Johns Creek PRIMARY CARE

4365 Johns Creek Parkway, Suite 400 ● Suwanee, Georgia 30024 ● (678) 957-1910 ● Fax: (678) 957-1911

Patient Information Sheet **Date_____/_____/______**

NAME: LAST_______________________________ FIRST ___________________ MIDDLE INITIAL _______ NICKNAME: ____________________

STREET ADDRESS ____

CITY ____ STATE ______________ ZIP_________________

HOME PHONE (______) ______ - ________ CELL PHONE (______) ______ - ________ WORK PHONE (______) ______ - ________ EXT. _________

PERMISSION TO LEAVE MESSAGE: HOME □YES □NO CELL □YES □NO WORK □YES □NO
PREFERRED CONTACT NUMBER: □ HOME PHONE □ CELL PHONE □ WORK PHONE

REFERRING PHYSICIAN __________________________ REFERRAL SOURCE: How did you find out about our practice? __________________

DATE OF BIRTH _____/_____/______ SEX □ F □ M SOCIAL SECURITY: XXX-XX-______________

RACE: □ American Indian or Alaska Native □ ASIAN □ NATIVE Hawaiian □ BLACK OR AFRICAN AMERICAN □ WHITE
□ HISPANIC □ LATINO □ OTHER RACE __________ □ PACIFIC ISLANDER □ UNREPORTED / REFEUSED TO REPORT

MARITAL STATUS: □ SINGLE □ DIVORCED □ LEGALLY SEPARATED □ PARTNER □ MARRIED (SPOUSE NAME _______________________)

□ WIDOWED □ UNKNOWN

EMPLOYER NAME ____ ADDRESS ____

EMPLOYMENT STATUS: □ FULL TIME □ NOT EMPLOYED □ RETIRED □ PART TIME □ SELF EMPLOYED □ ACTIVE MILITARY

STUDENT STATUS: □ FULL TIME □ PART TIME □ NOT A STUDENT

EMERGENCY CONTACT:
NAME LAST_______________________________ FIRST ______________ RELATIONSHIP__________________

ADDRESS________________________________ CITY _____________________ STATE ______ ZIP __________

HOME PHONE (_______) _______ - _________ WORK PHONE (_______) _______ - _________ EXT. _______

I AUTHORIZE THE FOLLOWING PERSON/PERSONS TO RECEIVE INFORMATION ABOUT MY HEALTH:

____
NAME RELATIONSHIP PASSWORD
____
NAME RELATIONSHIP PASSWORD

I WILL NOTIFY THE PRACTICE IN WRITING IF I CHOOSE TO MAKE CHANGES TO THE ABOVE NAMED PERSON/PERSONS.

EMAIL ADDRESS FOR PATIENT:____

PHARMACY:
NAME __________________________ LOCATION/CITY__________________ _________________________ PHONE (_____) _____ - ________

PRIMARY INSURANCE ____ POLICY HOLDER NAME_____________________________________
POLICY HOLDER SEX □ F □ M POLICY HOLDER DOB_____/_____/______ RELATIONSHIP TO PATIENT _____________________________

ID#____ GROUP #____

SECONDARY INSURANCE _________________________ ____________ POLICY HOLDER NAME_____________________________________
POLICY HOLDER SEX □ F □ M POLICY HOLDER DOB_____/_____/______

POLICY HOLDER RELATIONSHIP TO PATIENT ____

ID#____ GROUP #____

I authorize and consent to examination and treatment including procedures by Johns Creek Primary Care Providers. I understand that I or responsible party is financially responsible for charges not covered by my insurance company. I hereby authorize photocopies of this form to be as valid as the original. I have received a copy of Johns Creek Primary Care Physicians, LLC, Notice of Privacy Practices. I hereby grant permission to Johns Creek Primary Care to view my prescription history from external sources.

_______________________________________ ____
PATIENT, PLEASE SIGN FOR PERMISSION TO TREAT **IF PATIENT IS A MINOR, PARENTS SIGN HERE FOR PERMISSION TO TREAT IN YOUIR ABSENCE**

LEE E. HERMAN, MD, FACP
Board Certified Internal Medicine
Medical Director

M. EMILY ADAMS, APRN, FNP-C
Family Nurse Practitioner Certified

MICHAEL F. CONLIN, MD
Board Certified Internal Medicine
Board Certified Clinical Lipidologist

PAMELA WATSON, APRN, FNP-C
Family Nurse Practitioner Certified

Medication List: Name: DOB:

Name:	Strength:	Formulation:	Take:	Frequency:_____________
Name:	Strength:	Formulation:	Take:	Frequency:_____________
Name:	Strength:	Formulation:	Take:	Frequency:_____________
Name:	Strength:	Formulation:	Take:	Frequency:_____________
Name:	Strength:	Formulation:	Take:	Frequency:_____________
Name:	Strength:	Formulation:	Take:	Frequency:_____________
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Patient Name:____ Date:____________________

PAST MEDICAL HISTORY/ FAMILY HISTORY

Please check the appropriate box if you or your family members have any of the following medical problems. Write which family has the problem (father, mother, etc.).

Medical Problems	You	Family	Which Family Members?
Allergies	☐	☐	_
Asthma	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Heart disease/Heart Attack	☐	☐	
Congestive Heart Failure	☐	☐	
Colon Cancer	☐	☐	
Breast Cancer	☐	☐	
Ovarian Cancer	☐	☐	
Prostate Cancer	☐	☐	
Leukemia	☐	☐	
Other Cancers? Type__________	☐	☐	
Other Cancers? Type__________	☐	☐	
Seizures	☐	☐	
Strokes	☐	☐	
Alcoholism	☐	☐	
Depression	☐	☐	
Other Psychiatric Illness	☐	☐	
Other Illnesses	☐	☐	
Other Illnesses	☐	☐	
Other Illnesses	☐	☐	

Father Alive?_______ If not, age and cause of death ____
Mother Alive?_______ If not, age and cause of death____

Hospitalizations: Please list reasons____
____

Surgeries:____
____

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FINANCIAL POLICY

We are dedicated to providing the best possible medical care for you and we want you to completely understand our financial policy.

1. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, American Express and Discover. If you have special circumstances that require a payment plan, arrangements may be made with our practice manager while you are here. Once payment arrangements are determined, any violation of these arrangements will result in your account being forwarded to our outside collection agency and you may be dismissed from our practice.

2. As a service to you, we will file your insurance claim if you assign the benefits to the physician. Please be sure that we have accurate information and a copy of your most current insurance card. You will be responsible for any unpaid balances denied by insurance due to incomplete or inaccurate information.

3. Please be aware that your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the practice within a reasonable period (usually 30-45 days from date of service), we will expect payment from you. Any payment that is received from you and later paid by your insurance will be credited to your account.

4. Any copay that is indicated by your insurance plan is due at the time of service If you do not have your copay, your appointment will be rescheduled.

5. All services are not covered by insurance plans. Any service that is deemed to be "not covered" by your plan will be the responsibility of the patient. You will be notified by a statement from our office and payment is due upon receipt of the statement.

6. Our fee for returned checks is $35 and you will not be allowed to make an appointment until the bad check and fee is paid. Also, there is a $20 pre-pay form fee for preparation of all forms.

7. If you fail to show up for your appointment without cancelling 24 hours in advance, you will be assessed a no show fee of $50.00 for Physical Exams and $25.00 for all other office visits. We will try to make a courtesy call one or two days before your appointment, but the responsibility for making sure you show up for your appointment is yours not our office.

8. If you fail to pay your account, it may be sent to our collection agency. You agree to have them call you at any telephone number that is associated with your account which may include pre-recorded/artificial voice messages, text messages, emails and/or use an automatic dialing device, as applicable.

I have read and understand the financial policy for Johns Creek Primary Care and agree to the terms of this policy.

Printed Name:_________________________________ Date of Birth: ____________________

Signature of Patient __________________________________ Date _____________________
(or responsible party if minor)

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Consent to Use or Disclose Information for Treatment, Payment, Health Care Operations, or other Uses Permitted Under HIPAA

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information "protected health information" by Johns Creek Primary Care, in order to carry out treatment, payment, or health care operations. The Patient should review our Notice of Information Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Johns Creek Primary Care reserves the right to change the terms of its Notice of Information Practices for Protected Health Information at any time. If we do change the terms of the Notice of Information Practices, a copy of the revised notice will be mailed to you.

The Patient retains the right to request that Johns Creek Primary Care further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. Johns Creek Primary Care is not required to agree to such requested restrictions; however, if we do agree to the Patient's requested restrictions, such restrictions are then binding on Johns Creek Primary Care.

At all time, the Patient retains the right to revoke this Consent. Such revocation must be submitted to Johns Creek Primary Care in writing. The revocation shall be effective except to the extent that Johns Creek Primary Care has already taken action in reliance on the Consent.

Johns Creek Primary Care may refuse to treat the Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If the Patient (or authorized representative) signs this Consent Form and then revokes consent Johns Creek Primary Care has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I have read and understand this information. I have received a copy of this form and I am the Patient or am authorized on behalf of the Patient to sign this document verifying consent to the above stated terms.

Date: ________________________________

____
Signature of Patient (or authorized Representative)

____
Please Print Name of Patient

1/2016

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Authorization for Use/Release of Protected Health Information

This form applies only to the release/disclosure of information. It is not consent for treatment or intended for any other purpose. By signing this form, I authorize the below named physician or facility to release or disclose the protected health information described below. Please provide the following for the physician/facility:

****Please fill in the following information for the physician or facility that currently holds your medical records:**

Name of physician or facility: ______________________________

Address: ______________________________

____

Phone: ______________________________

Fax: ______________________________

Purpose of disclosure: ☐ Patient Request ☐ Employment ☐ Life Insurance
☐ Other, please specify: ____________________

Information to be faxed or mailed to:

Johns Creek Primary Care
4365 Johns Creek Parkway
Suite 400
Suwanee, GA 30024

Phone: (678)-957-1910 **Fax: (678)-957-1911**

I authorize the following information to be sent to the address above:

- ☐ Copies of all medical records (since you became a patient in this office)
- ☐ Only include specific information:
  - ☐ History & Physical Exam ☐ Lab, X-Ray, etc. ☐ Other, please specify:__________

I understand that Johns Creek Primary Care assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Johns Creek Primary Care from all legal liability that my arise from this authorization.

PATIENT NAME: LAST__________ FIRST__________ MIDDLE INITIAL ______
DATE OF BIRTH: __________ SEX: ________
ADDRESS______________________________

HOME PHONE:______________ WORK PHONE: ______________

My relationship to the patient is: ______________________________

PATIENT SIGNATURE: ______________________________ DATE: ______________

Expiration Date: One year from date of signature.

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WEB ENABLED – OFFICE POLICY

It is our office policy that every patient that has an email address be web enabled through our eClinicalWorks messenger service and our patient portal. We highly recommend this feature as we send all labs and other results along with patient communications through the portal. See "Benefits"

BENEFITS

1. Secure Website
2. Request Appointments
3. Send Request to Cancel appointments
4. View your personal healthcare record
5. Receive updates on future events (flu clinics, physicals, etc.)
6. Request Prescription Refills
7. "Ask" your healthcare provider
8. Request a referral
9. View Appointment Confirmation
10. View your lab results

______________________________ ____________________
Patient Name (Print) Date

______________________________ ____________________
Patient Signature Date of Birth

____
Email Address (Print)

☐ I **WANT** to be web enabled .

☐ I **DO NOT** want to be web enabled