/___

EMPLOYER INFORMATION

Employers's Name: ______________________________ Name of Business: ________________

Work#: __________________ EXT: _____________

Address: __________________________ City: ________________ State: _____ Zip Code: ______

Please Read and Sign Below

I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment or medical insurance benefit to my physician. Regulations pertaining to medical assignment or that which is above the usual and customary as determined by my insurance company. I, also voluntarily consent to treatment for myself or my child from the physician and his/her staff.

Signature: ____ Date: ___/___/___

ADULT HEALTH HISTORY

Name: ________________________________ DOB: ___/___/___ Age:_____ Sex: (F/M)

What is the reason for your visit today?: ____
____

Have you been hospitalized? Yes/ No, if yes explain why: ______________________________
____

List all of your previous surgeries: ____
____
____

When was your last tetanus shot? _______________ Not sure Don't remember

Have you had a TB test done? If so, when was it__________ Negative/Positive

Are you allergic to any medication? If yes, what? ____________________________________

Please list all of your medical problems:

1.________________________ 4.____________________________
2.________________________ 5.____________________________
3. _______________________ 6.____________________________

Current Medications: (Please list all the medications that you are currently taking)

Medicine	**Dose (mg/mcg)**	**Directions**

Family History

Have any of your relative had (list the family members and the age diagnosed)

Alcoholism______________ High Blood Pressure____________ Stroke ______________
Arthritis ______________ High Cholesterol _______________ Suicide ____________
Asthma ________________ Mental Illness _________________ TB ________________
Breast Cancer __________ Obesity _______________________ Other ______________
Colon Cancer ___________ Migraine ______________________
Diabetes ______________ Osteoporosis _________________
Glaucoma ______________ Ulcer Disease ________________
Hay Fever ______________ Ovarian Cancer _______________
Heart Disease ___________ Prostate Cancer ______________

GYN History

# of pregnancy___ #of vaginal delivery ___# of C-Section ___# of miscarriages___
# of termination ___

Menstrual History

Date of last Menstrual Period: ___/___/___ Date of Last Pap Smear: ___/___/__

Frequency of Periods ______________ Self Breast Exam: YES/ NO

Birth Control Method: _____________ Date of Last Mammogram: __/__/__

Social History

Marital Status: □ Single □ Married □ Separated □Divorced □ Widowed

Are you sexually active? Yes No

Do you smoke? If Yes, what and how often: ____

Do you drink? If Yes, what and how often: ____

Do you drink coffee? Tea? Or Pop sodas? If Yes, what and how often: ______________

____

Do you exercise? If Yes, how often: ____

Occupational History

Employer Status: □ Working □Unemployed □Retired □Disabled □ Student □ Other

Starting with your most recent job, list the type of work you have done

Type of work	Number of Years	Exposure
1.___________________	____________	□ Fumes & Dust □ Coal or Abestos
2. ___________________	____________	□ Radiation □ Lead or Mercury
3. ___________________	____________	□ Heavy Lifting □ Other:__________ ______________________________

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Statement of Financial Responsibility

Patient: ________________________________ DOB: ____________________

CPAUC appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for your bill.

You are responsible for payment of your deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by insurer. If your insurance company denies any part of your claim, or if your physician elects to continue past your approved period, you will be responsible for your balance in full. For every 30 days a balance is not paid after the first statement is given, a $15- non payment fee will apply. After 90 day 40% collection fee will be added and the account will be sent to a collection agency.

I have read the above policy regarding my financial responsibility to **CPAUC**, for providing service o me or the above named patient. I authorize my insurer to pay my benefits directly to **CPAUC**, the full entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurer.

Patient/Guarantor Signature: ____________________________ Date:____________________

Self-Pay without Insurance

I do not have health insurance and will be responsible for the services rendered here at **CPAUC**. I agree to pay **CPAUC** the full entire amount of treatment give to me or the above named patient at each visit.
Patient/Guarantor Signature: ____________________________ Date: ____________________

Self-Pay with Insurance/Medicaid

I freely choose not to bill my insurance for services rendered at **CPAUC**.
Patient/Guarantor Signature: ____________________________ Date: ____________________

Motor Vehicle or Workman's Compensation Insurance

I request my claims be submitted to my motor vehicle/workman's compensation insurance carrier, I understand I will be responsible for bills incurred by me in the event my motor vehicle/workman's compensation insurance benefit exhausts or denies.
Patient/Guarantor Signature: ____________________________ Date: ____________________

Consent for Treatment and Authorization to Release Information

I hereby authorize **CPAUC,** through its appropriate personnel, to perform or have performed on me, or the above named patient appropriate assessment and treatment procedures. I further authorize **CPAUC**, to release to the appropriate agencies any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: ____________________________ Date: ______________________

YOUR HEALTH INFORMACION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that rules for health care provider and health insurance companies about who can look and receive our health information. This law, called Health Insurance Portability and Accountability Act of 1996 (HIPPA), gives you rights over your health information including the right to get a copy of your information, make sure it is correct and known who has it.

Get It.
You can ask to see or get a copy of you medical record and other health information. If you want a copy, you may have to put your request in writing and pay pro the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.
You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong results for a test, the hospital must change it. Even if the hospital believes the test results is correct, you still have the right to have disagreement noted in your file. In most cases, the record should be updated within 60 days.

Know Who Has Seen It.
By law, your health information can be used and shared by specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when is in your area or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- Learn how your health information is used and shared by your doctor or health insurer. Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, you doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got a new health insurance, but you can ask for another copy anytime.

- Let your providers or health insurance companies know if there is information you do not want to share. You can ask that your health information not be shared with certain people, groups or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy no to tell your health insurance company about care you receive or drugs you take, if you pay for the care of drugs in full and the Provider or pharmacy does not need to get paid by your insurance company.

- Ask to be reached somewhere other than home. You can make reasonable requests to be contacted at any different places or in a different way. For example, you can ask to have nurse call you at your office instead of your home or to send mail to you in an envelop instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit www.hhs.gov/ocr/privacy/

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Patient's Signature

Office For Civil Rights
US. Department of Health & Human Services

INTRODUCTION TO YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains the Georgia Advance Directive or Health Care, which protects your right to refuse medical treatment that you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. The form contains three parts, any number of which may be filled out, and a fourth signature page that must be filled out for any of the three other parts to be effective

Part One: Health Care Agent. This allows you to choose someone to make health care decisions for you if you cannot (or do not want to) make health care decisions for yourself. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body.

Your health care agent's power becomes effective when your doctor determines that you are no longer able to make or communicate your health care decisions or when you decide to have your health agent make decisions for you.

Part Two: Treatment Preferences. This part allow you to state your treatment preferences if you are (1) unable to communicate your treatment preferences, and (2) your physician and one other physician determine that you either have a terminal condition or are in a state or permanent unconsciousness. If you also have a health care agent, then your agent is authorized to make all decisions discussed in Part Two, but will be guided by your written Treatment Preferences as well as any other factors you may have listed in section 4 of Part One.

Part Three: Guardianship. This part allows you to nominate a person to be your guardian should one ever needed.

Part Four: Signatures. This part needs to be filled out in order to make any of the three other parts effective. All three preceding parts are optional. You are free to fill out any or all of them.

These forms do not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney for mental care.

Note: These documents will be legally binding only if the person completing them is a competent adult, at least 18 years old, or an emancipated youth.

COMPLETING YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

How do I make Advance Directive for Health Care Legal?
The law requires that you sign your document, or another person signs it in your presence and at your express direction, in the presence of two witnesses who must be at least 18 years of age and of sound mind.

Your witnesses cannot be your health care agent, someone who will knowingly inherit anything from you or otherwise gain a financial benefit from your death, or someone who is directly involved in your health care.

Only one witness can be an employee, agent, or medical staff member of the facility in which you are receiving health care.

Note: You do not need to notarize your Georgia Advance Directive for Health Care.

Whom should I appoint as my agent?
Your health care agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your health care agent may be a family member or a close friend whom you thrust to make serious decisions. The person you name as your health care agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

No physician or health care provider may act as your health care agent if he or she is directly involved in your health care.

You can appoint a second and third person as your alternate health care agent(s). The alternate(s) will step in if the firs person you name as agent is unable, unwilling, or unavailable to act for your.

Should I add personal instructions to may Advance Directive for Health Care?
One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document t may help your health care agent carry out your wishes, but be careful that you do not unintentionally restrict your health care agent's power to act in your best interest. In any event, be sure to talk with your future medical care and describe what you consider to be an acceptable "quality of life".

____
Pt's Signature

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ________________________________ (healthcare provider) to use and disclose the protected health information described below to _____________________________________ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _______________ to _______________.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____________________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ________________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and his or her relationship to patient

____

Date