Fayette CARE Clinic Patient Information Sheet **DOB:** _____

Name: _____ _____ _____
First Middle Last

Race: ☐American Indian or Alaska Native ☐Asian ☐Black ☐Pacific Islander ☐Patient Refused ☐White/Caucasian

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Patient Refused

Today's date: _____ Social Security #:_____ Sex: ☐ M ☐ F

Street address (no PO boxes): _____City: _____State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Employer? _____ If unemployed, please state date employment was terminated: _____

Employment status: □ Full time □ Part time □ contract □ Self-employed □Unemployed □ Other _____

Primary Language: _____Do you need a translator for medical visits or calls? ☐ No ☐ Yes

If yes, who translates for you? _____

Emergency Contact Information: Name_____

Number:_____ Relationship to patient:_____

How do you prefer to be contacted? (circle one.) Home phone Work Phone Cell Phone

May we contact you by Email? Yes_____ No_____ May we contact you by text? Yes_____ No_____

Family Size: Adults: _____ Under 18: _____ 18-21 Student: _____ Unborn: _____ Family Total: _____

☐ Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for _____ years

Spouse's Name_____ Spouse's DOB: _____

Spouse's Employer: _____ if unemployed, please state when employment was terminated: _____

Employment status: □ Full time □ Part time □ Contract □ Self-employed □Unemployed □ Other _____

Household members: (Do not list yourself)

First Name	Last Name	Date of Birth	Relationship to patient

Office Use Only

Patient: New ____ Recert ____ SCANNED FPL _____% PCP HIPPA MRN#_____

In order to provide health care, we must ask for certain financial information. All information will be held confidential according to our privacy policy. Please provide the following documents for each adult family member: gross earned monthly income from all current employers, a wage letter if unemployed, or unearned income, which ever applies to you and/or your spouse.

By my signature, I certify that I am a resident of Fayette County, Georgia, or approved surrounding county, with no insurance at all and this information is true and complete. I grant this clinic permission to verify the information. I understand that it is **my responsibility** to notify the clinic if this information changes and/or my contact information changes.

_____ _____

Signature of patient, parent, guardian, or personal representative — Date

_____ _____

Print name of the patient, parent, guardian, or personal representative — Relationship to patient

OFFICE USE ONLY

Please do not write below this line

OFFICE USE ONLY

Household Financial Information:

Monthly Income	
Employment	$
Unemployment/Severance	$
Self-employment	$
Interest/dividends	$
Pension/disability	$
Child support/alimony	$
Short-term disability	$
Long-term disability	$
Rental income	$
SSI benefits	$
Total average income:	$

OFFICE USE ONLY

Proof of Income ___gov't agency ___notarized letter ___paycheck stub ___tax return **FPL_____**

Approved by:_____ Date:_____

FAYETTE C.A.R.E. CLINIC
COMPASSION AND RESPECT FOR EVERYONE

The ongoing mission of Fayette CARE Clinic is to eliminate healthcare barriers with compassion and respect for everyone.

C. A. R. E. Compassion and Respect for Everyone

Patient name:_____ **DOB**:_____

Thank you for choosing the Fayette CARE Clinic (FCC) as your primary care provider and medical home. We are committed to working with you to manage chronic medical conditions and to help you set goals to manage your health and wellbeing. **Please read the following information and initial beside each policy. You will need to sign and date the bottom of the second page**. If you do not understand a statement, please ask and someone will be happy to explain.

Emergencies: We provide scheduled, non-emergency, medical care to our current, actively registered patients. We do not have walk-in appointments. However, if you are a current patient and you call the clinic at opening time, often same-day appointments are available. If you are sick, please call 770-719-4620 and every effort will be made to see you as soon as possible. _____ **(initials)**

Financial Information: Your financial information needs to be updated on an annual basis. If your financial information is not current, we **cannot** schedule an appointment, refill a prescription, order labs, or process referrals. We will attempt a courtesy call as the date approaches for you to complete the yearly registration process, but it is your responsibility to keep your registration current and complete. _____ **(initials)**

Demographics: It is your responsibility to inform our office of any changes in address, phone number, or financial information. If FCC does not have current contact information on file and you miss a scheduled appointment, it will be counted as a NO SHOW. _____ **(initials)**

Cancellation/No Show Policy: if you have an appointment at this clinic or one of our associates, you must call 24 hours in advance to cancel the scheduled appointment, if you do not call this is considered a No Show. Patients are allowed two No Show appointments each calendar year. The third No Show in a calendar year, will result in an automatic dismissal from the clinic**. Every attempt is made to remind you of your appointments; however, this is only a courtesy service. It is ultimately your responsibility to arrange transportation to remember the appointment and to be on time _____(initials)**

Medical Records: A written request with the signature is required before medical records will be released to you, another medical provider or to a third party. We will fax the records for you, but only after we have the signed release on file. Please allow four business days to complete. As your medical home, we expect you to provide to us reports on all medical care received by you from outside sources. If you do not bring these reports to us, you will need to sign a release so that we may request the reports to be faxed to us directly. **_____ (initials)**

Prescription Refill Policy: If you need a prescription refill between appointments every effort will be made to complete the request **WITHIN FOUR BUSINESS DAYS**. However, we do not have a provider in our facility on a daily basis and we must have ample time for your medical file to be reviewed. We ask that you call FCC for refills 3 to 4 weeks **before** you run out of medication. The provider will determine if an appointment is necessary before a prescription can be approved for refill**. _____ (initials)**

Prescription Assistance Policy: If you receive your medications as part of a prescription assistance program all orders will be shipped to FCC unless prohibited by the company's policy. We cannot prescribe or provide medications safely without regular office visits. If you miss or cancel a regularly scheduled appointment you will not be able to pick up any medication shipments until you see your medical provider. **_____ (initials)**

Test Results: We do not usually contact you regarding normal lab results, however, these are available for patient to review through the patient portal the same business day that they are received by the clinic. For abnormal lab results you will be contacted by telephone. While every effort will be made to contact you within four business days of the clinic receiving the report, please remember that non-emergency results can take **up to three weeks** for you to be contacted, as we do not have a provider in our facility on a daily basis. All critical lab results are reviewed by the Medical Director and handled on an emergency basis. **_____ (initials)**

Lab work: Piedmont Fayette Hospital provides FCC patients with basic lab work free of charge as long as you comply with their financial aid policy. You will need to turn in a Piedmont financial aid form to the clinic or the hospital business office **once a year** in order to avoid receiving a bill. Some specialized lab work may not be covered under the agreement and you will be responsible for arranging payment with the hospital's business office. Please get any requested lab work done one to two weeks prior to your scheduled appointment or as instructed by the provider. If labs have been requested and they are not completed before the time of your scheduled appointment, **we will cancel your appointment until the labs are complete**. Your medical provider cannot provide quality medical care without current labs. **_____ (initials)**

I have been given the opportunity to ask questions and by signing below I acknowledge that I have read and understand each of the FCC policies listed.

Patient signature: _____ Date: _____

Printed Name: _____

CONSENT FOR ROUTINE PROCEDURES AND TREATMENT

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, diagnostics, 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 dressings, range of motion checks, and other similar procedures.
   The material risks associated with these types of Procedures are rare. They can 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 the 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 methods 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.

Patient name:_____ **DOB:**_____

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 standards of care, 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 or tests including HIV testing; therefore, I agree to provide accurate and complete information about my medical history and conditions; and
- Volunteer physicians are protected by the Georgia Volunteer Healthcare Program Sovereign immunity protection.

By signing this form:

- I consent to Healthcare Professionals performing tests or Procedures as they 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 and will verbally explain and get my verbal consent at the time any invasive procedure is to be performed.

Signature of Patient (or Person giving consent)	Relationship	Date

Patient unable to sign because:	Witness

Fayette CARE Clinic
1260 Highway 54 West, #101
Fayetteville, GA 30214
770-719-4620

In order to comply with specific rules regarding HIPAA (Health Insurance Portability &Accountability ACT of 1996), we ask that our patients complete and sign this privacy and security of health information document. It is our policy **not** to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, or cell phone. Whenever returning telephones calls and the answering machine picks up **we cannot leave a message if your name is not on the recorded message to identify the residence.** Information will also **not** be left with an unauthorized person who may answer the phone.

I_____, authorize Fayette CARE Clinic to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Fayette CARE Clinic whenever this information changes.

This authorization will expire on_____(Date). If the date is left blank the authorization will automatically expire 1 year from the date of registration.

Home Number	_____	☐Yes	☐NO	☐Not Applicable
Answering Machine	_____	☐Yes	☐NO	☐Not Applicable
Work Number	_____	☐Yes	☐NO	☐Not Applicable
Cell Number	_____	☐Yes	☐NO	☐Not Applicable

If you would like to have information released to someone other than yourself, please complete the following. **Include the person who translates for you if you do not speak English.** Indicate in the space labeled "Relationship to patient" which people translate for you.

Please list names of people authorized to receive your health information.

Name_____

Relationship to patient _____

Name _____

Relationship to patient _____

☐**I do not wish any friends or family to receive my information. _____ (initial)**

By signing this authorization, I authorize Fayette CARE Clinic to use and/or disclose certain protected health information about me.

_____ _____

Date Signature

FAYETTE C.A.R.E.
CLINIC
COMPASSION AND RESPECT FOR EVERYONE

Acknowledgement of Understanding of "Notice of Privacy Practices"

I hereby acknowledge that I have received and have an understanding of the Fayette CARE Clinic's "Notice of Privacy Practices" and understand that a copy of such notice is available upon my request.

Print Name of Patient	Date of Birth
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 _____

Release of Medical Records

I acknowledge that referral providers may receive my medical records to be used in coordination of my care without a separate signed release of information form. All other requests for release of information will require a signed release.

I acknowledge receipt of this notice and signed it with full understanding prior to receiving any healthcare services. I was given an opportunity to ask any questions and receive responses. I give my informed consent to receive healthcare services from Fayette CARE Clinic.

Patient (Print) _____

Patient Signature _____ Date: _____

Patient's Authorized Representative: _____ Date: _____

Legal Relationship to patient: _____

Signature of Interpreter: _____ Date: _____

Fayette C.A.R.E. Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this Notice which describes the health information privacy practices of Fayette C.A.R.E. Clinic. A copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own copy by calling Fayette C.A.R.E. Clinic at (770) 719-4620 or asking for one at the time of your next visit.

If you have any questions about this Notice or would like further information, please contact the Executive Director at (770) 719-4620.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); or
- other types of information that may identify who you are.

REQUIREMENT FOR WRITTEN AUTHORIZATION

We will obtain your written authorization before using your health information or sharing it with others outside Fayette C.A.R.E. Clinic except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Executive Director at Fayette C.A.R.E. Clinic 1260 Hwy 54 W Suite 101 Fayetteville, GA 30214.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

1. Treatment, Payment, and Health Care Operations.

Fayette C.A.R.E. Clinic may use your health information or share it with others in order to provide health care services to you, obtain payment for those services, and run Fayette C.A.R.E. Clinic's normal business operations. Your health information may also be shared with your other health care providers so that they may jointly perform certain payment activities and business operations along with our medical practice. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these treatment, payment, and normal business operations without your written authorization.

Treatment. We may share your health information with health care providers in our clinic system who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor in our clinic may share your health information with another doctor inside our clinic system, or with someone at another hospital or medical practice, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Health Care Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

Appointment Reminders, Treatment Alternatives, Benefits and Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract with our business associate that ensures that our business associate also protects the privacy of your health information.

2. Friends and Family Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care.

3. Emergencies or Public Need.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if Notice is required by law.

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. We may also release your health information to government disease registries. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims of Abuse, Neglect, or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our clinic. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair and Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure and only with a written certification by the party issuing the subpoena in accordance with law.

Law Enforcement. We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, or if necessary to report a crime that occurred on our property.

To Avert a Serious and Imminent Threat To Health or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person, or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security and Intelligence Activities or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military and Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates and Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners and Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties consistent with applicable law.

Organ and Tissue Donation. In the unfortunate event of your death, if you are an organ donor we will disclose your health information to organizations involved in organ donation, organ and tissue procurement and transplantation, as necessary to facilitate organ, tissue or eye donation and transplantation.

Research. Under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

[Fundraising. We are permitted to use your demographic information and dates of your health care for purposes of fundraising. Fundraising is a communication from us or one of our business associates for the purpose of raising funds for our organization, including requests for donations or information about the sponsorship of events. You have the right to choose not to receive future fundraising requests from us. If you would prefer that we stop sending you fundraising materials, please follow the instructions included with each fundraising communication.

4. Completely De-identified or Partially De-identified Information. We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

5. Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information.

1. **Right To Inspect and Copy Records.** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Executive Director at 1260 Hwy 54 W Suite 101 Fayetteville, GA 30214. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

2. **Right To Amend Records.** If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records. To request an amendment, please write to the Executive Director at 1260 Hwy 54 W Suite 101 Fayetteville, GA 3021. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written Notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

3. **Right To an Accounting of Disclosures.** You have a right to request an "accounting of disclosures," which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice. Many routine disclosures we make will not be included in this accounting; however, the accounting will include many non-routine disclosures.

To request an accounting of disclosures, please write the Executive Director at 1260 Hwy 54 W Suite 101 Fayetteville, GA 3021 and indicate a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period.

4. **Right To Request Additional Privacy Protections.** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. To request restrictions please write to the Executive Director at 1260 Hwy 54 W Suite 101 Fayetteville, GA 30214. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction. You have the right to restrict certain disclosures of protected health information to a health plan where you pay, or someone on your behalf has paid for out of pocket and in full. You have the right to revoke the restriction at any time.

5. **Right To Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a way that is more confidential for you, such as calling you at home instead of at work. To request more confidential communications, please write to the Executive Director at 1260 Hwy 54 W Suite 101 Fayetteville, GA 30214. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.*

6. **Right To Have Someone Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

7. **Right To Obtain a Copy of Notices.** If this Notice is provided electronically, you have the right to a paper copy of this Notice, which you may request at any time. To do so, please call *the Executive Director at (770) 719-4620*. You may also obtain a copy of this Notice by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. We will post any revised Notice in our [waiting room/reception area]. You will also be able to obtain your own copy of the revised Notice. The effective date of the Notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the Notice that is currently in effect.

8. **Right To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact *the Executive Director at (770) 719-4620.*

No one will retaliate or take action against you for filing a complaint.

9. **Right To Be Notified Following a Breach of Unsecured PHI.** If you are affected by a breach of your unsecured protected health information, you have the right to, and will, receive notice of such breach.

10. **How To Learn About Special Protections For [HIV And Genetic Information].** Special privacy protections apply to [HIV test information, alcohol and substance abuse treatment information, mental health information, and genetic information]. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate Notices explaining how the information will be protected. To request copies of these other Notices, please contact *the Executive Director at (770) 719-4620.*

Patient name:_____ **DOB:**_____

Allergies: _____

_____

1. Please indicate which of the following **medical conditions** you have had in the past:
   □ None- I have no medical conditions

□ Allergies	□ Depression	□ Meningitis
□ Anemia	□ Diabetes	□ Heart Attack
□ Anxiety	□ Emphysema	□ Nerve/Muscle Disease
□ Arthritis	□ Reflux (GERD)	□ Osteoporosis
□ Asthma	□ GI ulcers	□ Seizures
□ Blood transfusion	□ Glaucoma	□ Sickle Cell Anemia
□ Cancer	□ Heart Murmur	□ Stroke
□ Cataracts	□ HIV/AIDS	□ Substance Abuse
□ Heart Failure (CHF)	□ High Blood Pressure	□ Thyroid Disease
□ Clotting Disorder	□ Kidney Disease	□ Tuberculosis
□ COPD		

2. **Other medical problems (not listed above):**_____

_____

3. Please indicate if you have had any of the following **surgeries** in the past along with **the year.**
   □ None- I have never had surgery

□ Appendectomy _____	□Cosmetic Surgery: _____	□ Prostate _____
□ Brain Surgery:_____	□ Eye Surgery _____	□ Small Intestine _____
□ Breast Surgery: _____	□ Fracture Surgery _____ Type:_____	□ Spine Surgery _____
□ C-Section _____	□ Hernia repair _____ Location: _____	□ Tubal Ligation _____
□CABG(heart surgery):_____	□ Hysterectomy_____	□ Valve Replacement _____
□ Gallbladder _____	□ Joint Replacement _____ Location: _____	□ Vasectomy _____
□ Colon Surgery _____		

4. **Other Surgical Procedures** (Please list year)_____

_____

5. **Please give the <u>date</u> you last had the following tests or procedures. Write "never" in the date column if you have never had it done (If you have been seen here at FCC before please list only what you have had done at other places, since you were last seen here)**

Test/procedure	Date?	Where?	Was the result normal?
Diabetic eye exam:			
Diabetic foot exam:			
Colonoscopy:			
Mammogram:			
Bone Density test:			
Chest X-Ray:			
EKG/ECG:			
HIV test			
Stool test for blood			
Pap smear			
PSA (prostate test)			
Physical exam			

Relative:	**Please circle the problem, if the relative listed to the left has had that problem:**
Mother	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Father	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Sister(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Brother(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Daughter(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Son(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Maternal Aunt(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Maternal Uncle(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Paternal Aunt(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Paternal Uncle(s)	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Maternal Grandmother	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Maternal Grandfather	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Paternal Grandmother	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke
Paternal Grandfather	Asthma, Cancer, Diabetes, Heart disease, High cholesterol, High blood pressure, Stroke

If you were adopted and do not know the medical history of your blood relatives check here ☐