DOUGLAS MEDICAL & SURGICAL GROUP

NEW PATIENT

LAST NAME:_____ FIRST NAME:_____

MIDDLE NAME/INITIAL:_____ SEX:_____ DOB:_____

SSN:_____ PROVIDER: Dr. Abigail Miller Dr. Charles Miller

ADDRESS:_____

HOME PHONE:_____ MOBILE PHONE:_____

WORK PHONE:_____ CONSENT TO CALL/TEXT/EMAIL: Y N

EMAIL:_____

Would you like to register for our online patient portal, where you can make an appointment, view your lab results, contact your doctor via secure message, view your record, and more? Y N

CONTACT PREFERENCE: Home phone Mobile phone Work phone Email

LANGUAGE: English Spanish

RACE: American Indian Asian Asian Indian Black/African American European
Filipino Japanese Korean Hawaiian/Pacific Islander White

ETHNICITY: Central American Cuban Dominican Hispanic/Latino-Spanish
Latin American Mexican Not Hispanic or Latino Puerto Rican
South American Spaniard

MARITAL STATUS: Married Single Divorced Separated Widowed Partner

PREFERRED PHARMACY:_____

LAB:_____

PRIMARY INSURANCE INFORMATION ☐None/Do Not Bill Insurance

SUBSCRIBER LAST NAME:_____

SUBSCRIBER FIRST NAME:_____

RELATIONSHIP TO SUBSCRIBER: ☐SELF _____

EMPLOYER NAME:_____

GROUP NAME:_____ GROUP #:_____

INSURANCE REMIT-TO ADDRESS:_____

COPAY/COINSURANCE/DEDUCTIBLE:_____

PRIMARY INSURANCE INFORMATION ☐None/Do Not Bill Insurance

SUBSCRIBER LAST NAME:_____

SUBSCRIBER FIRST NAME:_____

RELATIONSHIP TO SUBSCRIBER: ☐SELF _____

EMPLOYER NAME:_____

GROUP NAME:_____ GROUP #:_____

INSURANCE REMIT-TO ADDRESS:_____

COPAY/COINSURANCE/DEDUCTIBLE:_____

GUARANTOR INFO: (if other than the patient)

Name:_____

Address:_____

Relationship to patient:_____

DOB:_____ Phone:_____

ALLERGIES:_____
SURGERIES:_____

MEDICATIONS: _____

Occupation_____ Marital Status_____ #of Children_____

Alcohol Intake_____ Tobacco Use_____ Illicit Drugs_____

PAST MEDICAL HISTORY

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bedwetting
- ☐ Birth defect/inherited disease
- ☐ Bladder/Kidney problems
- ☐ Breast cancer
- ☐ Breast problem
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Congestive Heart Failure (CHF)
- ☐ Constipation
- ☐ COPD
- ☐ Coronary artery/heart disease
- ☐ Depression
- ☐ Development/Behavior disorder
- ☐ Diabetes (blood sugar)
- ☐ Diverticulitis
- ☐ Ear/Hearing problems
- ☐ Eating disorder
- ☐ Eczema
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension (blood pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lung disease
- ☐ Meniere's disease
- ☐ Mental Illness
- ☐ MRSA exposure
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Pulmonary Embolism
- ☐ Reflux/GERD
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Thrombophilia
- ☐ Tuberculosis
- ☐ Varicosities
- ☐ Vision/Eye problems

FAMILY HISTORY_____

PROBLEMS TODAY

- ☐ Fever
- ☐ Night Sweats
- ☐ Chills
- ☐ Weight gain
- ☐ Weight loss
- ☐ Dry eyes
- ☐ Vision change
- ☐ Difficulty hearing
- ☐ Ear pain
- ☐ Sore throat
- ☐ Snoring
- ☐ Sinus Problems
- ☐ Ringing in the ears
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Ankle swelling
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn/GERD
- ☐ Burning with urination
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Abnormal menstrual cycle
- ☐ Muscle aches
- ☐ Weakness
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Fracture
- ☐ Abnormal mole
- ☐ Rash
- ☐ Cut/laceration
- ☐ Ulcer
- ☐ Loss of consciousness
- ☐ Seizure
- ☐ Dizziness
- ☐ Depression
- ☐ Sleep Disturbance
- ☐ Anxiety
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Other:

PAYMENT POLICIES

We accept Medicare, Medicaid, and many private insurance carriers. We are happy to bill your insurance company for you. To do this, we need proper billing address and ID numbers, as well as a copy of your insurance card and a driver's license or other photo I.D. Please be aware that nearly all plans require payment of your deductible/copay/coinsurance. This payment is your responsibility. Please call the number on your insurance card in order to learn more about your payment responsibilities. Payment is due at the time of service.

Although we have a very low claims denial rate, unfortunately, a very few claims will inevitably be denied. If your claim is denied for any reason, the financial responsibility of the claim falls on the patient. We will try our best to help you appeal your claim with your insurance company; however, during the appeals process, you are expected to pay your bill. If your insurance company does eventually pay the claim, we will, of course, refund your payment promptly.

Automobile accidents: Patients being seen as a result of a motor vehicle accident (MVA) are required to pay for the visit in full at the time of visit. We will provide you with a receipt that you can submit to the automobile insurance carrier for reimbursement. We will not bill the automobile insurance carrier under any circumstance. If you have sought representation from an attorney, you must bring a check from the attorney's office for each and every visit. We will not bill the insurance company.

Worker's Compensation: Patients being seen as a result of a work-related injury are still held responsible for charges incurred by them. It is your decision to seek the opinion of Dr. Miller or Dr. Miller. Your employer must schedule your appointment and provide us with correct information for billing purposes. If the employer/insurer fails to pay any claim within 60 days or denies the claim completely, the patient will be responsible for charges incurred.

Signature:_____ Date:_____

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you hereby consent for this practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI below before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy by asking the Privacy Officer of this practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The practice is not required to agree to requested restrictions; however, if the practice agrees to your requested restrictions, the restriction is binding.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer. By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicated with (and only with) the following individuals regarding my condition or course of treatment:

_____

_____

_____

_____

You may communicate confidential information to me, including medical information and invoices for services, to the following address, email, and/or phone numbers (in addition to those listed elsewhere in my chart) both via text message and phone call:_____

_____

_____

_____

Signature:_____ Date:_____

If signed by Legal Representative, Relationship to Patient:_____

Signature of Witness:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describe show medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you, referred to below as protected health information (PHI).We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the provider. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use of and disclosure of medical information. Your personal doctor may have different policies or notices regard in the doctor's use and disclosure of you medical information created in our office.

How we may use and disclose medical information about you

For treatment. The doctor may use and disclose PHI in the course of providing, coordinating, and managing your medical treatment. These types of uses and disclosures may take place between physicians, nurses, medical students, and other health care professionals who provide you health care services or are otherwise involved in your care. For instance, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse/MA who is assisting in your care. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need such as prescriptions, lab work, and imaging. We also may disclose medical information about you in order to coordinate the different things you need. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the hospital, such as family members, clergy, or others we use to provide services that are part of your care.

For payment. The physician may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, the physician may need to give PHI to your health plan in order to be reimbursed for the services provided to you. The physician may also disclose PHI to its business associates, such as billing companies, electronic health record, claims processing companies, and others that assist in processing health claims.

For healthcare operations. The physician may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you, employee training, underwriting activities, compliance activities, planning and development, and management and administration. They may disclose PHI to doctors, nurses, technicians, medical students, attorneys, consultants, provide health care to its patients at a high level of quality.

Exceptions to Consent Requirement

Despite the general rules explained previously, the Physician may use or disclose your PHI without consent to carry out treatment, payment, or health care operations in certain circumstances. For instance, an emergency situation or other circumstance may cause the physician to be unable to obtain your consent prior to providing treatment, in which case prior consent would not be required before you could receive treatment. In some cases other persons are legally authorized to provide a required consent on behalf of a patient.

As required by law and law enforcement. The physician may use or disclose PHI when required to do so by applicable law. The physician also may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, the location of the crime or victims, or the identity, description, or location of a person who committed a crime, or for other law enforcement purposes.

For public health activities and public health risks. The physician may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse and neglect of other victims or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For health oversight activities. The physician may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions, or activities necessary for monitoring the healthcare system, government programs, and compliance with civil rights laws.

Coroners, medical examiners, and funeral directors. The physician may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ donation. The physician may release PHI to organ procurement organizations to facilitate organ donation and transplantation.

Research. Under certain circumstances, the physician may use and disclose PHI for medical research purposes.

To avoid a serious threat to health or safety. The provider may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious a serious threat to the health or safety of a person or the public.

Specialized government functions. The physician may use and disclose PHI of military personnel and veterans under certain circumstances. The physician may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Workers; compensation. The physician may disclose PHI to comply with workers' compensation or other similar laws.

Appointment reminders, health-related benefits and services. The physician may use and disclose your PHI to contact you and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you.

Other authorized uses and disclosures. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations you have the right to revoke in writing.

Regulatory requirements. The physician is required by law to maintain the privacy of your PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this notice. The physician reserves the right to change the terms of this notice and of its privacy policies, and to make the new terms applicable to all of the PHI it maintains. Before the physician makes an important change to its privacy policies, it will promptly revise this notice and post a new notice.

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR PHI:

You may request that the physician restrict the use and disclosure of you PHI. The physician is not required to agree to any restrictions you request, but if they do, it will be bound by the restrictions to which it agrees except in emergency situations.

You have the right to request that communications of PHI to you from the physician be made by particular means or at particular locations. For instance you may request that communications be made at your work address, or by e-mail rather than regular mail. We will accommodate your reasonable request without requiring you to provide a reason for your request. Generally, you have the right to inspect and receive a copy of you PHI that the physician maintains. Within thirty (30) days of receiving your request, the physician will inform you of the extent to which your request has or has not been granted. In some cases, the physician may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, the physician may impose a reasonable fee to cover copying, printing, postage, and related costs. If the physician denies access to your PHI, he or she will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed healthcare professional designated as reviewing official.

If you believe that your PHI maintained by the physician contains an error or needs to be updated, you have the right to request that the physician correct or supplement your PHI. Your request must be made in writing and must explain why you are requesting amendment to your PHI. Within sixty (60) days of receiving your request, you will be informed of the extent to which your request has or has not been granted. The physician generally can deny your request if your request relates to PHI: (i)not created by the physician; (ii) that is not part of the record the physician maintains; (iii)that is no subject to being inspected by you; or (iv) that is accurate and complete.

If your request is denied, the physician will provide you a written denial that explains the reason for the denial and your rights to: (i)file a statement disagreeing with the denial; (ii)if you don't file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the physician's denial attached; and (iii)complain about the denial.

You generally have the right to request and receive a list of the disclosures of your PHI the physician has made at any time during the six(6) years prior to the date of your request. The list will not include those uses and disclosures to which you have already agreed, such as those: (i)for treatment, payment, and health care operations; (ii)made to you; (iii)for persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. The list will be provided at no charge, but if you make more than one request in any 12-month period you will be charged a reasonable fee for each additional request.

You can receive a copy of this notice by calling (912)384-7300. You may complain to the physician if you believe your privacy rights with respect to your PHI have been violated by contacting our Privacy Officer Becky Miller. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. We will in no manner penalize you or retaliate against you for filling a complaint regarding our privacy practices. If you have any questions about this notice, please contact the Office Manager at (912)384-7300.

Signature:_____ Date:_____

If signed by Legal Representative, Relationship to Patient:_____

DOUGLAS MEDICAL & SURGICAL GROUP, P.C.
203 SHIRLEY AVE
(912)384-7300

AUTHORIZATION FORDISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure to Douglas Medical & Surgical Group, P.C.

_____

Address:_____Phone:_____Fax:_____

3. The type and amount of information to be disclosed is as follows: (include dates where appropriate)
   - ☐ ALL MEDICAL RECORDS
   - ☐ Most recent office visit from date _____ to date _____
   - ☐ Most recent History and Physical from date _____ to date _____
   - ☐ Most recent Discharge Summary from date _____ to date _____
   - ☐ Laboratory results from date _____ to date _____
   - ☐ XRay/Imaging Services from date _____ to date _____
   - ☐ Consultation reports from date _____ to date _____
   - ☐ Procedure notes from date _____ to date _____
   - ☐ Other_____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

   Douglas Medical & Surgical Group, P.C.
   203 Shirley Ave
   Douglas, Georgia 31533
   (912)384-7300
   Fax: (833)989-2422

   For the following purposes: ☐Legal Use ☐Insurance claim ☐Personal use ☐Continuing care ☐Other_____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthoriz3d re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Douglas Medical & Surgical Group, P.C. at (912)384-7300.

_____
Signature of Patient or Legal Representative

_____ _____
If signed by Legal Representative, Relationship to Patient Witness

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for DOUGLAS MEDICAL & SURGICAL GROUP, P.C.
- I hereby assign my insurance benefits to be paid directly to the healthcare provider
- I authorize DOUGLAS MEDICAL & SURGICAL GROUP, P.C. to release medical information required to process my claim
- I have read and understand the Payment Policy for DOUGLAS MEDICAL & SURGICAL GROUP, P.C.
- I authorize DOUGLAS MEDICAL & SURGICAL GROUP, P.C. to obtain/have access to my medication and immunization history
- I authorize my provider's office to contact me by mobile phone

Signed_____ Date:_____