Georgia Spine and Sports Rehab Dr. Joseph A. Krzemien

WELCOME TO OUR OFFICE PATIENT INFORMATION FORM

NAME ____DATE OF BIRTH _________________ AGE ______ SEX ☐M F☐

ADDRESS _____________________________________CITY _____________ STATE_____ZIP _________________

HOME PHONE __________________________WORK PHONE ___________________CELL ___________________

SOCIAL SECURITY NUMBER ________________ EMAIL ADDRESS _____________________________________

Check One ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated Name of Spouse: ______________________

PREFERED METHOD OF CONTACT: ☐HOME PHONE ☐CELL PHONE ☐WORK PHONE ☐EMAIL

MAY WE LEAVE A MESSAGE REGARDING YOUR HEALTHCARE AND/OR APPOINTMENT? ☐YES ☐NO

EMPLOYER _____________________________ POSITION ________________________________

EMPLOYER ADDRESS ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

PERSON TO CONTACT IN CASE OF AN EMERGENCY __________________________ CONTACT #____________________

IF PATIENT IS A MINOR DO YOU AUTHORIZE GEORGIA SPINE AND SPORTS REHAB TO TREAT SAID MINOR WITHOUT A PARENT/GUARDIAN PRESENT FOR FUTURE APPOINTMENTS? **SIGNATURE:** _________________________

COMPLETE THE FOLLOWING SECTION IF SOMEONE OTHER THAN PATIENT IS FINANCIALLY RESPONSIBLE:

RESPONSIBLE PARTY__________________________________ RELATIONSHIP TO PATIENT__________________________

ADDRESS____CITY________________STATE__________ZIP_____________

HOME PHONE___________________________WORK PHONE_____________________CELL___________________________

SOCIAL SECURITY NUMBER__________________________DATE OF BIRTH_______________________________________

EMPLOYER____POSITION_______________________________________

Who is Responsible for Your Bill, You and ☐Spouse ☐Health Insurance ☐Auto Insurance ☐Workman's Comp ☐Attorney

Personal Health Insurance (Name) _________________________ Policy ID ___________________Group #___________________

PLEASE GIVE YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE TO THE RECEPTIONIST FOR INSURANCE BILLING PURPOSES

I HEREBY GIVE CONSENT FOR THE ABOVE NAMED DOCTORS TO TREAT ME. THIS MAY OR MAY NOT INCLUDE THE NEED FOR X-RAYS. IF X-RAYS ARE NEEDED I WILL BE INFORMED BY THE DOCTOR FIRST. I AGREE TO ACCEPT FINANCIAL RESPONSIBILITY FOR ANY CHARGES INCURRED. I ALSO HEREBY ASSIGN TO THE ABOVE NAMED DOCTORS ALL BENEFIT PAYMENTS PROVIDED BY MY HEALTH INSURANCE COMPANY, AUTO INSURANCE COMPANY OR A SETTLEMENT FROM MY ATTORNEY FOR SERVICES DESCRIBED. I GIVE GEORGIA SPINE AND SPORTS REHAB PERMISSION TO TREAT ME IN AN OPEN ROOM WITH OTHER PATIENTS. I AM AWARE OTHER PERSONS MAY OVERHEAR SOME OF MY HEALTH INFORMATION. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM OR PENDING LEGAL CASE. I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF GEORGIA SPINE AND SPORTS REHAB'S FINANCIAL AND HIPAA POLICY.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY______________________________**DATE**_____________

MEDICAL/SURGICAL HISTORY:

Purpose of This Appointment: ____

Have you received chiropractic care before? YES NO

Other Doctors Seen For This Condition: YES NO Who? _____________________________________

Type of Treatment: _____________________________Results: ____

When Did This Condition Begin? ________________ Has This Condition Occurred Before? YES NO

Is This Condition Job Related Auto Accident Home Injury Fall Other: _____________________

Date and Time of Accident ______________________Have you made a report of your accident to your employer? Yes No

Major accidents or falls in the past? ____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

GENITO-URINARY

- Blood in Urine
- Frequent Urination

GASTRO-INTESTINAL

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

CARDIO-VASCULAR

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Poor Circulation
- Rapid Heart Beat

EYE, EAR, NOSE, THROAT

- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache
- Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision-Flashes
- Vision-Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in Moles
- Rash
- Scars
- Sore that won't heal

MEN only

- Breast Lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other:_____________________

WOMEN only

- Abnormal Pap Smear
- Bleeding between Periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other:____________________

Date of last Menstrual Period:

Have you had a mammogram? YES NO

Are you currently pregnant? YES NO

Do you take oral contraceptives?

Lack of bladder control   Swelling of Ankles   ☐ YES ☐ NO
Painful Urination   Varicose VeinsNumber of Children:
History of Blood Clotting

PLEASE TURN PAGE OVER TO COMPLETE FORM

CONDITIONS Check (√) symptoms you currently have or have had in the past year.

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High Cholesterol
☐ HIV Positive
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Stroke
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infections
☐ Venereal Disease

HOSPITALIZATIONS: (Women- Include Pregnancy History)

YEAR	HOSPITAL	REASON/OUTCOME

LIST ANY KNOWN ALLERGIES:

____
____
____
____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

____
____

___
___
___
___

FINANCIAL POLICY

1. STATEMENTS ARE MAILED OUT EACH MONTH. PAYMENTS ARE DUE 28 DAYS AFTER THE STATEMENT DATE UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.

2. IF NO PAYMENT IS RECEIVED BY THE NEXT STATEMENT DATE, A LATE FEE OF $20.00 WILL BE ADDED TO THE BALANCE DUE.

3. ACCOUNTS THAT HAVE NOT RECEIVED ANY PAYMENTS FOR 3 MONTHS WILL BE REFERRED TO A COLLECTION AGENCY. ADDITIONALLY, A 35% COLLECTION FEE MAY BE ASSESSED ON THE BALANCE.

4. CO-PAYS/ CO-INSURANCE ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

5. PATIENT MEDICAL RECORDS ARE THE PROPERTY OF GEORGIA SPINE AND SPORTS REHAB. ANY PATIENT REQUESTING A COPY OF THEIR MEDICAL RECORD WILL BE CHARGED A FEE THAT FOLLOWS THE GUIDELINES SET BY GEORGIA STATE MANDATE.

6. ALL PATIENTS ARE RESPONSIBLE TO KNOW AND MONITOR THEIR INSURANCE BENEFITS. IMPORTANT THINGS TO PAY ATTENTION TO ARE CO-PAYS, DEDUCTIBLES, REFERRALS, NUMBER OF VISITS, NONCOVERED SERVICES, AND WHETHER THE DOCTOR IS IN-NETWORK WITH YOUR PLAN.

7. WE WILL BILL YOUR INSURANCE FOR YOU, AND WE ALLOW THE INSURANCE COMPANY 60 DAYS TO PAY
US. IF THEY HAVE NOT PAID AFTER 60 DAYS, THE BALANCE WILL BECOME YOUR RESPONSIBILITY, AND YOU CAN FOLLOW UP WITH YOUR INSURANCE COMPANY FOR REIMBURSEMENT. PLEASE INFORM US IF YOUR INSURANCE HAS CHANGED TO PREVENT PAYMENT DELAYS.

8. ALL INSUFFCIENT FUND CHECKS WILL BE CHARGED A $25.00 FEE.

9. APPOINTMENT CANCELATION FEE IS $45.00 FOR ALL APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE.

10. ALL FINANCIAL ACCOUNT QUESTIONS SHOULD BE DISCUSSED WITH THE OFFICE MANAGER.

I understand the above stated financial policy of Georgia Spine and Sports Rehab. I have been given an opportunity to have all my questions answered regarding these policies. I agree to accept financial responsibility for any charges incurred.

Patient/Guarantor Signature: ______________________________ Date: ___________

Staff: ________________________________

HIPAA Notice of Privacy Practices

<u>GEORGIA SPINE AND SPORTS REHAB</u>
<u>4271 SOUTH LEE ST SUITE 201</u>
<u>BUFORD, GA 30518</u>
(770) 614-6551

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

<u>1. Uses and Disclosures of Protected Information</u>

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

<u>Treatment:</u> We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

<u>Payment:</u> Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

<u>Healthcare Operations:</u> We may use or disclose, as-needed, your protected health information in order to support the business activities, employee review of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclosure your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors. And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required uses and disclosures; under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>Your rights</u>
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

This notice was published and became effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

THIS IS YOUR COPY TO KEEP FOR YOUR RECORDS.