PIEDMONT MEDICAL
ASSOCIATES

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ☐ Male ☐ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Marital status**: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Email: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ☐ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____ **Sex**: ☐ Male ☐ Female

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer phone number**: _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____

Home phone number: _____ **Cell phone number**: _____ **Work number**: _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ☐ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber**: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary insurance: _____ **Patient relation to subscriber**: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ **Employer size**: ☐ 0 – 19 employees ☐ 20 – 99 ☐ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ☐ **Yes** or ☐ **No**

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DO NOT SCAN

PIEDMONT MEDICAL
ASSOCIATES

Medical History

Full name:_____ Date of birth:_____ Date:_____

Primary doctor:_____

Doctor who requested today's visit: _____

List current/previous doctors and their specialty:_____

_____

ALLERGIES AND REACTIONS

_____

_____

_____

_____

MEDICATIONS (list dosage and how you take them, including non-prescription, herbs, birth control)

_____

_____

_____

_____

PAST MEDICAL ILLNESSES (please check if you have had the following):

- ☐ Alcohol/Drug addiction
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer (type):
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ _____
- ☐ Crohn's disease
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis B or C
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Seizure
- ☐ Sexually transmitted disease (type):
  _____
- ☐ Sickle cell disease
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ (Positive) TB skin test
- ☐ Ulcerative colitis
- ☐ Other:_____
  _____
  _____
  _____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY ☐ Adopted

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brothers and Sisters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			
Sons and Daughters 1) ☐ M ☐ F			
2) ☐ M ☐ F			
3) ☐ M ☐ F			

SOCIAL HISTORY

Occupation: | Marital Status: | Children: ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No | How often? | How many drinks?

Do you smoke? ☐ Yes ☐ No | Packs per day: ☐ ¼ pack ☐ 1½ packs | How many years?_____

Are you a former smoke? ☐ Yes ☐ No | ☐ ½ pack ☐ 2 packs | Year quit?_____

Do you chew tobacco? ☐ Yes ☐ No | ☐ 1 pack ☐ Other:_____

Do you use recreational/illegal drugs? ☐ Yes ☐ No

Have you worked with asbestos or other hazardous materials? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No | Healthcare proxy? ☐ Yes ☐ No If so, who?

Advanced Directive for Healthcare

HEALTH MAINTENANCE

Last menstrual period:_____ Last pap smear:_____ Last mammogram:_____

Last colonoscopy:_____ Last prostate cancer screening:_____ Last bone density scan:_____

Immunizations: ☐ Pneumovax:_____ ☐ Flu:_____ ☐ Tetanus:_____ ☐ Hep A:_____ ☐ Hep B:_____

REVIEW OF YOUR SYMPTOMS (please check if you have recently had the following symptoms):

☐ Weight gain	☐ Persistent cough	☐ Blood in stool	☐ Headaches
☐ Weight loss	☐ Chest discomfort	☐ Difficulty urinating	☐ Memory loss
☐ Night sweats	☐ Palpitations	☐ Trouble holding urine	☐ Numbness/Tingling
☐ Weakness	☐ Fainting	☐ Frequency of urination	☐ Tremor
☐ Fatigue	☐ Change in exercise tolerance	☐ Penis discharge	☐ Uncontrollable mood swings
☐ Insomnia	☐ Difficulty swallowing	☐ Vaginal discharge/bleeding	☐ Anxiety
☐ Change in hearing	☐ Indigestion or heartburn	☐ Nipple discharge	☐ Depression
☐ Change in vision	☐ Nausea	☐ Breast pain	☐ Skin Rash
☐ Runny nose	☐ Vomiting	☐ Breast lump	☐ Back pain
☐ Nose bleed	☐ Constipation	☐ Pain with intercourse	☐ Leg pain
☐ Fever	☐ Diarrhea	☐ Feeling too hot	☐ Leg swelling
☐ Blood in sputum	☐ Change in bowel habit	☐ Feeling too cold	☐ Other:_____
☐ Shortness of breath	☐ Blood in vomit	☐ Dizziness	

Please list all your reason(s) for visiting today in order of priority:

1. _____
2. _____
3. _____

_____ Patient/Designee signature

_____ Patient name (**PRINT**)

_____ Date

_____ Time

_____ Relationship to patient

_____ Reason patient is unable to sign

PIEDMONT MEDICAL
ASSOCIATES

ASSIGNMENT OF BENEFITS, CONSENT TO TREAT, NOTICE OF PRIVACY, AND FINANCIAL AGREEMENT

NOTICE OF DEEMED CONSENT: WHEN EITHER A PERSON PROVIDING HEALTH CARE SERVICE OR A PATIENT IS DIRECTLY EXPOSED TO THE BODY FLUIDS OF THE OTHER IN A WAY THAT MAY TRANSMIT HUMAN IMMUNO-DEFICIENCY VIRUS(HIV) OR HEPATITIS VIRUSES, SUCH OTHER PERSON IS DEEMED TO HAVE CONSENTED TO TESTING FOR THOSE VIRUSES AND TO RELEASE THE TEST RESULTS TO THE PERSON SO EXPOSED, AND ACTUAL CONSENT IS NOT REQUIRED. (INT___)

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE ANY MEMBER OF PIEDMONT MEDICAL ASSOCIATES (PMA) AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID INSURANCE INFORMATION, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COSTS, ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY PMA AND A $35 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. (INT___)

DISCLOSURE OF INFORMATION: WE MAY DISCLOSE YOUR MEDICAL INFORMATION TO OPERATE THE PMA PRACTICE PLAN. FOR EXAMPLE, WE MAY USE YOUR MEDICAL INFORMATION IN ORDER TO EVALUATE THE QUALITY OF HEALTH CARE SERVICES, TO EVALUATE THE PERFORMANCE OF THE HEALTH CARE PROFESSIONALS, AND TEACHING AND TRAINING OF HEALTH CARE PERSONNEL. WE MAY ALSO PROVIDE YOUR MEDICAL INFORMATION TO OUR ACCOUNTANTS, ATTORNEYS, CONSULTANTS, AND OTHERS TO MAKE SURE WE'RE COMPLYING WITH THE LAWS THAT AFFECT US. (INT___)

NOTICE OF PRIVACY PRACTICES: I HAVE BEEN OFFERED THE PMA PRIVACY NOTICE WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY PMA AND ITS AFFILIATES. (INT___)

PATIENT RESPONSIBILITY: I UNDERSTAND THAT FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR MYSELF AND ANY PARTY FOR WHOM I AM FINANCIALLY RESPONSIBLE. I UNDERSTAND THAT IS SOLEY MY RESPONSIBILITY TO CONFIRM WHICH TREATMENTS OR PROCEDURES ARE COVERD AND/OR PAID BY MY INSURANCE (INCLUDING, BUT NOT LIMITED TO, ANY APPLICABLE EXCLUSIONS, DEDUCTIBLES, AND ANNUAL OR LIFETIME MAXIMUMS). ANY CLAIMS DENIED AS A RESULT OF ME PROVIDING INCORRECT INFORMATION (NAME, DOB, SUBSCRIBER INFORMATION, CORRECT INSURANCE CARRIER AND ID INFORMATION, etc.) MAY RESULT IN MY RESPONSIBILITY

TO PAY FOR THE CLAIM. I UNDERSTAND THAT ALTHOUGH I PAY MY ESTIMATED PATIENT BALANCE ON THE DATE OF SERVICE, THE INSURANCE ESTIMATE MAY DIFFER FROM WHAT MY INSURANCE CARRIER ULTIMATELY PAYS. I WILL BE RESPONSIBLE FOR ANY AMOUNTS NOT PAID BY MY INSURANCE FOR ANY REASON, AND I MAY RECEIVE A BILL/STATEMENT FOR A BALANCE DUE.

(INT___)

CANCELLATION POLICY: WE ATTEMPT TO SCHEDULE AS EFFICIENTLY AS POSSIBLE TO REDUCE WAIT TIMES. WE REQUIRE PATIENTS TO CANCEL APPOINTMENTS 24 HOURS PRIOR TO THE SCHEDULED DATE AND TIME. A FEE WILL BE ASSESED TO ALL APPOINTMENTS CANCELLED WITH LESS THAN 24 HOUR NOTICE. THE FEE IS $50.00 FOR OFFICE VISITS AND $100.00 FOR PHYSICALS. WE UNDERSTAND THAT EMERGENCIES MAY OCCUR THAT PREVENT THE REQUIRED NOTIFICATION, EMERGENCIES WILL BE ADDRESS ON A CASE BY CASE BASIS. ALL RETURNED CHECKS WILL BE ASSESED A 35.00 FEE, THIS FEE MAY INCREASE DEPENDING UPON THE BANK'S CHARGES. (INT___)

MEDICAL RECORDS REQUEST AND FORMS: I UNDERSTAND THAT UNLESS RECORDS ARE SENT DIRECTLY TO ANOTHER PROVIDER, THE CHARGE FOR COPIES UP TO THE FIRST 50 PAGES IS $35.00 AND .25 CENT PER PAGE FOR EACH ADDITIONAL PAGE AFTER 50. ALL FORM REQUEST TO BE COMPLETED INCLUDING (DMV, FMLA, APPLICATIONS FOR EMPLOYMENT, DISABILITY FORMS, ASSISTED LIVING, NURSING HOME, SHOR AND LONG TERM DISABILITY, ECT.) WILL ASSESED A $45.00 FEE. (INT___)

PATIENT NAME (PRINT) PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE

PMA STAFF DATE

PIEDMONT MEDICAL
ASSOCIATES

Authorization for Release of Information

Many of our patients allow family members and significant others access to personal health information. Under the requirements of HIPAA, (**Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers**) we are not allowed to share this information to anyone without the patient's written consent. If you wish to have your medical or billing information released you must sign this form. Signing this form will only give information to the individuals indicated below.

I authorize Piedmont Medical Associates to release my medical and/or billing information to the following individual(s): **This information being released includes refill request, picking up of prescriptions, scheduling appointments, discussing medical records including lab results, and discussing financial matters.**

Name of Relative	Relationship to Patient	Phone number of Relative

I _____(print) understand I have the right to revoke this authorization at any time. You have the right to revoke this consent in writing. I understand that the information disclosed to any of the individuals listed above is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Name: _____ PMA Staff: _____

Patient Signature: _____ Date: _____

PIEDMONT MEDICAL
ASSOCIATES

Acknowledgement of Receipt of "Notice of Privacy Practices"

☐ I hereby acknowledge that I received a copy of

Piedmont Medical Associates "Patient Notice of Privacy Practices"

_____

First and Last Name of Patient

_____

Signature of Patient or Patient Authorized Representative **Current Date & Current Time**

———————— OR ————————

Certification of Good Faith Efforts to Obtain Patient Acknowledgement

☐ I hereby certify that as an employee or agent of Piedmont Medical Associates, I have made a good faith effort to obtain from the patient or an authorized representative of the patient a written acknowledgement of Piedmont Medical Associates Physicians "Notice of Privacy Practices" in compliance with the practice policy known as "Notice of Privacy".

_____

First and Last Name of Staff or Agent of Piedmont Medical Associates

_____

Signature of Staff or Agent of Piedmont Medical Associates Current Date & Current Time

_____

Brief reason for not obtaining "Patient Notice of Privacy"

Piedmont Medical Associates: Cynthia Hurley, MD • David Scurlock, MD
4062 Peachtree Rd NE Ste. C, Atlanta, GA 30319 • Phone: 404.231.4231 • Fax: 404.231.4378

PIEDMONT MEDICAL
ASSOCIATES

Medical Records Release / Receive Form

Authorization for Use / Disclosure of Protected Health

Patient full name: _____ Patient phone #_____

Patient date of birth: _____/_____/_____ Patient SSN #_____

Patient current address: _____

_____

I hereby request / authorize Piedmont Medical Associates to:

☐ **Release a copy of my medical records to:**

- or -

☐ **Receive a copy of my medical records from:**

Name of person(s) or medical facility: _____

Address of person or medical facility: _____

Fax # of person or medical facility: _____

Telephone # of person or medical facility: _____

Description of information to be released/received: ** _____ / _____ **Staff Initials & Date**

☐ **ENTIRE MEDICAL RECORD** ☐ **SPECIFIC DATE OF SERVICE:**_____

☐ **OTHER: describe –** _____

**** The health information requested will not include psychotherapy notes, although they may include other sensitive patient health information.

PURPOSE OF AUTHORIZATION / DISCLOSURE OF INFORMATION: ☐ **At the request of patient.** ☐ **Other:** _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Piedmont Medical Associates Health Information Management. The completed revocation must be presented directly to PMA HIM. I also understand that this Authorization is specific to the information noted above and for the purpose written above. Piedmont Medical Associates shall not condition treatment on the receipt of this Authorization except when such conditioning is permitted in instances where the sole purpose of creating the health information is for disclosure to a third party, ex: fitness for duty physical exam. This Authorization is valid for ninety days from the current date and will expire at that time unless another date is clearly noted _____.

_____

Signature of patient or legal representative **First and Last Name - Printed** **Current Date** **Current Time**

As legal representative – relationship to patient is: _____ document proving such authority must be attached / included with this authorization form. Patient is unable to sign because: _____

NOTE: Fees may apply for provision of any or all requested information. Under most circumstances, the law permits up to thirty days for record requests to be processed. Records for treatment may be immediately faxed to the patient's healthcare provider when requested.

Piedmont Medical Associates: Cynthia Hurley, MD • David Scurlock, MD • Andrea Ledbetter, PA-C
3925 Peachtree Rd NE Suite #350 Atlanta, GA 30319 • Phone: 404.622.7622 • Fax: 404.869.9636