Patients Name/First:________________________________/**MI**_______/**Last**_______________________________________

Preferred/Nick Name:______________________ **Birthdate**: _____/_____/_____

Age:_____________ **Marital Status**:____________________

Address:____**City**:___________________**State**:_________**Zip**:_____________

Home Phone:( )_______-____________**Mobile**:( )_______-____________Other:( )_______-____________

Patient Email Address:____**Male**_____**Female**_____

Primary Care Doctor_________________**SSN#**_______-_____-_______**Preferred Language:**__________________________

Race:______________________ **Ethnicity** (*Circle One*)**:** Hispanic or Latino Non-Hispanic Undetermined

GUARANTOR Information. (A guarantor is the person responsible for paying the bills.)

______*I am the* **patient listed above, I am 18 years of age or older and I am aware that I am legally responsible for paying my bills.**

Go to Guarantor Signature.

______*I am not* **the patient listed above but I am legally responsible for paying the bills for the patient named above.**

Complete the following area and sign.

First:________________________________/**MI**____/**Last**____

Mailing Address:______________________________________**City**:_______________________**State**:______**Zip**:____________

Home Phone:( )______-________Cell:( )______-________Other:( )_____-________Email :_____________________________

SSN#_______-_____-_______**Patient's Relationship to Guarantor:**______________________________**Birthdate:**_____/_____/_____

Occupation:______________________________**Employer:**____

Financial Obligation for Evans Medical Group: I authorize payment of medical benefits to *Evans Medical Group* for services rendered. I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for services provided, regardless of insurance coverage or other third party coverage unless waived by contractual agreements between *Evans Medical Group* and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account, including collection agency cost, and/or reasonable attorney fees if applicable, if the account is placed for collection. All returned checks incur a $35.00 service charge or the maximum allowed by law, to be paid by cash or credit card along with balance of patients account within 10 days of notification by *Evans Medical Group*, or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

Guarantor Signature:____**Date:**_____________________

Emergency Contact? ______________________________________Phone:( )______-________Relationship?_____________

1. **Primary Insurance Co Name**:

____

*Co-Pay Amount:*___________________

ID:#______________________________

*Group#:*__________________________

Insured/Employee Persons Name:

____

Address:

____

____

____

Primary Phone:( )______-________

DOB:___/___/___

SS#________-______-________

*Occupation:*______________________

*Employer:*_______________________

2. **Secondary Insurance Co Name**:

____

*Co-Pay Amount:*___________________

ID:#______________________________

*Group#:*__________________________

Insured/Employee Persons Name:

____

Address:

____

____

____

Primary Phone:( )______-________

DOB:___/___/___

SS#________-______-________

*Occupation:*______________________

*Employer:*_______________________

3. **Tertiary Insurance Co Name**:

____

*Co-Pay Amount:*___________________

ID:#______________________________

*Group#:*__________________________

Insured/Employee Persons Name:

____

Address:

____

____

____

Primary Phone:( )______-________

DOB:___/___/___

SS#________-______-________

*Occupation:*______________________

*Employer:*_______________________

Contact me: It is my understanding that appointment reminders are by phone call to the primary phone number provided above.

Consent for Treatment: I, the undersigned, a patient of *Evans Medical Group*, requests and authorize my attending physician and whomever he may designate as his/her associates or assistants, to administer such treatment as is medically necessary. **I give my physician permission to give and receive prescription history information with pharmacies, other providers, and medication prescribing networks.** I voluntarily consent to said medical care, evaluation and treatment, as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of services involving pathology, radiology and immunizations. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Privacy Notice (HIPAA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by *Evans Medical Group* and a copy provided, upon request, for me at my discretion. I hereby authorize *Evans Medical Group* to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment, and healthcare operations.

I also authorize Evans Medical Group to communicate with the individuals named below about my condition or treatment, all other individuals will be excluded.
I understand that these contacts may potentially be aware of my medical chart information at this office.

HIPAA CONTACT NAME	Relationship	Phone Number
1.____	____________________	( )______-_____________
2.____	____________________	( )______-_____________
3.____	____________________	( )______-_____________
4.____	____________________	( )______-_____________

(If you are a parent/guardian and are responsible for completing this form you must list yourself in the contact area above.)

I acknowledge, that it is my responsibility as a patient or parent/guardian of Evans Medical Group to notify the office in regards to any changes of the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information. Signature required by patient, parent if minor child, guardian, or representative/ caregiver if Medicare, for acknowledgement of the above *Consent of Treatment, Financial Obligation and Privacy Notice*:

Signature:____**Date:**_________________________

3/2011

Thank you for your assistance in completing this form!

DATE:____________________

NAME____ DATE OF BIRTH _______________________

PAST MEDICAL HISTORY Have you been diagnosed with a medical condition? ***Circle all that apply:***
Diabetes, High Blood Pressure, High Cholesterol, Heart Rhythm Problems, Coronary Disease (such as Heart Attack or Angina), Congestive Heart Failure, Asthma, Emphysema or other Lung Problems, Seizures, Acid Reflux (GERD), Stomach Ulcers, Intestinal Problems, Kidney Problems, Anemia, Cancer- what kind___________, Depression, Anxiety, Arthritis, Major Back Problems, Osteoporosis.
Other____

Have you ever been hospitalized for any reason other than surgery ? ______No ______Yes
Date ______________ Reason for hospitalization ____
Date ______________ Reason for hospitalization ____
List any doctors you see regularly and their specialty: ____
____

Have you ever had surgery? ______No ______Yes ***Circle all that apply and give DATE/YEAR of surgery***
Tonsils _______ Gallbladder_______ Appendix_______ Hysterectomy_______ Hernia_______
C-section_____________ Breast Biopsy or Mastectomy______________ Breast Implants____________

(Other, please list)

Type of surgery	Date

FEMALE PATIENTS: How many times have you been pregnant? _______ Miscarried _______ Aborted _______
Have you had an abnormal Pap Smear in the past _______No ______Yes
If yes explain outcome ____

List all medications you currently take (including vitamins, remedies and non prescription medications).

Name	Strength	Directions (once a day, etc)

Are you allergic to any medication? ______No ______ Yes
Medication____________________________________ Reaction______________________________
____________________________________ ______________________________
____________________________________ ______________________________
____________________________________ ______________________________

SOCIAL HISTORY

Preferred Nickname ____
Marital status : ***Circle one*** Single Engaged Married Widowed Separated Divorced
Who lives in your home with you? (Children,Grandparents, other relatives)___________________________________
Do you have any children? ______No ______Yes Number of children ____________
Occupation: ____
Highest level of education completed ____
School attended: ____
Hobbies: ____
Inside pets: ______No ______Yes Type: ____
Religion: __________________________________ Church attended: ____
To what level is religion (and/or God) a source of strength and comfort to you? ***Circle one***
Not very much Somewhat Quite a bit A great deal
Have you ever been exposed to TB (tuberculosis) or worked in a prison or with homeless people? ______No ______Yes

Have you ever traveled overseas? ______No ______Yes To which country/countries? ______________________________

Do you smoke? ______No ______Yes Packs per day ______________ Year started _________________
Have you smoked in the past? ______No ______Yes Year started ______________ Year stopped _______________
Do you use any smokeless tobacco products (chewing tobacco or dip)? ______No ______Yes

Do you drink alcohol? ______No ______Yes Amount per day: ***Circle one*** <1 1, 2, 3, 4+
Type: ***Circle all that apply*** Beer Wine Mixed drink Hard liquor
Have you ever used illegal drugs? ______None ______Past ______Recent past ______Present
Type of drug: ____
Are you sexually active outside of marriage? ______No ______Yes
Do you have any risk factors for HIV, such as IV drug use, multiple sex partners, or past of present gay lifestyle?
______No ______Yes
Have you ever received a blood transfusion? ______No ______Yes

FAMILY HISTORY (Specifically; Father, Mother, Sister, Brother)

Condition/Disease	Circle one		Relative/ Relatives
Diabetes	Yes	No	
Heart Attack/Heart Disease	Yes	No	
Stroke	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Drug/Alcohol Problem	Yes	No	
Psychiatric Problem	Yes	No	
Colon Cancer/Polyps	Yes	No	
Breast Cancer (including grandmothers)	Yes	No	
Prostate Cancer (including grandfathers)	Yes	No	
Osteoporosis (including grandparents)	Yes	No	

Other family history that you may think your physician may consider important information concerning your health.
____

____

project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the Practice. We will almost always ask for your specific permission if the researcher obtains access to your name, address or other information that reveals who you are, or will be involved in your care at the Practice.

To Avert a Serious Threat to Health or Safety. *We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.*

Treatment Alternatives. *We may use and disclose medical information to inform you about, recommend possible treatment options or alternatives that may be of interest to you.*

LESS FREQUENT USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION INVOLVING THOSE NOT DIRECTLY INVOLVED IN YOUR CARE COULD INCLUDE:

- ***Coroners, Medical Examiners and Funeral Directors.*** *We may release medical information to a coroner or medical examiner, in order to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their services.*
- ***Health Oversight Activities.*** *We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations,* inspections, and *licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.*
- ***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. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.*
- ***Law Enforcement.*** *We may release medical information if asked to do so by a law enforcement official:*
  - *In response to a court order, subpoena, warrant, summons or similar process;*
  - *To identify or locate a suspect, fugitive, material witness, or missing person;*
  - *About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;*
  - *About a death we believe may be the result of criminal conduct;*
  - *About criminal conduct at the Practice; and*
  - *In emergency circumstances to report a crime; the location of the crime or victims; or to identify, description or location of the person who committed the crime.*
- ***Lawsuits and Disputes.*** *If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.*
- ***Military and Veterans.*** *If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.*
- ***National Security and Intelligence Activities.*** *We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.*
- ***Organ and Tissue Donation.*** *If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.*
- ***Protective Services for the President and Others.*** *We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, and foreign heads of state or conduct special investigations.*
- ***Public Health Risks.*** *We may disclose medical information about you for public health activities. These activities generally include the following, but are not limited to:*
  - *Preventing or controlling disease, injury or disability;*

EVANS MEDICAL GROUP, P.C.
Caring for the Whole Family
465 North Belair Road Ste 1B
Evans Georgia 30809

Effective 1996 (rev. 06/2010)

NOTICE OF PRIVACY PRACTICES

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.
HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. Evans Medical Group creates a record of the care and services you receive at the Practice. We need this record in order 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 Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives.
Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security

and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:
Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.
Right to Amend. If you feel that medical information 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, the Practice. To request an
amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your
request. We may deny your request for an amendment.
Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.
Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.
CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.
COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services.
To file a complaint with the Practice, contact:

Evans Medical Group
Attn: HIPAA Officer
465 North Belair Road, Suite 1B
Evans, Georgia 30809
or
Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W., Room 509F, HHH Building
Washington, DC 20201

All

This is a Notice of Privacy Policy only. Signature required on the Evans Medical Group Acknowledgement of Receiving Privacy Policy and Authorization to Use and Disclose Protected Health Information.

complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. Evans Medical Group understands that medical information pertaining to you and your health is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at the Practice. We need this record in order 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 Practice, whether made by Practice personnel *or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. This notice will inform you about the different 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 and disclosure of medical information.*

The law requires us to:

- *Make sure that medical information that identifies you is kept private;*
- *Give you this notice of our legal duties and privacy practices with respect to medical information about you; and*
- *Follow the terms of the notice that is currently in effect.*

OTHER CATEGORIES OF INFORMATION THAT WE MAY USE OR DISCLOSE INCLUDE.

Appointment Reminders. *We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Practice.*
As Required By Law. *We will disclose medical information about you when required to do so by federal, state or local law.*
Fundraising Activities. *We may use medical information about you to contact you in an effort to raise money for the Practice and its operations. We may disclose medical information to a foundation related to the practice so that the foundation may contact you in raising money for the Practice. We would only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Practice. If you do not want the Practice to contact you for fundraising efforts, you must notify in writing.*
Health-Related Benefits and Services. *We may use and disclose medical information to tell you about health-related benefits or services that may be of interests to you.*
Practice Directory. *We may include certain limited information about you in the practice directory while you are a patient at the Practice. This information may include your name, location in the Practice, your general condition (e.g. fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family,*
friends and clergy can call the Practice about you and generally know how you are faring.
Individual Involved in Your Care or Payment for Your Care. *We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also inform your family or friends about your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your*
condition, status and location.
Research. *Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received another treatment, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information in order to balance the research needs with patients' need for privacy of their medial information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research*