Georgia Family Care, LLC

REGISTRATION FORM

(Please Print)

Today' s Date:

PATIENT

Patient's last Name:	First:	Middle:	❑Mr. ❑Mrs.	❑Miss ❑Ms.	Marital status (circle one) Single/ Mar/ Div/Sep /Widow

Is this your legal name? ❑Yes ❑No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑M ❑F

Street address/P.O. Box:	Social Security no.:	Cell phone#

City:	State:	Zip:	Home phone#
Occupation:	Employer:		Employer phone no.: ( )

Referred by (please check one box):			**Insurance Y N**	❑Insurance Plan ❑Hospital
❑ Family/Friend	❑Local Newspaper	❑Close to home/work	❑ YP	**E-MAIL**_____

*** Emergency Contact**

Name: _____ **Phone#:** _____ **Relationship :**_____

Name and location of your Pharmacy

Name:_____ **City:**_____

Co-Pay Policy

I understand and agree that upon any office visit, I am responsible for my co-pay at all times, **NO EXCEPTIONS.** If I am called to return to the office to discuss my labs, I also understand that at the time of service I am responsible for my Co-pay;

I certify that Georgia Family Care LLC does not bill out or provide any credits for my Co-pay.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Prescription Refills Policy

I understand that all prescription refills will be transferred to their voicemail and checked during the operation of office hours, I certify that any prescription called in. I must allow 24 hours prior to the message for someone to contact me, or for my prescription to be called into the pharmacy. I also understand that your office discourages prescribing new medications over the telephone, as an accurate diagnosis is usually possible only with an office visit.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Lab Policy

I understand and agree that if my labs are abnormal I must report to the office to receive information pertaining to my abnormal labs, Per HIPPA Regulations. I cannot receive or discuss lab results over the phone.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

GEORGIA FAMILY CARE,LLC

Dharmeshkumar Patel, M.D.

Patient Name: _____ DOB: _____

Name of Insurance: _____ Policy#: _____

Name of Policy Holder/Guarantor: _____

Relationship: _____ DOB: _____ Social Security#: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to Dharmeshkumar Patel, M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may release my healthcare information to the Insurance Company (ies) or their agents named above for the purpose of obtaining payment for services, and for determining insurance benefits or the benefits payable for related services.

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Missed Appointment Policy

I understand and agree that if I do not show or do not call to cancel to cancel 24 hours before my appointment time, **a fee of $25.00** will be charged to my account. I also understand that insurance companies do not pay for such fees.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

GEORGIAFAMILY CARE, LLC

Dharmeshkumar Patel, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE-JUNE1, 2005

PATIENT'S NAME_____

1. I understand that as part of my healthcare, Georgia Family Care, LLC originates, records, and maintains health information about me, describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, as well as claims and payment status. I understand that this health information may be used or disclosed by Georgia Family Care, LLC for treatment, payment, and health care operations.

2. For Example, my health information serves as:
   - A basis for planning for my care and treatment;
   - A means of communication among the many health professionals who contribute to my care;
   - A source of information for applying my diagnoses and surgical information to my bill
   - A means by which a third party payer can verify that services billed were actually provided.
   - A tool used for routine healthcare operations, assessing quality and reviewing the competence of healthcare professionals.

3. I acknowledge that I have been provided with Georgia Family Care, LLC Notice of Privacy Practices that provides a more complete description of information uses and disclosures and my rights regarding my medical information. I understand that Georgia Family Care, LLC reserves the right to change its Notice of Privacy Practices and at my request, will make available to me, a copy of any revised notice.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations, and that Georgia Family Care, LLC is not required to agree to the restrictions requested. If it does, it is bound by such restrictions.

FOR CONFIDENTIAL COMMUNICATION:

CONTACT ME □by phone/Text or □ by mail, □at home or □at work

_____ _____

Print Name of Patient or Legal Representative Date

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient (i.e. legal guardian, Power of Attorney)

_____ _____

Witness Date

Georgia Family Care, LLC

Disclosures of Protected Health Information to Personal Representatives

The Providers/Staff may use or disclose the following Health and Financial information only to the following list of people:

Spouse: Name: _____ Phone#: _____

Parents: Name: _____ Phone#: _____

Children: Name: _____ Phone#: _____

Other: Name: _____ Phone#: _____

SIGN HERE ONLY IF YOU DO NOT want your Medical or Financial information discussed with anyone other than yourself.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Standards for Transmitting Electronic Data:

As your provider, we are committed to maintaining the privacy of your healthcare information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize Georgia Family Care Medical Group to contact me regarding my medical information by means of the listed methods. I will also be responsible for contacting the office should my information change.

Home Telephone #:_____

May we leave messages on your home answering machine? **YES** **NO**

Cell Phone #: _____

May we leave a Voice/Text messages on your cell phone? **YES** **NO**

Work Telephone #: _____

May we leave messages on your work voice mail? **YES** **NO**

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

GEORGIA FAMILY CARE, LLC

Consent for Routine Procedures & Treatments: We are required by law to obtain consent to treat and disclose "all material risks and alternative treatments." I understand that it is not possible to list every material risk for every Procedure or Treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the Procedures and Treatments.

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

1) **Needle Sticks**, such as injections (shots), intravenous injections. 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 of limb 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 or 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 alternative 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 method of administration and/or refusal of treatment, no practical alternatives exist
4) **Drawing Blood, Bodily Fluids or Tissue Samples,** such as 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.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary 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.**
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risk of the Procedures; and practical alternatives to the Procedures.
- If I have any questions or concerns regarding these Treatments or Procedures, I will ask my physician to provide me with additional information.
- In order to insure medication safety and lack of drug interactions. I grant Georgia Family Care, LLC and its staff the right to access my electronic pharmacy and prescription information.

Signature of Patient (authorized person to sign): _____ Date: _____

Printed Name of Patient: _____ Date: _____

Reason Patient is unable to sign (if applicable): _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy (HIPPA): I acknowledge that I have received the Notice of Privacy Practices.

Signature: _____ Date: _____

Patient Approval Form for Physician Assistant: If this practice has a certified Mid-Level Provider available to treat patients for the level of care, which have been approved by the Georgia State Board of Medical Examiners, your signature on this form conveys that you are in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

Signature: _____ Date: _____

Dharmeshkumar Patel, M.D
Sheila Kennedy, M.D
Jenny Than, PA-C
Payal Shah, NP-C

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fax: 678-205-4989

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Suite 220
Lawrenceville, GA 30044
ph: 678-578-4983
fax: 678-578-4388

Georgia Family Care, LLC

Where Patients Come First

Patient Portal – Consent Form

Purpose of this Form:

Georgia Family Healthcare offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

Email (Please Print)

Georgia Family Care, LLC

Dharmeshkumar Patel M.D
Sridula Reddy, M.D
Jenny Tran, PA-C
Payal Shah, NP-C

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1450 Five Forks Trickum Rd.
Suite 520
Lawrenceville, GA 30044
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fax: 678-573-4366

Consent To Obtain External Prescription History

I,_____, authorize GEORGIA FAMILY CARE'S providers and staff to view my external prescription history in the Rx Hub service. I understand history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers will be viewable by GEORGIA FAMILY CARE'S providers and staff, and the information may include prescriptions I had filled over the past several years.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____

Patient or Parents Signature

Date