Family Practice of Conyers

1039 E Freeway Dr, SE

Conyers, GA 30094

Patient Information

Patient Registration

Last Name_____First Name_____M.I._____

Address_____APT#_____City_____

State_____Zip_____Home Phone(____)_____-_____ Cell Phone(____)_____-_____

SSN_____-_____-_____DOB____/____/_____Sex(M)____(F)_____Race_____

Email_____ Marital Status (Circle) S M W D

Employer_____Occupation_____

Preferred Language_____ Ethnicity (Circle) Hispanic Non-Hispanic

Emergency Contact_____

Relationship_____Phone Number_(____)_____-_____

Primary Insurance Company_____I.D.#_____

Subscriber's Name_____DOB___/___/_____Relationship_____

Secondary Insurance Company_____I.D.#_____

Subscriber's Name_____DOB___/___/_____Relationship_____

I authorize any holder of medical or other information about me to be released to my insurance company or the Social Security Administration needed for this or any related medical claim. I request payment of medical insurance benefits to Family Practice of Conyers/Total Care Family Medicine. I understand that the charges I incur are my responsibility. I understand that it is my responsibility to know if my physician is in network with my plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill.

Signature_____Date____/____/_____

Patient Name_____ Date of Birth_____

Telephone Number (770) 922-0076

Fax Number (770) 922-0734

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HIPAA-Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice have the necessary medical and PHI to provide our patients the highest quality of medical care possible. Patients should not be afraid to provide information to our practice, physicians, or staff members for purpose of treatment, payment, and healthcare procedures. Our HIPAA policy in its entirety can be obtained through out office at any time. Let us know if you would like to receive a copy prior to signing this consent.

Authorization

Please Initial _____ I understand HIPAA and its policies.

Please Initial _____ I authorize the release of medical information necessary to process insurance claims and to healthcare providers for treatment or care.

Please Initial _____I hereby acknowledge that Family Practice of Conyers/Total Care Family Medicine will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.

Prescription History Authorization

I, _____, authorize the review of my prescription history for reasons of evaluation and treatments.

Patient Confidentiality

Patient confidentiality is a top priority at Family Practice of Conyers/Total Care Family Medicine. Therefore, it is important that you provide us with the following information to ensure there is not a violation of this policy.

In the event that I, _____, am unable to be reached, Family Practice of Conyers/Total Care Family Medicine may leave my test results with the following: (check all that apply)

____ I may be reached at work. Telephone #_(____)_____-_____
____ May leave normal results on answering machine/ voicemail at work.
____ May leave normal results on answering machine/ voicemail at home
____ May leave normal results on answering machine/ voicemail on cell phone
____ May leave all results on answering machine/ voicemail at home/ cell/ work.
____ Other, Describe _____
_____
_

Signature_____ Date_____

Patient Name_____ Date of Birth_____

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Authorization To Release All Medical Records

Patient Name:_____ Address:_____

DOB:_____ _____

Phone Number:_(____)_____-_____

Patient Authorization

I understand that my medical records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment.

_____ I give my specific authorization for these records to be released.

_____ If not, Initial the information that you DO NOT want released:

___ Drug/alcohol abuse/treatment ___ Sexually transmitted disease

___ HIV/AIDS diagnosis/treatment ___ Psychiatric diagnosis/ treatment

This authorization will automatically expire one year from date signed. You may revoke this consent at any time, except to the extent that action has already been taken. You do not have to sign this authorization in order to obtain treatment, payment or enrollment. You may revoke or terminate this authorization by submitting a written revocation to Family Practice of Conyers/Total Care Family Medicine. Information disclosed under this authorization may be disclosed again by the person/ organization to which it was sent. It may not be possible to ensure your right to protection of the privacy of this information once Family Practice of Conyers/Total Care Family Medicine discloses it to another party.

Signature_____

Witness_____

Date_____

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Consent To Disclose Protected Health Information

I, _____, am granting permission for Dr. Kelvin Burton or his staff to allow the following people to have access to my:

_____ Medical Records

_____ Account Information

I understand that I may revoke this permission by completing a new form.

Name	Relationship	Phone Number

_____ _____

Patient Signature Date

Patient Name_____ Date of Birth_____

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Patient Portal User Agreement

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, EClinicalWorks, for the exclusive use of established patients. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:
-View medical summary from an appointment
-Review Next Scheduled Appointment(s)
-Review labs
-Receive health maintenance reminders

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

-No internet-based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is seen by the doctor or nurse practitioner.
-No communication or services authorized through the portal. Any communication and emergency conditions should be handled by calling the office directly, going to an urgent care clinic, emergency room, or by calling 911 should the emergency be life threatening.
-No requests for any medications.
-If you lose your password or username, you may request a new one through the web portal, or in person at the office by providing valid identification.
-Always remember to log out and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information.

<u>You should never use a public computer to access the Patient Portal</u>

This Patient Portal is provided as a courtesy to our patients. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate the Patient Portal offering, suspend user access and modify services available through the Patient Portal.

Our data is HIPAA compliant with high level encryption. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee that unforeseen, adverse events cannot occur. To the extent possible,

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our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. If you do not recall having signed a HIPAA agreement, or need to reacquaint yourself with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given our system generated unique user identification and password, along with login instructions.

Patient Acknowledge and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between Family Practice of Conyers/Total Care Family Medicine and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any instructions or guidelines that my physician may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered.

Patient Name: _____

Patient Signature: _____

Patient Email Address: _____

Date: _____

☐ Check this box to decline participation in the Patient Portal & sign above

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GENERAL AUTHORIZATION

TREATMENT/CONTACT

I authorize physicians, nurse practitioners, and/or physician assistants of Family Practice of Conyers/Total Care Family Medicine who may attend me, their assistants, including those employed by Family Practice of Conyers/Total Care Family Medicine to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ (initials)

I consent and give permission to Family Practice of Conyers/Total Care Family Medicine to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes._____ (initials)

ANNUAL WELLNESS EXAM

I understand and consent to be a patient of Family Practice of Conyers/Total Care Family Medicine. As part of my care, I acknowledge that Family Practice of Conyers/Total Care Family Medicine will perform the Annual Wellness Exam, which is required by insurance companies each year. For these appointments, I consent to the scheduling and attending of a one-hour telephone call with Family Practice of Conyers/Total Care Family Medicine's nurse care team to complete my health questionnaire prior to the visit._____(initials)

NO SHOW POLICY

I understand that Family Practice of Conyers/Total Care Family Medicine requires at least 24 hours' notice for all appointment cancellations. Missed appointments without notification at least 24 hours in advance are considered "no-show" appointments. A $50.00 no-show fee will be automatically applied to my account. I acknowledge that three (3) no-shows within a six (6) month period may result in dismissal from the practice. _____ (initials)

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Family Practice of Conyers/Total Care Family Medicine to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Family Practice of Conyers/Total Care Family Medicine and/or its physicians any and all benefits up to the

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amount of my bill pertaining to all charges incurred. I assign to Family Practice of Conyers/Total Care Family Medicine, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Family Practice of Conyers/Total Care Family Medicine and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full._____(initials)

I understand and agree that I am personally responsible for any account balances, co-pays or self-pay fees at check-in. _____ (initials)

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

Telephone Number (770) 922-0076
Fax Number (770) 922-0734

FAMILY PRACTICE OF CONYERS
1039 E. FREEWAY DR SE
CONYERS, GA 30094
Phone: 770-922-0076
www.fpconyers.com

SMS Consent Form for Payment Link

I hereby authorize Family Practice of Conyers/Total Care Family Medicine to send text (SMS) messages to the mobile phone number I have provided, for the purpose of:

- Sending secure links to pay outstanding medical bills online.

I understand and agree to the following:

1. The payment link may be delivered via text from an outside service provider, 315 Health LLC, on behalf of Family Practice of Conyers/Total Care Family Medicine.
2. Standard text messaging rates from my mobile carrier may apply.
3. I am not required to consent to receive SMS messages in order to receive treatment.
4. Text messages will not include detailed health information (PHI).
5. I may revoke this consent at any time by notifying the office in writing.
6. My phone number will not be shared or used for any purpose other than billing communication.

Please complete the information below:

Patient Name: _____

Mobile Phone Number: _____

Date of Birth: _____

Signature: _____

Date: _____