MEDICAL ASSOCIATES OF ALBANY, PC
101 Oakland Crossing Dr.
Leesburg, GA 31763
Phone: (229)-432-1440 Fax: (229) 889-8263

PATIENT INFORMATION

Name_____ **Soc.Sec.**_____
Last Name First Name Initial

Address_____ **Home Phone**_____
Street City State Zip

Email Address_____

Sex: **Age**____ **Birthdate**_____ **Cell Phone**_____

- o **Male**
- o **Female** **Circle One: Single Married Widowed Separated Divorced**

Patient Employed by_____ **Business Phone**_____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency, who should be notified_____
Name Relationship Phone

GUARANTOR INFORMATION

Person Responsible for Account_____
Last Name First Name Intitial

Relationship to Patient_____ **Birthdate**_____ **soc.sec.**_____

Address(if different from Patient's)_____ **Phone**_____
Street City State Zip

Person Responsible Employed by_____ **Phone**_____

PRIMARY INSURANCE

Insurance Company_____ **Contract#**_____ **Group#**_____

Subscriber Name_____ **Relation to Patient**_____ **Birthdate**_____

Address(if different from Patient's)_____ **Phone**_____
Street City State Zip

Subscriber Employed by_____ **Business Phone**_____

SECONDARY INSURANCE

Is patient covered by additional insurance? Circle one: Yes No

Subscriber Name_____ **Relation to patient**_____ **Birthdate**_____

Insurance Company_____ **Contract#**_____ **Group#**_____

Address(if different from Patient's)_____ **Business Phone**_____
Street City State Zip

Subscriber Employed by _____ **Business Phone**_____

ASSIGNMENT OF BENEFITS/INFORMATION RELEASE/CONSENT FORM

I authorize the release of any medical information, including information related to psychiatric-care, drug and alcohol abuse and HIV/AIDS confidential information necessary to process insurance claim of my medical information that is needed for any utilization review of quality assurance activities, I assign all medical benefits including major medical benefits to which I am entitled to above signed physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I hereby, consent to any treatment or diagnostic studies considered necessary by the physician.

_____ Date_____
Person giving consent

_____ Patient unable to sign due to_____
Relationship, if not patient

Medical Associates of Albany, P.C.

Name_____ SS#_____ Date_____

Address_____ Occupation_____

Phone (best contact#)_____ Work#_____ DOB_____ Age_____

Chief Complaint_____

DRUG ALLERGIES_____

CURRENT MEDICATIONS_____

_____

FAMILY HISTORY	Father	Mother	Father's Parents	Mother's Parents	Sibling	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS or SURGERIES

Date_____ REASON_____

Date_____ REASON_____

Date_____ REASON_____

Female Only - Pregnant _____Yes _____No Planning Pregnancy _____Yes _____No

MEDICAL HISTORY

- ☐ Headache
- ☐ Shortness of Breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness/Fainting
- ☐ Peripheral Vascular Disease
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ GI Disorder
- ☐ Lactose Intolerant
- ☐ Gallbladder Disease
- ☐ Prostate Disease
- ☐ Bowel Irregularity
- ☐ Incontinence
- ☐ Sexual/Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Frequent Urination
- ☐ Hepatitis
- ☐ HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ Depression
- ☐ Gout
- ☐ Scarlet Fever
- ☐ Chronic Rashes
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diptheria
- ☐ Tetanus
- ☐ Other

Explain any Items Checked Above_____

_____

_____

HABITS

- ☐ Pack(s) Daily_____
- ☐ How Long_____
- ☐ Interested in Quitting?___
- ☐ Exercise Routine_____
- ☐ Coffee: Cups Daily _____
- ☐ Other Caffeine_____
- ☐ Alcohol: Type ___ _____
- ☐ Diet: Salt Intake_____
- ☐ Fat Intake_____

Sleep

- ☐ Difficulty falling to sleep
- ☐ Continuity disturbance
- ☐ Snoring
- ☐ Early morning awakening
- ☐ Daytime drowsiness

HEPATITIS C RISK FACTOR

- ☐ Blood transfusion before 1992
- ☐ IV Drug use (more than once)
- ☐ Contact with blood/bodily fluids
- ☐ Tatoos
- ☐ Shares razor/toothbrush
- ☐ Body Piercing

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: ____-____-____ SS #: ____-____-____ Medical Record #: _____
Mo Day Year

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

I hereby authorize _____ (Print Name of Provider) to release information from my medical record as indicated below to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	DATES:
☐ History and physical exam	_____
☐ Progress notes	_____
☐ Lab reports	_____
☐ X-ray reports	_____
☐ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)
☐ Mental health (including psychotherapy notes)
☐ HIV related information (AIDS related testing)

_____
SIGNATURE OF PATIENT OF LEGAL GUARDIAN

PURPOSE OF DISCLOSURE: ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care ☐ Legal ☐ School ☐ Insurance ☐ Workers Compensation ☐ Other (please specify) _____

1 I understand that this authorization will expire on _____ (Print the Date this Form Expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _____ (Print Name of Provider) for the purpose of: _____
   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it,.
   c. I have been informed that _____ (Print Name of Provider) ☐ will/ ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Georgia statute, I will pay a fee of $ _____ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____
Signature of Patient or Legal Guardian/Authorized Person Date

If signed by Legal Guardian/Authorized Person, state relationship to patient: _____

Records Received by _____ Date _____

Relationship to Patient _____

For OFFICE USE only

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $_____

MEDICAL ASSOCIATES OF ALBANY, P.C.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I acknowledge that a copy of the Notice of Privacy Practices of Medical Associates of Albany, P.C. has been made available on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Medical Associates of Albany, P.C.

I also understand that if I wish to receive additional copies of the Notice of Privacy Practices in the future or if I have any questions regarding this Notice of Privacy Practices, I may contact:

Terri K. Johnson
Practice Administrator
101 Oakland Crossing Drive
Leesburg, Georgia 31763
(229) 432-1440

_____

Signature of Patient

PRINT NAME_____

DATE

This space to be used by Practice only.
Date Acknowledgement denied by Patient:

Reason Denied by Patient:

Name of Person reviewing denial:

Date:

MEDICAL ASSOCIATES OF ALBANY, P.C.

MEDICAL ASSOCIATES OF ALBANY, P.C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS PRIVACY NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS PRIVACY NOTICE CAREFULLY
IF YOU HAVE QUESTIONS, PLEASE CONTACT THE PERSON LISTED AT THE BOTTOM OF THIS NOTICE

I. OUR COMMITMENT TO YOUR PRIVACY

Medical Associates of Albany, P.C. (the Practice) is committed to maintaining the privacy of your protected health information (PHI). As we provide treatment and services to you, we create records that contain your medical and personal information, referred to as protected health information, or PHI. We need these records to provide you with quality care and to comply with various legal requirements. The terms of this Privacy Notice apply to all records containing your PHI that are created or retained by our Practice. We are required by federal and state law to maintain the privacy of your PHI maintained in such records. We also are required by law to provide you with this Privacy Notice of our legal duties and the privacy practices that we maintain in our Practice concerning your PHI. We must follow the terms of the Privacy Notice that we have in effect at the time.

This Privacy Notice provides you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights with respect to your PHI.
- Our obligations concerning the use and disclosure of your PHI.
- Important contact information.

II. CHANGES TO THIS PRIVACY NOTICE

We reserve the right to revise or amend this Privacy Notice. Any revision or amendment to this Privacy Notice will be effective for all of your records that our Practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. We will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

III. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe and give some examples of the different ways in which we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall within one of the categories listed below.

1. **Treatment.** We may use your PHI to treat you. For example, we may suggest that you to have x-rays or diagnostic tests, and we may use the results to help us reach a diagnosis. Your PHI may be disclosed to the facility at which you have your diagnostic tests in order for the healthcare providers at such diagnostic facility to provide services to you.

2. **Payment.** We may use and disclose your PHI in order to bill and collect payment from you, an insurance company, or other designated third party payor, for the treatment and services we provide to you. For example, we may contact your health plan to certify that you are eligible for benefits, and we may provide your plan with details regarding your treatment to determine if the plan will cover, or pay for, your treatment.

3. **Healthcare Operations.** We may use and disclose your PHI to operate our business. For example, we may use your PHI to conduct quality assessment and improvement activities, review the performance of our healthcare professionals, or for general management or business planning for our Practice.

4. **Appointment Reminders.** We may use and disclose your PHI to contact you and remind you of an appointment.

5. **Release of Information to Family/Friends.** We may release your PHI to a friend or family member who is involved in your care, or who assists in taking care of you. We may also give information to someone who pays, or helps pay, for your medical care. As stated in Section V below, you have the right to request restrictions on who receives your medical information. Therefore, if there are specific family members or other persons to whom you do not want your PHI disclosed, please let us know in the manner required by Section V.

IV. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe special situations in which we may use or disclose your PHI:

1. **As Required By Law.** We will disclose PHI when required to do so by federal, state or local law.

2. **Public Health Risks.** We will disclose your PHI to public health or government authorities that are authorized by law to collect information for purposes such as, but not limited to, the following:

- Maintaining vital records, such as births and deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure to a communicable disease.
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- Reporting reactions to drugs or problems with products or devices.
- Notifying individuals if a product or device they may be using has been recalled.
- Notifying appropriate and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances required by law primarily relating to workplace injury or illness or medical surveillance.

3. **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for oversight activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions, or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the healthcare system in general.

4. **Lawsuits and Similar Proceedings.** We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if the requesting party has made an effort to inform you of the request or to obtain a qualified protection order protecting the information the party has requested.

5. **Law Enforcement.** We may release PHI if asked to do so by law enforcement. For example:

- Reporting certain types of wounds and physical injuries, as required by law.
- Regarding a person believed to be a crime victim in certain situations.
- Concerning a death the healthcare professional suspects has resulted from criminal conduct.
- Regarding reasonably suspected criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

6. **Coroners, Medical Examiners, and Funeral Directors.** We may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

7. **Organ and Tissue Donation.** If you are an organ donor, we may release PHI to organizations that handle organ or tissue procurement or transplantation, including organ donation banks, as necessary.

8. Serious Threats to Health or Safety. We may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. If you are a member (or veteran) of U.S. or foreign military forces, we may release your PHI as required by the appropriate authorities.

10. National Security. We may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

11. Inmates. If you are an inmate of a correctional institution, or under the custody of law enforcement officials, we may disclose your PHI to such correctional institutions or law enforcement officials. Disclosure for these purposes would be necessary: (a) for the institution to provide healthcare services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. We may disclosure your PHI for workers' compensation and similar programs, as required by applicable laws.

V. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Requesting Restrictions. You have the right to request a restriction on our use or disclosure of your PHI for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. *We are not required to agree to your request.* However, if we do agree, we are bound by our agreement, except when otherwise required or permitted by law, or when the restricted information is necessary to treat you in an emergency. In order to request a restriction on our use or disclosure of your PHI, you must make your request in writing in accordance with our practice's policies. Your request must be in writing and described in a clear and concise fashion:

(a) The information you wish restricted and how you want it restricted;
(b) Whether you are requesting to limit our Practice's use, disclosure or both; and
(c) To whom you want the limits to apply.

2. Confidential Communications. You have the right to request that our Practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work, or by mail, rather than telephone. We will accommodate reasonable requests, but we are *not* required to accommodate all requests. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. You do not need to give a reason for your request.

3. Access and Copies. You have the right to inspect and obtain a copy of the PHI that we maintain about you, including patient medical records and billing records, but not including psychotherapy notes or certain other information that may be restricted by law or pursuant to a legal or administrative process or proceeding. You must submit your request in writing in order to inspect and/or obtain a copy of your PHI. Our Practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request in accordance with Georgia law.

We may deny your request to inspect and/or copy some or all of your PHI in certain limited circumstances; however, you may request a review of our denial. A licensed healthcare professional, who was not involved in the denial, will be chosen by us to conduct reviews of denials. We will comply with the outcome of the review.

4. Right to Amend. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this Practice.

To request an amendment, your request must be made in writing and in addition, you must provide a reason that supports your request for the amendment.

We may deny your request for an amendment if it is not in writing or if it does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the practice;
- Is not part of the information you would be permitted to inspect and copy; or
- Is accurate and complete.

5. Accounting of Disclosures. You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures made of your PHI for non-treatment or operations purposes. We are not required to provide you with an accounting of the following:

(i) Disclosures for treatment, payment or the healthcare operations of our Practice;
(ii) Disclosures to you;
(iii) Disclosures incident to uses or disclosures of your information for permitted purposes;
(iv) Disclosures that you have authorized us to make;
(v) Disclosures [from our facility's directory;] to others involved in your care; or for notifying your family member or personal representative about your general condition, location, or death when you have had the opportunity to agree to such disclosures (or they were otherwise permitted);
(vi) Disclosures for national security or law enforcement;
(vii) Disclosures that were part of a "Limited Data Set" (which is a set of information containing only limited identifiable information, as permitted by the HIPAA Privacy Rules); or
(viii) Disclosures that occurred prior to April 14, 2003.

In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our Practice may charge you for additional lists within the same 12-month period. Our Practice will notify you of the costs involved with additional requests, and you may withdraw or modify your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated by our Practice or an employee of our Practice, you may file a complaint with our Practice or with the Secretary of the Department of Health and Human Services. Because we are always interested in improving the quality of services provided to you, we would encourage you to contact Terri Johnson with our Practice first. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted or required by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Terri K. Johnson
2002 Palmyra Rd., Suite 101
Albany, GA 31701