Johns Creek PRIMARY CARE

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

AMIT S. NARAYAN, MD
Board Certified Internal Medicine

CANDACE M. McNAIR,APRN,FNP-C
Family Nurse Practitioner Certified

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

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

WELCOME

Welcome to Johns Creek Primary Care. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits. Depending on the day's schedule, walk ins may or may not be accepted. You will need to bring your insurance card with you for each appointment. Please let our staff know if you have had any information changes since your last appointment (address, phone number,etc). You will be asked to fill out new demographic forms annually so we may update your information.

All co-pays and past due balances are expected to be paid at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

If possible, please bring all of your prescription and over-the-counter medications with you at each visit.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Johns Creek Primary Care does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physicians.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.

a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit (if needed) in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.

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3. For the safety and well-being of our patients,

a. Requests for **new** medications (including antibiotics) and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician.

b. No **new** medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.

c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

Johns Creek Primary Care is affiliated with Emory Johns Creek Hospital. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link with Emory Johns Creek Hospital services. This is an important resource in meeting our goal of providing high quality care in a timely manner.

For all laboratory services and tests we use either Quest or LabCorp, depending on your insurance coverage.

Welcome to our practice and thank you for choosing Johns Creek Primary Care for all your health care needs.

Lee E. Herman, MD

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OFFICE INFORMATION FORM

Your time is valuable and being aware of the information below will make your interaction with our office efficient and flow smoothly.

Hours of operation: 7:00 am to 4:00 pm Monday – Friday. The office closes for lunch from 12 noon – 1:30 p.m. each weekday.

Emergencies: On the occasion that you need us when the office is **closed**, one of our providers are on call. Please call our office **678-957-1910**, press **2** to be connected with our answering service. They can page the provider on call.

Insurance cards: They **Must** be presented to the front desk at the time of arrival. **Each** office visit requires you to present your card. If you are not able to present your card, you will be given the opportunity to sign a waiver stating that your card will be in our office within **24 hours** of office visit. In the case that your insurance card is not received, you will be billed for the entire visit. **We do not accept any Workman's Compensation claims.**

Appointments: We charge a **$50.00** no show fee for missed appointments or cancellations of less than 24 hours. As a courtesy, we will try to call 1- 2 days before your scheduled visit to remind you of your upcoming appointment. We cannot guarantee you will receive a call. It is your obligation to be aware of your appointments.

Prescription Refills: Call our office at **678-957-1910** and leave a message for the Medical Assistant of your provider as to what you are requesting a refill for. Dr. Herman is at **extension 260**, Dr. Narayan is **ext 210**, Pam Watson is **ext 250** and Candace McNair is an **ext 280**. You can bring all your Rx's to any office visit and request refills when seen by your provider.

Patient Portal: You will be asked to sign up for our Patient Portal. This is an extremely useful site. You can request appointments, review your labs, ask the provider or staff questions, ask for refills and much more. All you need is a valid email address.

Test Results: Blood work or diagnostic testing will be reviewed by your provider once it is received. If results are abnormal you will be called promptly. Notifications of normal results are posted to your Patient Portal**.**

Referrals: Managed care referrals generally require a visit with your primary care provider. Please allow one week to process non-emergency referrals. You may reach the referral line by calling **678-957-1910, dial 150.**

Medical Records: A **Release Form** must be signed by the patient or guardian before records can be released. Please allow 15-30 days to process medical records for transfer. There is a $25.00 fee (plus mailing costs) for records sent to the patient but no fee sent to another provider**.**

Medicaid – We do not take Medicaid, even if it is your secondary or tertiary insurance. You will not be able to be seen by our providers if you currently have Medicaid or get it in the future.

Signature_____ I do not have Medicaid Insurance

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 **(NO PO BOXES)** _____

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 #_____

ALL VIDEO AND/OR AUDIO RECORDING IS EXPRESSLY FORBIDDEN UNLESS CONSENT IS GIVEN BY THE PROVIDER OR PRACTICE MANAGER

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

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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:
Name:	Strength:	Formulation:	Take:	Frequency:
Name:	Strength:	Formulation:	Take:	Frequency:
Name:	Strength:	Formulation:	Take:	Frequency:
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Name:	Strength:	Formulation:	Take:	Frequency:
Name:	Strength:	Formulation:	Take:	Frequency:
Name:	Strength:	Formulation:	Take:	Frequency:

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

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Patient Name:_____ Date:_____

Date of Birth: _____

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

1. Payment is due at the time of service. 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 may 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 all 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. We allow **2** no show office visits in a **12** month period. If you miss **3** appointments in those **12** months, you may be dismissed from our practice. If you are **15** minutes late for your appointment it may be rescheduled.

8. If you fail to pay your account, it will be sent to our collection agency. When your account goes to collections, or is considerably past due, you will not be able to be seen or make an appointment at our office (Emergencies Only) until your account is paid in full or satisfactory payment arrangements are made. You will also not be able to access your Patient Portal.

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 times, 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) **Date of Birth**

_____

Please Print Name of Patient

Johns Creek
PRIMARY CARE

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