PHOENIX MEDICAL OFFICE

COLLEGE PARK

PLEASE PRINT

PATIENT'S NAME: _____

STREET ADDRESS: _____

STATE: _____ ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____

CELL: _____ EMAIL: _____

D.O.B.: _____ MALE / FEMALE SOCIAL SECURITY #: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

SPOUSE'S NAME: _____ D.O.B.: _____ SOCIAL SECURITY #: _____

CELL: _____ EMAIL: _____

SPOUSE'S EMPLOYER: _____ WORK NUMBER: _____

EMPLOYER'S ADDRESS: _____

IN CASE OF AN EMERGENCY, (OTHER THAN SPOUSE), PLEASE CONTACT: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ ID #: _____ GROUP #: _____

POLICY HOLDER: _____ D.O.B.: _____ SOCIAL SECURITY #: _____

SUBSCRIBER NAME: _____

ADDRESS: _____

PHONE #: _____ D.O.B.: _____ SSN #: _____

RELATION TO PATIENT: _____ ID #: _____ GROUP #: _____

I authorize PHOENIX MEDICAL OFFICE to release, to my insurance company, any information required in the course of my examination or treatment. I also authorize any physician, hospital or clinic to provide details of my medical history to PHOENIX MEDICAL OFFICE.

_____

Patient's Signature **Date**

PHOENIX
MEDICAL
OFFICE

COLLEGE PARK

PHOENIX MEDICAL OFFICE is dedicated to ensuring your privacy.

Please review the following questions and inform the front desk staff of any changes that may apply to you:

1. Do we have permission to leave a message on the phone number(s) you have provided us?

   ☐ YES ☐ NO

2. May we discuss your medical information with family and friends?

   ☐ YES ☐ NO

3. If someone calls for you or comes and asks for you while you are here, do we have permission to tell them you are here?

   ☐ YES ☐ NO

Signature: _____ Date: _____

Phone :678-788-8950 1631 Phoenix Boulevard College Park, Georgia 30349 Fax: 678-788-8953

PHOENIX MEDICAL OFFICE

COLLEGE PARK

Patient Information

CONSENT TO ROUTINE PROCEDURES & TREATMENTS

Important: Do not sign this form without reading and understanding its contents.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

1) **Needle Sticks,** such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

3) **Administration of Medications** whether orally, rectally, topically or through my eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

5) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these type of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

6) **Other** _____

_____

_____

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Procedures;
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- **If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information.** I also understand that my physician may ask me to sign additional Informed Consent documents.

Signature of Patient (or Person giving consent)	Relationship	Date
Patient unable to sign because:	Witness	

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

☐ I hereby acknowledge that I have received a copy of the PHOENIX MEDICAL OFFICE "Notice of Privacy Practices."

Print Name of Patient

Signature of Patient or Patient's Authorized Representative — Date

As the Patient's Authorized Representative, my relationship with the patient is _____

The Patient is unable to sign because _____

------OR------

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

☐ I hereby certify that, as an employee or agent of the PHOENIX MEDICAL OFFICE I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the PHOENIX MEDICAL OFFICE "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

Print Name of Employee/Agent and Department

Signature of Employee/Agent — Date

Reason(s) For Not Obtaining Acknowledgment:

☐ Patient's medical status (critical, unconscious, etc.) ☐ Patient refuses to sign

☐ Other _____

April 17, 2006

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

Our practice is dedicated to maintaining the privacy of your health information. If you have any questions about this notice, please contact our compliance officer.

OUR OBLIGATIONS

We are required by law to: Maintain the privacy of protected health information
Give you this notice of our legal duties and privacy practices regarding health information about you
Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you (*Health Information*). Except for the following purposes we will use and disclose Health information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment We may use and disclose Health Information for your treatment and to provide you with the treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the surgical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services of interest to you.

Individuals Involved in Your Care or Payment for Your Care When appropriate, we share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to any entity assisting in a disaster relief effort.

Research Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As required by Law We will disclose Health Information when required to do so by intentional, federal, state or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other that as specified in our contract.

Organ and Tissue Donation If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement, other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls or products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose Health 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.

PHOENIX MEDICAL OFFICE

Phone :678-788-8950 | 1631 Phoenix Boulevard College Park, Georgia 30349 | Fax: 678-788-8953

This office has a policy to keep patient information confidential. You may Designate below if you want someone other than yourself to have access to Your private health information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PATIENT NAME:_____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices Of PHOENIX MEDICAL OFFICE

_____ _____

Signature of Patient Date

RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF

I allow the people listed below to receive medical information about my condition at any time:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

_____ _____

Signature of Patient Date

PHOENIX MEDICAL OFFICE

KELVIN M. HAMNER, M.D.

NAME _____

DATE OF BIRTH _____

TODAYS DATE _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

DATE OF LAST MAMMOGRAM: _____

- WHERE WAS IT PERFORMED/MD WHO ORDERED:

  _____

DATE OF LAST COLONOSCOPY: _____

- WHERE WAS IT PERFORMED/MD WHO ORDERED:

  _____

DATE OF LAST BONE DENSITY TEST (DEXA SCAN): _____

- WHERE WAS IT PERFORMED/MD WHO ORDERED:

  _____

DO YOU SMOKE? YES NO

HOW MANY CIGARETTES PER DAY? _____

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PATIENT POLICIES

WE WELCOME YOU TO OUR PRACTICE. TO BETTER SERVE YOU, WE ASK THAT YOU REVIEW THE FOLLOWING PRACTICE POLICIES AND PROCEDURES. PLEASE SIGN THIS FORM AND RETURN TO THE RECEPTIONIST FOR YOUR CHART. YOU MAY RECEIVE A COPY OF THIS AT YOUR REQUEST.

WE ASK THAT YOU...

1. PRESENT YOUR INSURANCE INFORMATION AND VALID PICTURE ID UPON YOUR FIRST VISIT. IT IS YOUR RESPONSIBILITY TO UPDATE THIS INFORMATION SHOULD CHANGES OCCUR.
2. PROVIDE US WITH INSURANCE REQUIREMENTS REGARDING PRE-CERTIFICATION AND REFERRAL FOR DIAGNOSTIC TESTS, HOSPITALIZATION AND VISITS TO SPECIALISTS.
3. NOTIFY US OF CANCELLATIONS OF SCHEDULED APPOINTMENTS WITH 24 HOUR NOTICE OR YOU WILL BE BILLED A $25 NO-SHOW FEE.
4. BRING A COMPLETE LIST OF ALL CURRENT MEDICATIONS WITH DOSAGES AND INSTRUCTIONS TO EACH OFFICE VISIT FOR YOUR DOCTOR TO REVIEW.
5. NOTIFY US OF RECENT VISITS TO OTHER DOCTORS/HOSPITALS AND ANY NEW ALLERGIES TO MEDICATIONS SINCE YOUR LAST VISIT.
6. CALL OUR OFFICE APPROXIMATELY ONE WEEK AFTER BLOOD OR OTHER LABORATORY WORK IS ORDERED, IF YOU WOULD LIKE TO KNOW THE RESULTS. WE WILL CALL YOU ONLY IF LAB/BLOOD WORK RESULTS RETURN WITH AN ABNORMAL RESULT AND/OR NECESSITATE TIMELY FOLLOW-UP.
7. UNDERSTAND THAT ALL CO-PAYS, DEDUCTIBLES AND PATIENT BALANCES ARE DUE AT THE TIME OF SERVICE. IF YOU ARE UNABLE TO PAY, YOU MUST MAKE ARRANGEMENTS WITH OUR OFFICE PRIOR TO YOUR OFFICE VISIT.

I HAVE READ THE PATIENT POLICIES:

_____ _____

SIGNATURE **DATE**

PHOENIX MEDICAL OFFICE

PATIENT HISTORY FORM

PATIENT LEGAL NAME	DATE OF BIRTH

FAMILY HISTORY: Has any blood relative had any of the following(please indicate which relative):

Allergies	Diabetes	High Blood Pressure	Stroke
Anemia	Drug/Alchoholism	High Cholesterol	Thyroid Disease
Arthritis	Epilepsy	Kidney Disease	Tuberculosis
Asthma	Glaucoma	Mental illness	Other
Bleeds easily	Gout	Migraine	Other
Cancer	HIV/AIDS	Obesity	Other
Depression	Heart Disease	Osteoporosis	Other

SIGNIFICANT HOSPITALIZATIONS/SURGERIES/INJURIES: (attach additional page if needed)	DATE

CURRENT MEDICATIONS: (attach page if needed)	DOSE	FREQUENCY

DRUG ALLERGIES	REACTION

PHOENIX MEDICAL OFFICE

PATIENT HISTORY FORM(cont'd)

TOBACCO USE:

_____Never smoked _____Less than ½ pack/day _____1/2 pack/ day

_____1 pack/day _____2 packs/day _____More than 2 packs/day

_____Chewing tobacco _____Dip Snuff _____Smokers in home?

Stopped Smoking _____/_____/_____

ALCOHOL USE:

_____Never drink _____Rarely drink _____Alcoholics in home?

Average: _____Beers(per day) _____Glasses of wine(per day) _____Mixed drinks(per day)

Stopped Drinking _____/_____/_____

REVIEW OF SYSTEM: Do you now or have you had any of the following symptoms/diseases?

_____High Blood Pressure _____Heart Attack/Failure _____Arthritis

_____Stomach Ulcer _____Asthma _____Chronic Lung Disease

_____Stroke _____Diabetes _____Cancer

_____Blood Disorder _____Glaucoma _____Internal Blood Clots

_____Thyroid Disease _____Mental Illness _____Depression

_____Kidney Stones _____Hepatitis _____Chest Pain

_____HIV/AIDS _____Veneral Disease _____Emphysema

Other significant medical history:_____

I affirm that the information I have given is correct and complete to the best of my knowledge.
I understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient /Legal Guardian	Date

PHOENIX MEDICAL OFFICE

KELVIN M. HAMNER, M.D.

RELEASE OF INFORMATION

I, _____ON THIS DATE, _____,

PERMIT THE OFFICE OF _____TO RELEASE

MY MEDICAL RECORDS, EITHER IN PART OR IN WHOLE, TO THE

OFFICE OF **PHOENIX MEDICAL OFFICE** AND RELEASE THE OFFICE

OF _____FROM ANY LIABILITY IN DOING SO.

PATIENT NAME/GUARDIAN_____
PRINT NAME

PATIENT NAME/GUARDIAN_____
SIGNATURE

DATE_____

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Patient Financial Responsibilities

Managed Care Patients

Patients with managed care health plans will be expected to follow the payment-at-time-of-service requirements of th particular plan under which they are covered. Managed care patients will not receive monthly statements except fc services that are not covered by the plan.

Your managed care plan may require a referral from your PCP in order to pay for your visit to a specialist. Please make sure yo have obtained any required referrals in advance of your visit. If your insurance plan requires a referral for your visit and we d not have one, we will notify you prior to the visit. If we are unable to obtain a referral while you wait, you will be given th option to pay for the visit out of pocket or reschedule the visit for a later date after the referral can be obtained.

Medicare Patients

Your physician accepts Medicare assignments on covered Medicare charges. Payment for the 20% Medicare coinsuranc amount is expected at the time of service, unless you have supplemental insurance. Insurance will be filed with you supplemental carrier; however, ***any unpaid balances are expected to be paid by you within 60 days of filing the claim if th supplemental policy does not pay the group.*** Medicare patients will not receive monthly statements except for services that ar either not covered or determined by Medicare to be not-medically-necessary.

The Medicare deductible or any non-covered charges is expected at the time of service unless you have secondar insurance accepted by the group (see "Secondary Insurance" policy below).

Medicare may not pay for certain services it determines to be medically unnecessary. If there is a possibility that a servic to be provided to you may fall into this category, you will be asked to sign a form indicating that you acknowledge thi possibility and that you agree to pay for all services Medicare determines to be medically unnecessary.

Medicaid Patients

Medicaid patients must show proof of current Georgia Medicaid eligibility (current Medicaid card or DMA 964 form) prior t seeing a physician. Co-payments are to be paid at the time of service. Medicaid patients will not receive monthl statements except for services that are not covered by Medicaid.

Secondary Insurance

We file secondary insurance only for plans accepted by the group. We also file Medigap insurance plans for our Medicar patients. We allow 60 days from the date of service for your secondary payer to pay. Beyond 60 days, unpaid secondar balances are patient responsibility.

Worker's Compensation Insurance

Validated worker's compensation services are billed either to the employer or the employer's carrier, depending o company policy. In the absence of validation by the employer of a work-related injury, the patient will be held responsible fo payment for services rendered. Should the employer or carrier subsequently deny a validated worker's compensation service such charges will be the financial responsibility of the patient.

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Patient Financial Responsibilities

Phoenix Medical Office welcome you to its family of physicians and healthcare providers. We are pleased you have chosen us to care for you and we commit to enhance the value and quality of your care. This policy statement is intended to answer questions you may have regarding payment for services rendered at our facilities or in the hospital setting by members of the group. Your questions and comments are welcomed.

While we hope to maintain a longstanding relationship with you, we must ensure all patients follow our policies. Failure to adhere to these financial policies can result in dismissal from the practice.

Payment For Services

For your convenience, we accept cash, VISA, MasterCard, American Express, traveler's checks and personal checks. Starter checks are not accepted. A valid picture ID is required on all checks. **If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered.**

Self Pay Patients

The group welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the office manager in advance of the visit to determine if reasonable payment arrangements can be established with the group.

INSURANCE COVERAGES

Your Physician's Participation With Your Insurance Plan

Our group accepts most major insurance plans. Prior to your initial visit with your physician, you should confirm that he or she participates with your personal insurance. If the physician does not participate with your insurance plan, you will be responsible for payment of all charges at the time of your visit. You will be provided a completed superbill listing all the pertinent information you will need to submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information

If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurances or services that are not covered by your plan. For the group to file your insurance, we must have the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. Please bring your insurance card to every visit so that we can confirm your coverage. A current copy of your card must be kept on the file in order for us to file insurance claims on your behalf.

Patient Payment Responsibility For Non-Covered Services

In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. For this reason, we will provide you a form letter to complete by contacting your insurance plan and verifying the specific coverage you have prior to your preventive health visit. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date.

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IMPORTANT INFORMATION ABOUT PRESCRIPTIONS:

Effective March 1, 2002, medications will only be prescribed or refilled during office visits. **No more prescription phone ins.** During your visit today and in the future, make sure you get enough refills for all your medicine to last until your scheduled return visit.

If you do run out of medicine it will mean one of three things. Either you are past due for your return appointment, you are taking your medication incorrectly, or your condition has changed. All of these would indicate a need for an office visit for re-evaluation. This is why we have made the policy to only refill or prescribe medication at the time of your visit.

We believe this new policy is more respectful of our joint venture together...keeping you well.

Thank you for you cooperation and understanding of this new policy, designed to help us take even better care of you.