Prestige Medical Group

REGISTRATION FORM

Last Doctor seen: Today's date:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Preferred Contact method:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address / PO Box:		Social Security #	Home phone # ( )			
City:	State:	ZIP Code:	Cell Phone # ( )			
Email:	Occupation / Employer:		Employer phone # ( )			
Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital			
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						
Race:	Ethnicity	Preferred Language:				

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)*

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone : ( )		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Blue Cross - PPO	❑ Blue Cross HMO	❑ Blue Cross POS	❑ Medicare	❑ Medicaid
❑ United Healthcare	❑ Tricare	❑ Coventry	❑ Welfare *(Please provide coupon)*	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Internal Medicine Associates of Jasper, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Financial Policy & Consent to Treat

Insured Patients: If you have insurance coverage, as a courtesy Prestige Primary Care (PPC) will file all claims directly with your insurance company. In order to provide this service for you, we must have all of your current insurance data. Insurance cards must be presented at each visit, a valid Driver's License or photo ID, as well as the guarantor's Social Security number are also required. Any patient that does not provide our office with the above mentioned data with be registered as **Self Pay** and payment in full will be expected at the time of service.

We are required by our contract with your insurer to collect your portion of the visit's charges. **It is your responsibility to pay any deductible, co-pay, or any other portion of the charge as specified by your plan.** Any medical services **not covered** by the patient's plan are the patient's responsibility for paying the charges within 30 days of our statement if not collected at the time service was rendered. For your convenience we accept cash, money order, all major credit / debit cards at our office. ***We do NOT accept personal checks.*** Any payments received may be applied to any unpaid bill(s) for which the patient is liable. Any and all balances assigned as patient responsibility may be subject to collection efforts after 90 days, as well as credit reporting.

Assignment of Medicare, Medicaid Benefits, Third Party Insurance, Patient Certification, and Payment Request: You hereby certify that the information given by you in applying for payment under Title XVII and XIX of the Social Security Act is correct. You request that payment of these authorized benefits be made and assign the benefits payable for services rendered during this visit to the physician or organization furnishing the services. The undersigned if other than the patient and the patient are responsible for and agree to pay charges not covered by this assignment, including any Medicare deductibles.

PPC participates with most of the area insurance plans. However, if you have insurance that we do not participate in, though we still file the claim out of courtesy, payment in full is expected at the time of service. **It is the patient's responsibility to know if we are a network provider for their insurance before service is rendered.**

Charges for Missed Appointments:
We require 24 hours notice for the cancellation of any appointments. Failure to provide 24 hour notice for the cancellation will have the following charges:
- ❖Office Visit - $25
- ❖Ultrasound, ECHO, Stress Tests - $50
- ❖Any Type of Physical Exam - $50

Billable Service Charges:
- ❖**Co-pay not paid at time of service $20**
- ❖Return Check $35
- ❖Monthly Finance Fee 1.5% per month on balances over 30 days

Initials_____

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SIGNATURE REQUIRED ON BACK

Lab Testing:
Laboratory services are provided by Quest Diagnostics. They are not affiliated with PPC and there may be an additional charge if your insurance coverage does not include this lab. Please check with your insurance co. Any questions about billing from laboratories are to be resolved by contacting the lab company directly.

All Physicals:
Your provider may recommend that you have an annual physical. Each insurance plan has different benefits and each policy pays for physicals differently. It will be the patient's responsibility to verify with his or her insurance company to see if and what is covered for an annual physicals. If the services are rendered and your insurance does not pay for the services then the patient will be responsible for the visit. When tests are ordered, the patient **will** be expected to return to the office to discuss results. Please note the follow up visit is **not** part of the PE and therefore your insurance does charge a copay or coinsurance.

Referrals:
If your plan requires a referral for diagnostic testing performed outside our office or a referral to another provider, the **referral must be obtained prior to your appointment.** We **require 10 business days** to obtain your referral authorization. Some plans may require these to be issued by your primary care physician. Once your appointment is scheduled and you have verified with your plan that referral is needed, call our office with the following information:

1. Date of appointment
2. Physician's name or facility, their phone number and fax number
3. If it is a diagnostic test, we need the name of the test and location of the test.
4. Your insurance plan's name and your identification number

Patient Authorizations:
I hereby give authorization to be treated as a patient at Prestige Primary Care and I authorize release of medical information necessary to pay the claim.

By my signature below, I herby authorize PPC and the physicians, and staff to release medical and other information acquired in the course of my exam/ treatment to the necessary insurance companies, third- party payors, or other physicians or healthcare entities required to participate in my care.

By my signature below, I hereby authorize assignment of financial benefits directly to PPC for services rendered under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment; I further understand that any balances not paid by my insurance within 90 days are the patients/my responsibility. I understand that account balances not paid within 90 days will be sent to collections and that I may be charged collection charges up to 40% and / or court costs and attorney fees.

I have read and understand this explanation of my responsibilities for services I receive from Prestige Primary Care providers:

_____ _____

Printed Name /Date of Birth **DATE**

_____

Signature

Prestige
Medical Group

Acknowledgement of Receipt of Privacy Notice

I, _____ acknowledge that I have had an opportunity to review a copy and/or have been provided a copy of Prestige Medical Group's "Notice of Privacy Practices". This notice describes how Prestige Medical Group may use and disclose my protected health information, certain restrictions on the use of my healthcare information, and any rights I may have pertaining to my protected health information.

_____ _____

(Signature of Patient/Guardian/Personal Representative) (Date)

_____

(Relationship to Patient)

Office Use Only

If the patient did not sign an acknowledgement of Receipt of Privacy Practices, please complete the following.

____ Individual refused to sign

____ Communication barriers prohibited us from obtaining the acknowledgement

____ Other (specify) _____

Prestige
Medical Group

RELEASE OF CONFIDENTIAL INFORMATION FORM

Patient confidentiality is a priority at Prestige Medical Group.
Therefore, it is important that you provide us with the following information to ensure your privacy.

In the event that I, _____(print your name here), am unable to be reached, Prestige Medical Group has my permission to leave any test results or lab results in the following manner(s) –

Please check all that apply.

☐ Spouse_____

☐ Children – Name(s)_____

May Call or leave message on voicemail at/on:

☐ Home phone:_____
☐ Cell phone:_____
☐ Work phone:_____

☐ Other option/person – Name(s) _____

Complete the information below to authorize release of information

PATIENT NAME:_____

I, _____, **DO NOT** GIVE Prestige Medical Group
(Print Full Name of Person Signing)
permission to release any medical records and billing information.

I, _____, **GIVE** Prestige Medical Group permission to
(Print Full Name of Person Signing)
release medical records and billing information to the following person(s):

Name _____Relationship _____Phone_____

Name _____ Relationship _____Phone_____

Name _____ Relationship _____Phone_____

My Consent will remain in effect as long as I am a patient of Prestige Medical Group unless I notify Prestige Medical Group in writing of any changes. This authorization will remain in effect until a new Authorization is completed.

By signing below, I understand that I have read and understand the privacy practices for Prestige Medical Group. I also understand that I may obtain a copy either by request or by visiting PrestigeMedicalGroup.org.

Signature_____ Date_____

Prestige Pediatrics

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.		Date:
Child's Name (Last, First, M.I.):	☐ **M** ☐ **F**	DOB:
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed in your child		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital
Has your child ever had a blood transfusion?	☐ Yes	☐ No

List your child's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction child had	

49 Gordon Rd. Suite 103, Jasper, GA 30143 – 3755 Sixes Rd Suite 201, Canton, GA 30114
(706) 692-9768 Fax: (706) 692-4040

FAMILY HEALTH HISTORY					
	Age	SIGNIFICANT HEALTH PROBLEMS		Age	SIGNIFICANT HEALTH PROBLEMS
Child's Father			**Child's Children** *(if applicable)*	☐ M ☐ F	
Child's Mother			**Child's Grandmother** *Maternal*		
Child's Siblings	☐ M ☐ F		**Child's Grandfather** *Maternal*		
	☐ M ☐ F		**Child's Grandmother** *Paternal*		
	☐ M ☐ F		**Child's Grandfather** *Paternal*		

SOCIAL HEALTH		
What school does your child attend?		
What grade are they in?		
Who does your child currently live with?		
How many siblings does your child have?		
Are they exposed to tobacco smoke? If yes, by who? _____	☐ Yes	☐ No

GIRLS ONLY		
Age at onset of menstruation: Date of last menstruation: _____		
Monthly periods? _____		
Heavy periods and/or painful periods?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No

BOYS ONLY		
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any concerns about possible hernia or abnormal nodules in groin area?	☐ Yes	☐ No

Signature:_____ Date:_____

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Internal Medicine Associates of Jasper
DBA Prestige Medical Group

Notice of Privacy Practices

Effective: July 01, 2014

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you may be used and disclosed, and how you can get access to your individually identifiable health information (also referred to as *protected health information or* PHI*)*. Please review this notice carefully.

Who is covered by this privacy notice:

- All physicians, nurse practitioners, other healthcare professionals or employees authorized to access your PHI maintained by Internal Medicine Associates of Jasper DBA Prestige Medical Group.

- Any persons or companies (business associates) with whom Internal Medicine Associates of Jasper DBA Prestige Medical Group contracts for services to assist in practice operations and who have access to your PHI.

Our Promise to Protect Your Privacy:

We are committed to retaining the privacy of your protected health information (PHI). In the course of conducting business, we will create records pertaining to you and the treatment and services provided to you. We understand that the laws are complicated, however, we are required to provide you with the following information:

1. How we may use and disclose your PHI.

2. Your rights concerning your PHI.

3. Our obligations regarding the use and disclosure of your PHI.

The terms of this notice apply to all records created and/or maintained by our practice. We hold the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for any of your records that our practice created or maintained in the past, or records we may create or maintain in the future.

If you have any questions about this Notice, please contact our Privacy Officer, *at (706) 692-9768* or in writing at *Prestige Medical Group, 501 Gordon Road, Suite 201 Jasper, GA 30143.*

How We May Use and Disclose Your Protected Health Information (PHI)

The following categories describe different ways that we use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. 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 these categories.

- **Treatment**. We may use your PHI to provide you with treatment. We may need to disclose your PHI to a pharmacy when we write a prescription for you, or may use your PHI to obtain a diagnosis from laboratory tests that have been performed. Our practice staff, including, but not limited to our doctors, nurses and medical assistants may use or disclose your PHI so that they may provide treatment to you or to assist others involved in your care. We also may disclose your PHI to other health care providers for purposes related to your treatment. Finally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

- **For Payment**. We may use and disclose your PHI to bill you or your insurance company for the treatment and services you may receive from our practice. For instance, we may contact your health insurance provider to verify your eligibility for coverage, the range of benefits your coverage provides, and we may disclose to your insurer information regarding your treatment to determine if they will cover or pay for your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

- **For Health Care Operations**. We may use and disclose your PHI for healthcare operations. These uses and disclosures are necessary to run Internal Medicine Associates of Jasper DBA Prestige Medical Group and make sure that all of our patients receive quality care. For example, we may use your PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We may combine the PHI of many patients to determine if there are additional services we should offer, if there are services that are not needed and for review and learning purposes. We may combine our PHI with information from other healthcare providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study healthcare and healthcare delivery without learning the identities of specific patients. We also may disclose your PHI to another healthcare provider for its healthcare operations purposes if you also have received care from that provider.

- **Treatment Alternatives**. We may use and disclose your PHI to inform you about or recommend different ways to treat you.

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

- **Individuals Involved in Your Care or Payment for Your Care**. We may release your PHI to a family member or friend who is involved in your care. This would include any person(s) named in a durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. 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. You can object to these releases by telling us

that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

- **As Required or Permitted By Law.** We may use and disclose your PHI when required or permitted to do so by federal, state, or local law.

SPECIAL SITUATIONS

- **Public Health Risks.** We may disclose your PHI without your consent to public health authorities that are authorized by law to collect information for the purposes of:

    1. Maintaining vital statistics, such as births and deaths.
    2. Reporting child abuse or neglect.
    3. Preventing or controlling disease, injury, or disability.
    4. Notifying a person regarding potential exposure to a communicable disease.
    5. Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
    6. Reporting reactions to drugs or problems with products or devices.
    7. Notification of product or device recalls.
    8. Notifying the appropriate government agency or agencies, authority or authorities regarding the possible neglect or abuse of an adult patient, including domestic violence; however, we will only disclose this information if we are required or authorized by law to disclose this information or if the patient agrees.
    9. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

- **Health Oversight Activities.** We may your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and disciplinary actions: civil, administrative and criminal procedures and actions. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we must disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request or other lawful process from other parties involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

- **Law Enforcement**. We may release PHI to law enforcement official:

    1. In response to a court order, warrant, summons, grand jury demand, or similar process.

    2. Regarding a crime victim in certain situations, if we are unable to obtain the person's consent.

    3. Regarding criminal activity at our offices.

    4. To identify or locate a suspect, material witness, fugitive or missing person.

    5. Regarding a death we believe is a result of criminal activity.

    6. 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.

    7. To comply with mandatory reporting requirements for violent injuries, such as gunshot or stab wounds and poisoning.

- **Serious Threats to Health or Safety.** We may use and disclose PHI when it is necessary to reduce or prevent a serious threat to the health and safety of you, another individual or the public. Under these circumstances, we will only disclose the information to the person or organization able to help prevent the threat.

- **Coroners and Medical Examiners**. We may release PHI to a coroner or medical examiner to identify a deceased person or determine the cause of death. We also may release PHI funeral directors to carry out their duties.

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

- **National Security and Intelligence Activities**. We may release PHI as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security. We may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release PHI to the correctional institution or law enforcement official. The release of this information would be necessary: (1) to provide you with healthcare services; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you.

- **Workers' Compensation.** In accordance with state law, we may release PHI for a work-related injury or illness covered under workers' compensation or a similar program.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI:

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about health and related matters in a certain manner or at a certain location. For example, you can ask that we only contact you at home or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to our Privacy Officer, *at Prestige Medical Group 501 Gordon Road, Suite 201 Jasper, GA 30143*. Please specify how or where you wish to be contacted.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or healthcare operations. You also have the right to restrict disclosure of your PHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request;** however, if we agree with your request, we are bound by the agreement, with the exception of where we are required by law, in emergencies or when the information is necessary to treat you.

  To request restrictions, make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to restrict; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

  You may request that we not disclose your PHI to your health insurance plan for services you receive during a visit to any Prestige Medical Group location, if you pay in full for those services you do not want disclosed. We are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **Right to Inspect and Copy**. You have the right to inspect and receive a copy of the PHI that may be used to make decisions about you, including patient medical and billing records, not including psychotherapy notes. You must submit your request in writing in order to inspect and/or obtain a copy of your PHI. If we have any or all of your PHI in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct the review. Send your written request to our Privacy Officer, at *Prestige Medical Group 501 Gordon Road, Suite 201 Jasper, GA 30143.*

- **Right to Amend**. If you feel that your PHI 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 our practice. To request an amendment, make your request in writing to our Privacy Officer, at. *Prestige Medical Group 501 Gordon Road, Suite 201 Jasper, GA 30143.*

You must provide a reason that supports your request for amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (a) is found to be accurate and complete; (b) not part of the PHI maintained by or for our practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the PHI is not available to amend the information.

If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your PHI.

- **Right to an Accounting of Disclosures**. You have the right to request an accounting of disclosures. This is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or healthcare operations. The use of your PHI as part of routine patient centered care in our practice is not required to be documented, such as the doctor sharing information with the medical assistant or nurse: or the billing department using your information to file an insurance claim. In order to obtain a list of disclosures, you must submit a request in writing to our Privacy Officer, at *Prestige Medical Group 501 Gordon Road, Suite 201 Jasper, GA 30143.* Your request must state a time period that may not be longer than six 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 will be free. We may charge you for additional lists within the same 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

- **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of this notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our Privacy Officer, at *(706) 692-9768.*

- **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer, at *Prestige Medical Group 501 Gordon Road, Suite 201 Jasper, GA 30143.* All complaints must be in writing. **You will not be penalized for filing a complaint.**

- **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted 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. Please note: we are required to maintain records of your care.

INVESTIGATIONS OF BREACHES OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your PHI to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.