Habersham Medical Group
Internal Medicine & Geriatrics

PATIENT REGISTRATION FORM

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: _____

Social Security: _____ Primary Phone: _____ Secondary Phone: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Race: ____ White/Caucasian _____ Black/African American _____ Asian ____ Decline_____ Other(explain): _____

Ethnicity: ____ Non-Hispanic/Non- Latino ____Hispanic/Latino ____Unknown ____Decline

Preferred Language: ____ English ____Spanish ____ Other: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR RELEASE OF MEDICAL INFORMATION.

□ I do not authorize any information to be released to anyone other than myself.

- **Do we have your permission to leave you messages on a voicemail? Yes / No**
- **Do we have your permission to discuss your medical condition with any member of your household? Yes / No**.

□ Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

APPOINTMENT TIMES AND NO SHOWS

Internal Medicine and Geriatrics 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 Habersham Medical Group- Internal Medicine and Geriatrics 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.

HABERSHAM MEDICAL GROUP PATIENT PORTAL

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 can 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:

- Request appointments
- Communicate with staff and your providers
- Request prescription renewals from your providers
- See test results and chart notes

PLEASE MAKE NOTE:

IF YOU SIGN UP FOR A PATIENT PORTAL ACCOUNT. INTERNAL MEDICINE AND GERIATRICS STAFF WILL USE THIS PORTAL ACCOUNT TO COMMUNICATE RESULTS WITH YOU. SO PLEASE MAKE SURE THAT IF YOU SIGN UP FOR THE PATIENT PORTAL THAT YOU REGISTER AND ACCESS YOUR ACCOUNT TO RECEIVE RESULTS.

PATIENT PORTAL REGISTRATION

The patient portal is available through Habersham Medical Center's website. **Through this portal the patient can view medication lists and discharge information, test results, message providers, as well as schedule appointments. If you are interested in signing up for the patient portal, please complete the form below.**

Patient's Name: _____Date of Birth: _____

Email Address:

_____

Please sign below authorizing temporary patient portal information to be sent to the above email address listed. ID must be presented at time of request. We cannot look up copies of ID that may be on file.

Signature: _____ Date: _____

Habersham Medical Group
Internal Medicine & Geriatrics

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:

Internal Medicine and Geriatrics

800 Austin Drive, Demorest GA 30535

P: 706.839.4092 F: 706.839.1970

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
Internal Medicine & Geriatrics

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
Too avert a serious and protective services
Too 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 have received a copy of the Notice of Privacy Practices for Habersham Medical Center. 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: _____

Habersham Medical Group
Internal Medicine & Geriatrics

CONSENTS, CONDITIONS, AND AUTHORIZATION FOR TREATMENT

PLEASE READ– THEN SIGN AT THE BOTTOM – THANK YOU

I hereby give my consent for treatment to Internal Medicine and Geriatrics. This consent includes treatment by health care professionals employed by HMC. This care may include office injections, laboratory procedures, office 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 HMC/Internal Medicine and Geriatrics, 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 HMC/Internal Medicine and Geriatrics, 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 HMC/Internal Medicine and Geriatrics 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 HMC/Internal Medicine and Geriatrics 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 HMC/Internal Medicine and Geriatrics, 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 HMC/Internal Medicine and Geriatrics 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 HMC/ Internal Medicine and Geriatrics and that HMC/ Internal Medicine and Geriatrics 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 HMC/ Internal Medicine and Geriatrics will attempt to obtain pre-certification. If requested, I received a copy of the HMC/ Internal Medicine and Geriatrics 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

Habersham Medical Group
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ADVANCE BENEFICIARY NOTICE

(ABN)

PATIENT NAME: _____ INSURANCE CARRIER: _____

NOTE: You need to make a choice about receiving these health care items or services.

Your insurance company does not pay for all of your health care costs. Your insurance company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. Please understand that you are responsible for the amount in which your insurance company does not cover.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services provided at this clinic, knowing that you might be responsible for the remainder of your bill that insurance does not cover. Before you make a decision about your options, you should read this entire notice carefully. ? Ask the staff to explain, if you do not understand why your insurance company may not pay in full. ? Ask the staff how much the services will cost.

Please choose ONE option. Check ONE box. Sign and Date

□ OPTION 1: YES, I WANT TO RECEIVE THESE ITEMS AND OR SERVICES. I understand that my Insurance Company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. I understand that you may bill me for the items and or services and that I may have to pay the bill while my Insurance Company is making its decision. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for the payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal my Insurance Company's decision.

□ OPTION 2: NO, I HAVE DECIDED NOT TO RECEIVE THESE ITEMS AND OR SERVICES. I will not receive these items and or services. I understand that you will not be able to submit a claim to my insurance company and that I will not be able to appeal your opinion that my insurance company will not pay.

_____ _____

Signature of patient or person acting on patient's behalf Date

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential

Habersham Medical Group
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NEW PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **PHARMACY**: _____

LIST THE FOLLOWING AS IT PERTAINS TO YOUR MEDICAL HISTORY

-Prior Hospitalizations and surgeries (include dates and diagnosis):

_____

_____

-Past serious illness/current medical problems/psychological issues for which you are under treatment

_____

_____

-Current Medications and dosages: or check box if you have attached your list of medications □

_____

_____

_____

-Medication Allergies (describe reaction):

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

-Smoking History: Never Smoked: ___ Stopped Smoking: ___yrs. ago Currently smoke ___ a day

-Approximate # of alcohol drinks consumed per week: None: ___ Less than 7: ____ More than 7: ____

-Any history of alcohol problems? Yes / No Have you ever used recreational drugs? Yes / No

-Do you have regular periods: Yes / No Date of last regular period: ___ /___ / ____

-Does anyone live with you or help you at home: Yes / No _____

Please Describe the Following:

-Describe your weekly exercise routine: _____

-Describe your typical diet: _____

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NEW PATIENT MEDICAL HISTORY

PLEASE LIST THE DATES AND RESULTS OF ANY OF THE FOLLOWING TESTS/VACCINES YOU HAVE HAD

Physical Exam: Date: _____ Results: _____

Colonoscopy: Date: _____ Results: _____

Cardiac Stress Test: Date: _____ Results: _____

Mammogram: Date: _____ Results: _____

Pap Smear: Date: _____ Results: _____

Bone Density: Date: _____ Results: _____

Pneumonia Vaccine: Date: _____ Results: _____

Diphtheria Tetanus Shot: Date: _____ Results: _____

Chickenpox Vaccine: Date: _____ Results: _____

Hepatitis B Shot: Date: _____ Results: _____

HPV Vaccine: Date: _____ Results: _____

Shingles Vaccine: Date: _____ Results: _____

Travel Vaccines: Date: _____ Results: _____

HAVE ANY RELATIVES (MOTHER/FATHER/SIBLINGS) HAD ANY OF THE FOLLOWING CONDITIONS

___Yes ___No - Colon cancer (what age___) Which Family Member: _____

___Yes ___No - Melanoma Skin Cancer Which Family Member: _____

___Yes ___No - Prostate Cancer before age 70 Which Family Member: _____

___Yes ___No - Breast Cancer (what age___) Which Family Member: _____

___Yes ___No - Uterine Cancer Which Family Member: _____

___Yes ___No - Ovarian Cancer Which Family Member: _____

___Yes ___No - Angina or Heart Attack before age 60 Which Family Member: _____

___Yes ___No - Stroke Which Family Member: _____

___Yes ___No - High Blood Pressure Which Family Member: _____

___Yes ___No - Diabetes Which Family Member: _____

___Yes ___No - Osteoporosis Which Family Member: _____

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NEW PATIENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY TO THE PATIENT

___Yes ___No - A change in your usual headache pattern

___Yes ___No - Difficulty Hearing

___Yes ___No - Recent sudden vision changes

___Yes ___No - Pain with swallowing food or liquid

___Yes ___No - Chest pain at rest or with exertion

___Yes ___No - Fever or Night Sweats

___Yes ___No - Shortness of breath at low exercise levels

___Yes ___No - Chronic Cough

___Yes ___No - Unexplained loss of consciousness

___Yes ___No - Unexplained weight loss

___Yes ___No - Abdominal Pain

___Yes ___No - Blood in your stools or black stools

___Yes ___No - Difficulty with urination on a regular basis

___Yes ___No - Blood in your urine

___Yes ___No - Trouble with sexual function

___Yes ___No - Signification joint pain

___Yes ___No - Loss of interest in daily activities or feeling of hopelessness

___Yes ___No - Unexplained weakness in any extremity or loss of balance

___Yes ___No - Vaginal bleeding after menopause

___Yes ___No - Are you dissatisfied with your personal weight

PLEASE COMPLETE THE FOLLOWING 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#: _____

Habersham Medical Group
Internal Medicine & Geriatrics

Appointment Information

Please answer the questions below so the providers and their staff can make sure to address major concerns during your visit.

Patient Name:_____ Date of Birth: _____

Pharmacy Name and Location: _____

Please check the items that need to be addressed during your visit today:

☐ **New Problem(s)**? Please briefly explain: _____

_____

☐ **Routine Follow up:**

- Were labs completed prior to this appt? ☐ YES ☐ NO

- Any additional test that need to be review? ☐ YES ☐ NO
  - What Test:_____

☐ **Medication Refill (please list medications):**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____