Patient Profile

Location 1: Beaver Ruin Rd. NW Ste E, Lilburn GA 30044
Location 2: Satellite Blvd. NE Ste 109/100, Suwanee GA 30044
Phone: (678) 369-9399 Fax: (833) 464-3867

PATIENT INFORMATION

(Please Print All Information—Thank you!)

Name: _____

Middle Initial _____ **Date of Birth:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Other ☐Widowed

Address: _____

_____

City/State:_____ Zip Code: _____

Contact Phone Numbers:
Primary (_____)_____ ☐Home ☐Work ☐Cell
Secondary (_____)_____ ☐Home ☐Work ☐Cell

E-mail _____

(If over 18 yrs. of age)

Sex: ☐Male ☐Female ☐Undetermined

Social Security #: _____

Primary Physician: _____

Referring Physician: _____

Language Spoken: _____

Race: _____

Ethnicity: _____

Employment Status: ☐Employed ☐Retired ☐Unemployed ☐Student

Employer/ School: _____

Name of Assisted Living Facility If Applicable:

_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone Number _____

LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION

☐ *If same as patient then don't need to fill out below info.*

Name: _____

Address: _____

_____

City/State: _____ **Zip Code:** _____

Phone:_____

Employer: _____

Phone: (_____)_____

Social Security Number #: _____

Date of Birth: _____

**** ONLY Fill Out The Following Section If Your Insurance Card Is Not Present During Registration****

Primary Insurance ☐Same as Patient ☐Same as Guarantor ☐Other

Insured Party: _____

Insured Phone: _____

Social Security #: _____

Date of Birth: _____

Relationship to Primary: _____
Insured/Guarantor

Company: _____

Insured ID: _____

Policy Group: _____

If you also have secondary insurance, please speak with the front office.

Financial Agreement & Release of Information

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to **TrueCare Medical, LLC** for any services furnished to me by **TrueCare Medical, LLC**. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to determine these benefits or the benefits payable for related services.

I authorize the release of my personal Health Care Information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage.

Office Policy Agreement

I understand that my services will be billed to my insurance company(s) provided I have given proof of my insurance coverage at the time services are rendered. **If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier within 30 days of notification.

If I am over the age of 18, I am ultimately responsible for any patient balance for services I have received. If I am under the age of 18, my parent or legal guardian is responsible for my patient balance until my 18th birthday.

Patient Signature _____ **Date** _____

Signature of Parent / Legal Guardian _____

Notice of Privacy Practices – Acknowledgement

TrueCare Medical, LLC has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact **TrueCare Medical's** Privacy Office at (678) 369-9399 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By initialing below,

I agree I have received the Notice of Privacy Practices of TrueCare Medical.

Patient's Initials _____

Authorization to Request/Disclose Protected Health Information

Location 1: Beaver Ruin Rd. NW Ste E, Lilburn GA 30044
Location 2: Satellite Blvd. NE Ste 109/100, Suwanee GA 30044
Phone: (678) 369-9399 Fax: (833) 464-3867

Patient name: _____Date of birth: _____
Previous name: _____
☒ **May REQUEST Protected Information From**: ___**Anywhere as needed for my medical care**_____
☒ **May DISCLOSE Protected Health Information To (a person's name)** : _____
Address: _____ City: _____ State: _____ Zip: _____

MY AUTHORIZATION APPLIES TO ALL THE FOLLOWING HEALTH CARE INFORMATION *(Please check all that apply)*

☐All health care information in my medical record
☐Health care information in my medical record relating to the following treatment or condition:
_____

☐Health care information in my medical record for the date(s): _____

☐ Other (e.g., X-rays, bills)—specify date(s): _____

DISCLOSURES REQUIRING SPECIFIC AUTHORIZATION (Please check all that apply)

You may disclose health care information regarding testing, diagnosis, and treatment for:
☐ HIV/AIDS
☐ Mental Health or Illness
☐ Reproductive Care (minors only)
☐ Sexually Transmitted Diseases ☐ Drug and/or Alcohol Abuse
☐ Electronic Format
*PLEASE NOTE: A minor patient's signature is REQUIRED in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

REASON(S) FOR THIS AUTHORIZATION TO DISCLOSE MY HEALTH CARE INFORMATION: *(Please check all that apply)*

☐ At My Request ☐Other (Specify) _____ ☐For Marketing Purposes
TrueCare Medical does not participate in personal health information fund raising nor provide health care information for marketing purposes to third party products or services.

This authorization ends:
☐ On (date): _____ ☐When the following event occurs: _____
☐ In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form: To receive research-related treatment in connection with research studies **OR** to receive health care when the purpose is to create health care information for a third party.
I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by TrueCare Medical in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance.

TO REVOKE THIS AUTHORIZATION: Write a letter to **TrueCare Medical**.

PROTECTION AFTER DISCLOSURE:

I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____
Patient or Legally authorized individual signature **Date** **Time**

_____
Printed name (if signed on behalf of the patient) **Circle Relationship** (parent, legal guardian, personal representative)

_____
***Minor patient's signature, if applicable** **Date** **Time**

This form will be retained in your medical record *Last updated April 2026*

Annual Physical/Wellness Consent Form

Location 1: Beaver Ruin Rd. NW Ste E, Lilburn GA 30044
Location 2: Satellite Blvd. NE Ste 109/100, Suwanee GA 30044
Phone: (678) 369-9399 Fax: (833) 464-3867

This consent form is valid ONLY when you receive your annual physical/wellness examination at TrueCare Medical, LLC.

Patient Name: _____ **DOB:** _____

We are glad to have you as our patient and appreciate your selection of one of our provider as your own. All of our providers feel very strongly about communication with our patients.

Regarding your insurance, your visit today has been scheduled as an annual physical/wellness appointment. Today's charges will be submitted to your insurance company as a routine/wellness exam. If you are seeing the provider for anything in addition to an annual physical/wellness exam, you may incur additional office visit charges along with any testing and/or labs. YOUR INSURANCE COMPANY MAY NOT COVER THESE CHARGES.

Any questions about your benefits, you will need to contact your insurance company. You will be responsible for any unpaid /non-covered services.

The following are the test/labs that may be ordered as part of your annual physical:

General Health Panel (CMP, CBC, TSH)	CPT 80050
Cholesterol Panel	CPT 80061
Urinalysis	CPT 81002
PSA (Men)	CPT 84153
Pap Smear (Women)	CPT 88175
FOBT (Stool)	CPT 82270
HIV/STI Testing	CPT 86701
Vitamin D (May or May not be covered)	CPT 82306
EKG (May or may not be covered)	CPT 93000
Hemoglobin A1C	CPT 83036

***There may be additional labs that are ordered during your visit if you have a specific complaint and it is not part of your annual/physical wellness exam. These may incur additional charges.**

Patient Signature: _____ **Date**: _____

Informed Consent for Telemedicine Services

Location 1: Beaver Ruin Rd. NW Ste E, Lilburn GA 30044
Location 2: Satellite Blvd. NE Ste 109/100, Suwanee GA 30044
Phone: (678) 369-9399 Fax: (833) 464-3867

PATIENT NAME: _____ DATE OF BIRTH: _____

A **Telemedicine service** is a type of service that allows a patient to receive the proper diagnosis and treatment by a healthcare provider in an off-site location through available audio-visual equipment.

Possible Risks: There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment.
3. There may be limitations in using telemedicine because the healthcare provider and I will not be physically in contact with each other during the visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I understand that my telemedicine visit with my healthcare provider will be billed to my insurance, and I will be responsible for any charges or payments my insurance will not cover.

Patient Consent To The Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all my questions have been answered to my satisfaction. I hereby give my informed consent to: **TrueCare Medical LLC** for the use of telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):_____

If authorized signer, relationship to patient: _____

Today's Date: _____

TrueCare
MEDICAL
625 Beaver Ruin Rd., Suite E, Lilburn GA 30047 *Phone: (678) 369-9399 Fax: (833) 464-3867*
302 Satellite Blvd. NE, Ste. 109 & 110 Suwanee, GA 30024

Advance Directive Rights Notification (Age 18 and Older)

PLEASE REVIEW THIS NOTICE CAREFULLY

Patient Rights Statement

In accordance with the Patient Self-Determination Act, **TrueCare Medical LLC** is required to inform all patients age 18 and older of their rights regarding advance directives.

You have the legal right to:

- Make decisions about your medical care
- Accept or refuse treatment
- Create an advance directive
- Have your healthcare wishes followed if you become unable to communicate
- Receive information about advance directives under Georgia law
- Not be discriminated against based on whether or not you have an advance directive

What is an Advance Directive?

An advance directive is a legal document that allows you to communicate your healthcare wishes in advance.

Types include:

- **Living Will** – states your wishes for life-sustaining treatment
- **Healthcare Power of Attorney (POA)** – designates someone to make decisions for you
- **Do Not Resuscitate (DNR)** – indicates you do not want CPR if your heart stops

Patient Acknowledgment

Please complete the following:

Do you have an advance directive?
☐ Yes
☐ No

If YES:
☐ A copy has been provided to the clinic
☐ I will provide a copy at a later date

If NO:
☐ I would like more information

☐ I decline additional information at this time

Signatures

Patient Name:

_____

Patient Signature:

_____

Date: _____

This form will be retained in your medical record *Last updated April 2026*

Acknowledgement of Office Policies

Location 1: Beaver Ruin Rd. NW Ste E, Lilburn GA 30044
Location 2: Satellite Blvd. NE Ste 109/100, Suwanee GA 30044
Phone: (678) 369-9399 Fax: (833) 464-3867

I have read and understood the following forms:
(Please initial next to the title of forms.)

_____ Terminating the Physician-Patient Relationship Policy

_____ We reserve the right to charge $25 for any appointments that are missed. We ask that you provide us with 24 hours of notice of cancellation for any appointment. If not, it is considered a missed appointment.

_____ Advance Directive Rights Notification

_____ Authorization to Request/Disclose Protected Health Information

_____ Annual Physical/Wellness Consent Form

_____ Informed Consent Form for Telemedicine Services

_____ Mask is required at all times in the office regardless of your vaccination status for your protection and the protection of our patients and staffs. We reserve the right to decline service if this is not followed.

_____ _____

Print Your Name **Date**

_____

Signature: