East Georgia Internal Medicine & Pediatrics

Delene P. Musielak, M.D., F.A.C.P., F.A.A.P.

PLEASE FILL OUT COMPLETELY AND PLEASE PRINT NEATLY. THANK YOU!

Patient Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip

Primary Phone This phone will receive appointment reminder calls.	Cell Phone Appointment reminders via text? Yes ❍ No ❍	Work Phone Permission to contact you at work? Yes ❍ No ❍

Date of Birth	Age	SSN	Race

Sex ❍ Male ❍ Female	Marital Status ❍ Married ❍ Single ❍ Divorced ❍Widowed

Emergency Contact	Phone Number	Relationship to Patient

PROVIDE THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18
OR IF SOMEONE OTHER THAN YOURSELF IS THE INSURANCE POLICY HOLDER.

Parent/Guardian Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip

Phone Number	SSN	DOB	Employer

Primary Insurance	Secondary Insurance
Insurance Company	Insurance Company
Policy & Group Numbers	Policy & Group Numbers
Name & DOB of Insured	Name & DOB of Insured
Relationship to Patient	Relationship to Patient

Patient Preferences	
Preferred LOCAL Pharmacy & Location	
Insurance Preferred Mail Order Pharmacy & Phone #	
Preferred Imaging Center?	❍ EGRMC ❍ Statesboro Imaging Center ❍ Other, _____
Preferred Appointment Times	❍ AM Only ❍ PM Only ❍ Any
Preferred Appointment Days	❍ Monday ❍ Tuesday ❍ Wednesday ❍ Thursday ❍ Friday

Consent for Treatment

The signature below serves as consent for services/treatment/referrals to be rendered by East Georgia Internal Medicine & Pediatrics for the above named patient. This also authorizes the practice to release or receive protected health information for the purposes of treatment, payment, or health care operations necessary for such services.

_____ _____

Patient (or legal guardian) signature Date

_____

If legal guardian, print name and relationship to patient

How did you hear about East Georgia Internal Medicine & Pediatrics?
❍ Word of Mouth ❍ Newspaper ❍ Physician Referral ❍ Internet ❍ Other

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East Georgia Internal Medicine & Pediatrics
Delene P. Musielak, M.D., F.A.C.P., F.A.A.P.

1449 Brampton Ave.
Statesboro, GA 30458
Phone 912.871.2900

Release of Information

In order to allow East Georgia Internal Medicine & Pediatrics and its employees to discuss patient information with others involved in your treatment or the payment of services rendered, such as spouse, child, relative, friend, neighbor, caretaker, etc., please provide the following information.

Patient Information:

Name: _____ DOB: _____

Phone Number: _____

I hereby allow East Georgia Internal Medicine & Pediatrics physician and employees to discuss/release my medical information, such as appointment reminders, prescription pick up, lab results, care or treatment needs, etc., with the following individuals. (***If you do not wish to list anyone, please write NONE on the first row***)

1. Name _____ Phone Number _____

Relationship to Patient _____

2. Name _____ Phone Number _____

Relationship to Patient _____

3. Name _____ Phone Number _____

Relationship to Patient _____

My signature below indicates I understand the following: I may change the names of the individuals listed above at any time. Changes must be made in writing.

Patient Signature: _____ Date _____

Print Name: _____

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No Show Policy and Refill Request Policy Acknowledgement

East Georgia Internal Medicine & Pediatrics imposes the following policies with regard to patients who fail to keep their scheduled office visit and/or procedure appointments.

- Patients who fail to show for their "New Patient" appointments will only be rescheduled once thereafter.
- Three (3) no-showed appointments will result in dismissal from the practice.
- We require 24-hour's notice if you are unable to keep an appointment. If we are not informed in a timely manner, your missed appointment will be counted as a no-show.

By signing below, I certify that I have read this agreement, that I fully understand the policies as listed above.

_____ _____
Print Patient Name DOB

_____
Signature of Patient or Guardian

East Georgia Internal Medicine & Pediatrics imposes the following policies with regard to Medication Refills.

- Medications for chronic diseases (i.e., high blood pressure or diabetes) will be written with ample refills for 30 or 90 days at time of service. When patients are down to a 30 day supply, we ask that you call and schedule a follow up appointment for a medication review.
- For the safety and well-being of our patients,
  a) Requests for new medications (including antibiotics) will not be taken over the phone or over the internet during office hours without an appointment and evaluation by the physician.
  b) No new medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.
  c) We understand that unexpected situations arise, thus a small refill of chronic medications will be granted for one or two days on an as-needed basis. This allows patients to be seen and evaluated by the physician during office hours for all their medications refills.

By signing below, I certify that I have read this agreement, that I fully understand the policies as listed above.

_____ _____
Print Patient Name DOB

_____
Signature of Patient or Guardian

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e-Prescribing/Medication History Download Consent Form

E-Prescribing is defined as a physician ability to electronically send an accurate, error free understandable prescription directly to a pharmacy from the point of patient care. Congress has determined the ability to electronically send a prescription is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have been included in an e-prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by drug benefit plans.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling if the patient's prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Health Management Physician Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Health Management Physician Associates to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all questions have been answered to my satisfaction.

_____ _____
Print Patient Name DOB

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

Laboratory Testing Policy

It is your responsibility to notify us if your insurance requires you to use a preferred lab for diagnostic tests. We will be happy to send your specimen to your preferred lab. If you fail to notify us prior to specimen collection for In House testing and insurance denies, you will be responsible for the billed amount.

Please send my lab work to: ◯ EGRMC OP Lab ◯ LabCorp ◯ Quest Diagnostics

I acknowledge the diagnostic test policy.

_____ _____
Print Patient Name DOB

_____ _____
Signature of Patient or Guardian Date

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PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (A) an individual's acknowledgement of receipt of our Privacy Practices Notice or (B) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): 09/13/2013

Acknowledgement of Receipt of Privacy Practice Notice

I, _____, acknowledge that I have received a Privacy Practice Notice from East Georgia Internal Medicine & Pediatrics.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OCHA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain this acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: _____Date: _____

Print Name: _____

Title: _____

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Include this acknowledgment form in the individual's records.

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Statesboro, GA 30458
Phone (912) 871-2900
Fax (912) 871-3901

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ **Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

   _____
   Name of Facility

   _____
   Address

2. The types of information to be used or disclosed is as follows (please include dates of service).
   Date(s) of Service: _____

☐ Complete Medical Record

☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports

☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and Imaging Reports)
☐ X-ray and Imaging Reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other – list specific items: _____

Behavioral Health Reports

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission
☐ Other – list specific
☐ items:_____

☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ I understand that the Information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

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4. I understand that your facility may receive compensation for medical record copying in accordance with State Law.
5. This information may be disclosed to and used by the following individual/organization:

Name: East Georgia Internal Medicine & Pediatrics .

Address: 1449 Brampton Ave, Statesboro, GA 30458

For the purpose of:

- ☐ Further Medical Care
- ☐ Inspection/Copying of my records
- ☐ Personal
- ☐ Other (please specify): _____
- ☐ Insurance Eligibility/Benefits
- ☐ Legal Investigation or Action
- ☐ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendment of 1988, (42 U.S.C. section 263 (a), and certain other records.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.
8. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected under the terms of this authorization.
9. I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____

Signature of Patient Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____

Name of Patient (Please Print)

Patient is:

- ☐ Minor
- ☐ Disabled
- ☐ Incompetent
- ☐ Deceased

Legal Authority:

- ☐ Custodial Parent
- ☐ Executor of Estate of Deceased
- ☐ Authorized Legal Person Representative
- ☐ Legal Guardian
- ☐ Power of Attorney for Health Care

_____ _____

Signature of Witness Date

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Patient Portal Information

What is a Patient Portal?

East Georgia Internal Medicine & Pediatrics offers a Patient Portal via AthenaHealth, exclusively for established patients. The portal is designed to enhance patient-provider communications. The information is encrypted and available to you via a personal password protected website. It is imperative that our practice has your correct email address and that you inform us of any changes to your email address to ensure the privacy and protection of your health information. Your email address is confidential and protected information. Some of the features available with this service include:

- Request or review appointments
- Request medication refills for existing prescriptions
- View a Health Summary from office visits
- View available lab and imaging results
- View and update your demographics
- Pay balances
- Send messages and communicate directly with the physician and/or clinical staff

Who can use the Patient Portal?

Any active patient may be eligible to register for and use the Patient Portal. If you are authorized, a family access account can be created that will allow you to access selected family members' health information.

How secure is the Patient Portal?

All communications between you and your provider's office are carried over a secure, encrypted connection. This secure connection utilizes industry standard Secure Socket Layer (SSL) encryption to ensure secure data transmission as well as server-side digital certificate authentication. To prohibit unauthorized access, all medical information is stored behind our firewall in our electronic medical record system.

You should always make sure that the email address on file for your account is accurate, as notifications from the portal are sent to the email address on file. Make sure to sign out of your account each time you are finished using the portal.

Patient Enrollment

Patient Name _____ DOB _____

Patient Email Address _____
(Email Address will be your Patient Portal User Name)

Authorized User Representative

An authorized user is someone other than the patient who requires Representative access to the Portal Account of a patient to act on behalf of the patient (example: Minor patients) or to assist patients who are unable to access or use the Portal (example: Senior patients).

Representative Name _____ Relationship to Patient _____

Representative Email Address _____

☐ Full Access (Same rights as patient) ☐ View Only ☐ Billing Only

***Do not use portal communication if there is an emergency.
Please dial 911 or go to the nearest emergency room****