Welcome to WellStar Internal Medicine Associates of Marietta!

We truly appreciate you as a patient and we're grateful for the trust you've placed in our practice to provide your health care. Enclosed you will find your new patient paperwork to be filled out and brought with you to your future appointment. Please arrive twenty minutes prior to your appointment time and be sure to bring your insurance card(s), a valid driver's license, and the medications you are currently taking.

If you were informed that you needed to come fasting to your upcoming appointment please have nothing to eat or drink after midnight. However, our office does recommend that you drink plenty of water and you may have one cup of black coffee or unsweet tea (no sugar, creamers, or artificial sweeteners). You may take all of your daily medications except for diabetic medication and vitamins.

If you need to cancel or reschedule your appointment, please inform our office of this change twenty-four hours prior to your appointment time. If you have any questions or concerns please feel free to contact our office we will be happy to assist you.

WellStar Internal Medicine Associates of Marietta
355 Tower Road, Suite 300
Marietta, Georgia 30060
Phone: (770) 427-2457
Fax: (770) 427-2706
www.internalmedicineassociatesofmarietta.org

Patient Registration Form

1. Patient Information (Please complete all spaces)

Patient Last Name	First Name	Date of Birth	Age	Patient Gender ☐ M ☐ F
Street Address	City	State	Zip Code	Social Security Number
Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary	Email Address	
Need Interpreter? ☐ Yes ☐ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ☐ Yes ☐ No	Race	Religion
Activate MyChart ☐ Yes ☐ No	Employer Name	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student
Employer Address	City	State	Zip Code	Employer Telephone
Emergency Contact Last Name	First Name	Pharmacy Telephone Number
Emergency Contact Relation to Patient	Legal guardian? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Visually Impaired? ☐ Yes ☐ No	Home Telephone ☐ check if primary	Work Telephone ☐ check if primary	Cell Telephone ☐ check if primary
Primary Care Physician						

2. Responsible Party / Guarantor ☐ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code
Guarantor Relation to Patient	Guarantor Gender ☐ M ☐ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone	
Guarantor Employer	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student	Employer Telephone			

3. Medical Insurance Policy Holder ☐ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth
Secondary Insurance Company	Policy Holder Last Name	Policy Holder First Name		
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

WMG Patient Registration Form - page 2

Assignment of Benefits / Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize WellStar Medical Group to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Consent to Contact

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Signature of Patient / Legal Guardian:	Date:

PATIENT HISTORY FORM

PERSONAL INFORMATION:

Name:____ Date:______________

Date of Birth: ______________ Age:__________ Sex: ____M ____F

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Remarried

Occupation: ______________________________

Spouse Name: ______________________________ Spouse's Occupation: ______________________

List people in your household, relationship and year of birth:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

DRUG ALLERGIES/ADVERSE DRUG REACTIONS/OTHER ALLERGIES:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

CURRENT MEDICAL HISTORY:

How do you rate your present health status? ____Excellent ____ Good ____ Fair ____Poor

What do you regard as your **main** medical problem(s)? ____

____

Please list all prescriptions or over-the-counter medications with dose and frequency taken including vitamins and herbs:
Example: Motrin 400mg 3times a day:

________________________ ________________________ ________________________

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Please list any other source of health care (physician clinic, urgent care, laboratory, radiology, therapist, chiropractor, etc…)

Date	Provider or Site	Reason

Patients Initials: __________ Provider Initials:__________

WELLSTAR®
Medical Group

Patient Name:____________________
Birth Date:____________________

PERSONAL HABITS	YES	NO	PREVIOUS		
Do you wear seatbelts?	☐	☐	☐		
Do you exercise regularly?	☐	☐	☐	_______ times/wk	Type:__________
Do you smoke?	☐	☐	☐	_______ packs/day	Number of years:__________
Do you chew tobacco?	☐	☐	☐	_______ packs/day	Number of years:__________
Do you drink alcohol?	☐	☐	☐	_______ drinks/day	Number of years:__________
Do you drink caffeine?	☐	☐	☐	_______ drinks/day	Number of years:__________
Do you experience difficulty with drugs, alcohol or other substances?	☐	☐	☐	If *Yes, specify*:__________	

Have you ever had:	YES	NO	Any additional information:
Blood Transfusion	☐	☐	__________
I.V. Drug Use	☐	☐	__________
Unsafe Sex	☐	☐	__________
Sexually Transmitted Disease	☐	☐	__________

PAST MEDICAL HISTORY:

1. Indicate any operations you have had and the year performed:
____
____

2. Indicate all hospitalizations you have had for non-surgical illnesses and give the year hospitalized if possible:
____
____

3. Indicate any major adult or childhood illnesses with the year of the illness:
____
____

4. If you have had any of the following, please check and indicate date if possible:

	Date		Date		Date / Results
Physical Exams	______	Dental Exam	______	EKG	______ / ______
Tetanus shot	______	Eye Exam	______	Stress Test	______ / ______
Flu shot	______	Rectal Exam	______	Blood Pressure	______ / ______
PSA	______	Pneumonia shot	______	Cholesterol	______ / ______
Rubella Shot	______	Hepatitis Shot	______	Sigmoidoscopy	______ / ______

WELLSTAR
Medical Group

Patients Initials: __________ Provider Initials:__________

Patient Name:________________
Birth Date:________________

FAMILY HISTORY: Please give approximate date of onset of each disease, if known:

	Father	Mother	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐	Bro ☐ Sis ☐
Year of Birth						
Year of Death						
Cause of Death						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Anemia						
Stroke						
Diabetes						
Cancer (type)						
Kidney Disease						
Asthma						
Tuberculosis						
Migraines						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Other:						
Other:						

FOR WOMEN ONLY:

Date of last menstrual period: ____________________

Difficulty with periods? ____Y ____N

Describe:________________________________

Changes in menstrual pattern? ____Y ____N

Describe: ________________________________

When was your last Pap Smear? ________________

Number of pregnancies:____________________

Number of live births: ____________________

If menopausal, date of onset:________________

Date of last mammogram:________________

Do you practice breast self exam? ______Y _____N

What is your method of birth control? ____________

FOR MEN ONLY:

Do you practice testicular self-exams? _____Y _____N Need Instruction: ____________

Have you ever had a Prostate Screening Test? _____Y ____N Date: ____________

What method of birth control do you use?________________________________

Patients Initials: __________ Provider Initials:__________

WELLSTAR Medical Group

PLEASE CHECK ANY RECENT OR RECURRING PROBLEMS YOU HAVE EXPERIENCED:

____Abdominal Pain
____Back Pain
____Rapid Heart Rate
____Fever
____Skin Rash
____Depression
____Lack of Energy
____Hay Fever
____Problem Hearing
____Fainting
____Bleeding
____Vaginal Discharge
____Weight Gain
____Chills
____Violence at home

____Difficulty Swallowing
____Joint Pain
____Wheezing
____Swollen Glands
____Swelling of Extremities
____Anxiety
____Constipation
____Nasal Congestion
____Vision Problems
____Abnormal Vaginal Bleeding
____Pelvic Pain
____Poor Appetite
____Weight Loss
____Unsafe work conditions
____Hazardous work or hobbies

____Heartburn
____Chest Pain
____Cough
____Shortness of Breath
____Difficulty Sleeping
____Reaction to Anesthesia
____Nausea
____Headaches
____Dizziness
____Rectal Bleeding
____Hot Flashes
____Burning w/Urination
____Diarrhea
____Sexual Difficulties

COMMUNICATION NEEDS:

Language if other than English: ________________________________

Vision: _____Normal _____Glasses _____Contacts _____Blind

Hearing: _____Normal _____Hard of Hearing _____Hearing Aid _____Deaf

Interpreter Needed: _____Y _____N

Did someone else fill out this form? _____Y _____N Who?________________________

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for you? ____Y ____N
If YES, explain:________________________________

ADVANCE DIRECTIVES:

Do you have an Advance Directive: ____Y ____N

If YES, do you have:
- Living Will ____Y ____N
- Durable Power of Attorney for Healthcare ____Y ____N
- Directive for Final Healthcare ____Y ____N

Who would you want to make decisions for you in the event you are unable to make them for yourself?____________________

____

If you have an Advance Directive, please bring us a copy for your chart.

Patient Signature________________________ Date______________

Provider Signature:________________________ Date:______________

WELLSTAR
Health System

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name *First Name* *Middle Initial* ______________________

Date of Birth (Month / Day / Year) ______________________

Street Address Apt. # / P.O. Box # (Please include complete mailing address) ______________________

Medical Record # / Social Security # (optional) ______________________

City *State* *Zip Code* ______________________

Primary Contact Number ______________________

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number ____________ *Cell Phone Number* ____________ *Other Phone Number* ____________

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ Spouse: ______________________ *Name* *Phone Number*

☐ Child(ren): ______________________ *Name* *Phone Number*

______________________ *Name* *Phone Number*

☐ Other: ______________________ *Name* *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) ______________________ *Month / Day / Year*

Print Patient Name or Name of Legal Guardian / Personal Representative ______________________

Signature of Patient or Legal Guardian / Personal Representative ______________________

Indicate relationship to patient (required) ______________________

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

1-WMG055 **HIPAA Consent**

WellStar

Acknowledgment of Receipt
of
<u>"NOTICE OF PRIVACY PRACTICES"</u>
for
Protected Health Information

I, acknowledge that I have received a copy of WellStar Health System's ***"Notice of Privacy Practices"*** for Protected Health Information on the date set forth below.

Date of Receipt ____________________

Date of Birth ____________________

Patient Name ____________________

Print Name of Authorized Personal Representative ____________________

Signature of Patient ____________________

Signature of Authorized Personal Representative ____________________

Please Indicate Relationship to Patient ____________________

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY: ***[Complete if patient Acknowledgment is not obtained]***

An Acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:

- ☐ Patient refused to sign Acknowledgment.
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier.
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation.
- ☐ Other: *Please indicate reason* ____________________

Signature of WellStar Representative: ____________________ Date: ____________ ____________ AM / PM
Time

Please ☑ the appropriate facility:

☐ Kennestone Hospital ☐ Cobb Hospital ☐ Douglas Hospital ☐ Windy Hill Hospital ☐ Paulding Hospital
☐ Homecare ☐ Hospice
☐ Other: ____________________

WELLSTAR Health System

"Summary" Notice of Privacy Practices

Effective 04/14/2003

THIS 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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS VERY IMPORTANT TO US.

OUR LEGAL DUTY

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to maintain the privacy of your protected health information (PHI). In accordance with state and federal law, we are required to give you notice about our privacy practices, our legal duties and your rights concerning your medical information.

HOW WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. We may use and share your information for:

- **Treatment**
- **Payment**
- **Health Care Operations**

These uses are covered under state and federal laws.

Here are some other ways that we may use and share your personal information:

- To give out information if required by state and federal law.
- To other business who work for us.
- To help the sponsor of your health plan serve you.
- To people you have said may receive your information.
- To those having a relationship that gives them the right to act on your behalf.
- To researchers.
- Marketing and Fundraising.

Other times, we may need to get your permission to use or share your protected health information. For example, we may include your name in our patient directory unless you have objected to this use or disclosure of your health information.

YOUR PRIVACY RIGHTS

You have certain rights regarding your medical information. Please refer to WellStar's "Notice of Privacy Practices" for Protected Health Information (PHI) for additional details. These rights, with some limitations, include:

- Asking to review and get copies of your health information.
- Asking for corrections or amendments to your health information.
- Asking for restrictions on how we may use your health information.
- Asking for confidential communications.
- Asking for a report of how we may have shared your health information.
- You have the right to request a paper copy of WellStar's Notice of Privacy Practices.

COMPLAINTS

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made regarding your protected health information, you may contact our Chief Privacy Officer (listed below) or designated representative through our Compliance Hotline, at 770-792-1555.

Also, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Chief Privacy Officer can provide you with the address.

Under no circumstance will you be penalized or retaliated against for filing a complaint.

WellStar Administrative Offices
Attn: Chief Privacy Officer
805 Sandy Plains Rd.
Marietta, Georgia 30066
(O) 770-792-1456 / (F) 770-792-1457
privacyofficer@wellstar.org.

Para obtener esta información en español, por favor comuníquese con su proveedor de cuidado.

For Internal Purposes
Account Number: ____________
Medical Record Number: ____________

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____________ Social Security Number (last 4 digits only): ____________

Previous Name, if applicable: ____________

Address: ____________ City: ____________ State: ________ ZIP: ________

Date of Birth: ____________ Home Phone: ____________ Work Phone: ____________

1. WELLSTAR HEALTH SYSTEM FACILITY / FACILITIES

I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below: ***(Check one or more)***

- ❒ WellStar Cobb Hospital
- ❒ WellStar Douglas Hospital
- ❒ WellStar Kennestone Hospital
- ❒ WellStar Paulding Hospital
- ❒ WellStar Windy Hill Hospital
- ❒ WellStar Medical Group
  Name(s) of Provider(s): ____________
- ❒ Other: ____________

2. RECEIVING PARTY

❒ Please send my health information to:

Name: ____________

Address: ____________

City: ____________ State: ________ ZIP Code: ________

Phone Number: ____________ Fax Number (healthcare provider only): ____________

❒ I would like to pick up my medical records in person

❒ I authorize ____________ to pick up my medical records in person.
(Name of person authorized to receive the record)

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED

❒ Complete medical record *(please specify dates of service)* ____________

OR

❒ Partial medical record *(please specify records below)*

Information	Dates	Information	Dates
❒ History and Physical	________	❒ Office Notes	________
❒ Consultations	________	❒ Operative Reports	________
❒ Discharge Summary	________	❒ Pathology Reports	________
❒ Lab Results	________	❒ EKG Reports	________
❒ X-rays	________	❒ HIV / AIDS Information	________
❒ Drug / Alcohol Abuse treatment	________	❒ Mental Health Treatment	________

❒ Other: ____________ - *please specify dates of service:* ____________

❒ ***You must check this box if you are also requesting Billing Records***

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION - page 2

4. PURPOSE OF DISCLOSURE

☐ My personal records ☐ Attorney ☐ Disability
☐ Other: ______________________________

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, this authorization will expire on ______________________ *(insert date or event)*. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Health Information Management Department(s) of the WellStar Health System facility or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees as follows:

$0.97 per page from 1-20
$0.83 per page from 21-100
$0.66 for pages 101+
Plus taxes

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that WellStar Health System may decline to treat me if I refuse to sign this information only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

9. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

10. RELEASE AND WAIVER

If the health information that I have requested WellStar Health System to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.

I also release WellStar Health System, each of the WellStar Health System facilities checked above and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

______________________________________ ________________
Signature of Patient (or Patient's Legal Representative) Date

____
Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.