PATIENT REGISTRATION FORM FOR PHYSICAN PRACTICES

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON BEING SEEN TODAY.

Patient's First, Middle, Last Name: _____
Date of Birth: _____ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____
Work Phone: _____
Email: _____

EMPLOYER INFORMATION

Employer Name: _____ Employer Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

NEXT OF KIN

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

PERSON TO NOTIFY

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

GUARANTOR INFORMATION

Guarantor Name: _____
Date of Birth: _____ Sex: ____ Marital Status: __ Single __ Married __ Divorced __ Widowed
Social Security #: _____-_____-_____ Relationship to Pt: _____
Address: _____ City: _____State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

MEDICAL PROVIDER INFORMATION

Please list all current and previous physicians (primary, referring, specialist) who follow you and your condition(s):

Provider: _____ Phone: _____ Fax#: _____
Provider: _____ Phone: _____ Fax#: _____
Provider: _____ Phone: _____ Fax#: _____

Authorization to

Release Protected Health Information

I, _____ _____
(Patient's Full Name) (Date of Birth)

Hereby request and authorize: _____

to release the following information for continuation of care to:

ORTHOPAEDICS OF NORTH GEORGIA

800 AUSTIN DRIVE DEMOREST, GA 30535

P: 706-839-4096 F: 706-839-4097

Please Circle All That Apply:

All Records History & Physical Clinic Notes Abstract/Summary Discharge Summary

Surgical Reports Pathology Reports Emergency Notes Radiology Other:

_____

Delivery Method Preferred: Fax Mail Other: _____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____ (Please Initial)

I understand that: I may refuse to sign this authorization and that is it strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I do not specify expiration this authorization will expire in 365 days. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal Privacy Regulations and may be disclosed.

Signature: _____ Date: _____

HABERSHAM MEDICAL GROUP PATIENT PORTAL AND APPOINTMENT INFORMATION

The online health management tool allows all Habersham Medical Group patients and their families to become more involved in their healthcare. By providing a secure link to their health information, patients are able to access the most up-to-date information within their HMC Health Record. The portal makes time consuming tasks simple and convenient whether the patient is at home, on vacation or at another medical office.
MyPortal offers patients the ability to:

- Access complete health information online versus over the phone or in person
- Request appointments
- Pre-register for scheduled appointments at the hospital
- Pay your bills online

PATIENT PORTAL REGISTRATION

If you are interested in signing up for the patient portal, please complete the form below.

Patient Name: _____

Date of Birth: _____ Last four of Social Security: _____

Email Address: _____
Please sign below authorizing temporary patient portal information to be sent to the above email address listed.

Signature: _____ Date: _____

APPOINTMENT TIMES AND NO SHOWS

The providers and staff strive to provide the best medical care. This is only made possible if our patients attend all scheduled appointments and follow all of the medical advice provided. Please understand:

- If the patient is more than 15 minutes late for their appointment, he/she will be asked to reschedule.
- If a patient does not show up for his/her appointment more than (3) times without calling to cancel Orthopaedics of North Georgia will be obligated to release the patient from our care.

Patient Signature: _____ Date: _____

If patient is a minor, please have the legal guardian sign. Your signature acts as a consent to be treated.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties following the Notice: The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff, and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

- Treatment
- Payment
- Auditing
- Research
- Organ Donation
- Fundraising
- Health Care Operations
- Appointment Reminders
- Workers' Compensation
- Health oversight activities

As required by law
Lawsuits and disputes
Public health purposes
Activities of our affiliates
Law enforcement purposes
To military command authorities
National security and protective services
To avert a serious and protective services
To coroners, medical examiners, and funeral directors
Activities of managed care networks in which we participate

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories- Individuals involved in your care or payment.

Your Privacy Rights: You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health care.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of health information.

Change to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Hospital and Clinics.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Hospital Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services.

ACKNOWLEDGEMENT

Patient Acknowledgement: I acknowledge that I can obtain a copy of the Notice of Privacy Practices for Habersham Medical Center if requested. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. Time/Date: _____ Signature of Patient: _____

For use by Hospital Personnel Only: (Complete if patient acknowledgement has not been obtained)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because: _____

Consents, Conditions, And Authorizations for Treatment – Please Read Then Sign at the Bottom

I hereby give my consent for treatment at the Habersham Medical Group- Specialty Clinics. This consent includes treatment by health care professionals employed by HMC. This care may include x-ray examination, laboratory procedures, diagnostic procedures and nursing or medical/surgical treatment which my physician may deem necessary or advisable.

PATIENT'S NAME _____

Regarding the medical care and treatment to be rendered to me by the Habersham Medical Group- Specialty Clinics, I agree and consent to the following conditions:

1. MEDICAL AND SURGICAL TREATMENT: I agree and understand that all physicians, treating me or the patient in any way, are responsible and liable for their own acts or omissions and the hospital is not liable for the act and omissions aforementioned. I am aware that the practice of medicine is not an exact science and further state that no guarantee can be made as to the results of the treatment or examination in the office.

2. TEACHING ACTIVITIES: I recognize that among those who may attend the patient at the Habersham Medical Group- Specialty Clinics, are medical, nursing and other healthcare personnel, who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical training.

3. PERSONAL VALUABLES AND BELONGINGS: I agree and understand that the Habersham Medical Group- Specialty Clinics cannot be responsible for the safekeeping of any valuables or personal belongings. Therefore, the safekeeping of the patient's personal belongings will be the responsibility of the patient, the patient's responsible party, or the next-of-kin.

4. ASSIGNMENT OF ANY INSURANCE/PHYSICIAN BENEFITS: I assign and authorize payment directly to the Habersham Medical Group- Specialty Clinics for any benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third-party, payable by any party, organization, etc. to or for the patient, unless the account for the patient's services is paid in full upon completion of the office visit. I assign and authorize any benefits to any physician rendering care or treatment during my office visit to be applied to my bill. I understand that I am responsible for any charges not covered by my insurance company. If any insurance payment must be refunded to the payer, then the patient, patient's guarantor or patient's legal representative is responsible to pay the account for which the patient/guarantor is legally responsible. I authorize the Habersham Medical Group- Specialty Clinics, and all clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys, or other agents, who may work on their behalf, to contact me on my cell phone and/or home phone regarding my account, and I understand that automatic telephone dialing systems or other computer assisted technology may be utilized.

5. RELEASE OF MEDICAL INFORMATION: I authorize the Habersham Medical Group- Specialty Clinics and providers, to release my medical information and supporting documentation, as compiled in the medical records during this office visit, for purpose of benefit payment and continuing care. My medical care may be discussed with: _____ and/or _____.

6. BILLING: I understand it is the responsibility of the patient, guarantor, or legal representative to know if my insurance participates with the Habersham Medical Group- Specialty Clinics and the Habersham Medical Group- Specialty Clinics will file claims for Medicare, Medicaid (GA only), Blue Cross, Commercial Insurances, Tricare, Worker's Compensation and accident liability. If pre-certification is required by my insurance company, I understand that the Habersham Medical Group- Specialty Clinics will attempt to obtain pre-certification. If requested, I received a copy of the Habersham Medical Group- Specialty Clinics financial policy.

The undersigned certifies that he/she has read all of this document, and is the patient or the legal representative of the patient, and accepts, agrees and understands the above agreement and all the terms.

_____ _____

Date Patient or Legal Representative's Signature