

## PATIENT INFORMATION

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M / F  
FIRST M.I. LAST

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work/Daytime Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Race:  American Indian/Alaskan Native  Asian  Black/African American  
 Native Hawaiian/Other Pacific Islander  White  Unknown

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown Primary Language: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

### IF PATIENT IS A MINOR PLEASE PROVIDE FINANCIALLY RESPONSIBLE PARTY INFORMATION BELOW:

Name of financially responsible party: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
FIRST M.I. LAST

Date of birth: \_\_\_\_\_ Relationship to patient:  Parent  Legal Guardian  Other \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_  
STREET CITY STATE ZIP

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ ID # \_\_\_\_\_ Co-pay amount: \$ \_\_\_\_\_

Type:  HMO  POS  PPO  Medicare  Other \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_  
*(usually on back of insurance card)* STREET CITY STATE ZIP

Name of policy holder: \_\_\_\_\_ Policy holder's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
FIRST M.I. LAST

D.O.B. of policy holder: \_\_\_\_\_ Relationship to policy holder:  Self  Spouse  Child  Other \_\_\_\_\_

Address of policy holder (if different from patient): \_\_\_\_\_  
STREET CITY STATE ZIP

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Secondary Insurance Company (If applicable): \_\_\_\_\_

## EMERGENCY CONTACT

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_  Cell  Home  Work

Secondary Phone: \_\_\_\_\_  Cell  Home  Work Other info: \_\_\_\_\_

## My Responsibilities

To ensure that no billing issues occur, we need to inform you that it is **your responsibility** to check with your insurance company regarding the answers to the following questions:

- 1) Is Smyrna Family Medicine/Dr. David Kim considered **in-network** for my insurance plan?
  - a. If you have a **secondary** or **supplemental** insurance please call your secondary insurance and check the in-network status as well.
  - b. Also check and make sure your insurance is in **active status** and not inactive status.
- 2) Are **Annual Physicals** covered by my insurance? Are regular doctor visits (**Office Visits**) covered by my insurance? You need to inquire your insurance about these benefits.
  - a. Note that some insurance companies will not allow Annual Physicals to be scheduled **until 365 days have lapsed** since your last Annual Physical. Other insurance companies will allow Annual Physicals as long as it's a new calendar year. Please call your insurance company to find out your policy.
  - b. Note that **Medicare** patients have a **deductible** at the beginning of each year (amount is typically less than \$200). This amount **may or may not be covered** by Medicare Supplement/Secondary insurance companies. If it is not covered, it is the patient's responsibility to pay the deductible amount.
- 3) Are **labs and radiology studies** (x-rays, ultrasounds, etc.) covered by my plan?
- 4) Are cosmetic and elective procedures covered by my plan?
- 5) What is my portion of the bill? Typically, the patient's portion of the bill falls into 3 categories: **deductible**, **copay**, and **co-insurance**. You need to know what your insurance policy's amount is on each of these areas.
  - a. The **Deductible** is the amount per year that the patient has to pay before the insurance will begin paying. Most insurance companies have exceptions to the deductible, such as the annual physical visit which is not assigned to the deductible. You need to familiarize yourself with these rules.
  - b. The **Copay** is the fixed amount of dollars that the patient is responsible for and is collected at the beginning of the office visit. Most insurance companies do not have a copay for Annual Physicals, but you should check your policy to be sure of this.
  - c. The **Co-insurance** is the patient's responsibility but it's not a fixed amount but rather, a percentage of the final bill. Because the insurance has to process the claim and determine the final bill amount, we cannot collect this amount when you are at the visit. The Co-insurance will be billed to you after your insurance processes the claim (typically 1-2 months after the visit or procedure).

I understand that ultimately, it is my responsibility to know my insurance benefits and how they apply to me. I understand that I may contact my insurance company to inquire about my benefits by calling the customer service number on the back of my insurance card.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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## **PATIENT AGREEMENT & CONSENT**

### **1. Financial Agreement**

I hereby assume full responsibility for all charges incurred for professional services rendered by providers/physicians, unless the services are deemed "paid in full" as a result of contractual agreement between Smyrna Family Medicine office and my insurer. There may be a \$35 No Show fee charged for appointments not cancelled within 24 hours. If you have paperwork to be filled out, a charge of \$25 per page for the first 2 pages will apply and \$80 for 3+ pages will apply. The charges will be due up-front prior to being seen by the provider. If you do not have insurance, payment will be collected prior to being seen by the provider. If you have additional balance afterwards then it will be collected after the visit. If your balance is less than the final amount, then you will be refunded the difference.

### **2. Authorization for release of information**

I hereby authorize Smyrna Family Medicine to release any medical, psychiatric, infectious disease (including AIDS confidential information), drugs and/or alcohol related information to my referring provider/physician or any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this information is valid until such time as all my medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken in reliance hereon.

### **3. Group & Individual Insurance, assignment of benefits**

I authorize my health insurance benefit to pay directly to Smyrna Family Medicine, the surgical and/or medical benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Smyrna Family Medicine for charges not covered by this agreement.

### **4. Medicare claim authorization and payment request**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

### **5. Consent of Treatment**

I authorize request Smyrna Family Medicine to provide medical examinations, treatment, and/or diagnostic procedures, (including: venipuncture, urinalysis, glucose testing, oximetry, hemoglobin testing, injections) which now or during the course of my care as a patient are advisable. The frequency and type of treatments/ procedures will be decided between the provider/ physician and myself. I understand that the purpose of these treatments/ procedures will be explained to me and be subject to my verbal agreement. I understand that there is an expectation that I will benefit from these treatments/procedures, but there is no guarantee that this will occur.

### **6. Prescription Drug History Consent**

In order to give you the highest quality of medical care, we need accurate information regarding your prescription medications. Therefore, I grant Smyrna Family Medicine permission to view my prescription history from my current or previous pharmacies.

### **7. Notice of Physician Assistant's Services**

The physicians of this office employ the service of a Physician's Assistant, Michael E. Allen. Michael Allen is licensed in the State of Georgia to treat patients, order medications, and order other diagnostic testing under the supervision of the doctors of Smyrna Family Medicine. This waiver gives you permission to see the Physician's Assistant unless otherwise specified at the time you make your appointment. We will honor your request for the practitioner of your choice, unless in verifiable emergencies.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT (IF NOT PATIENT)

## PATIENT CONFIDENTIALITY & HIPPA ACKNOWLEDGEMENT

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
FIRST M.I. LAST

Patient confidentiality is a top priority at Smyrna Family Medicine. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I am unable to be reached, Smyrna Family Medicine may leave test results or other pertinent information with the following people:

Name		Relationship	Phone
_____ FIRST NAME	_____ LAST NAME	/ _____ / _____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other
_____ FIRST NAME	_____ LAST NAME	/ _____ / _____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other
_____ FIRST NAME	_____ LAST NAME	/ _____ / _____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other
_____ FIRST NAME	_____ LAST NAME	/ _____ / _____	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other

### MESSAGES

May leave messages on voicemail/answering machine at: (check all that apply)  home  cell  work phone

Other (Describe) \_\_\_\_\_

(Initials) \_\_\_\_\_ In the event I am unable to be reached, Smyrna Family Medicine may **NOT** leave tests results or any other information with anyone but myself or the person listed above.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff of Smyrna Family Medicine.

### Acknowledgment of Receipt of HIPPA Notice of Patient Privacy Practices

By signing this Written Acknowledgment of receipt of Smyrna Family Medicine Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of Smyrna Family Medicine Notice of Patient Privacy Practices.

\_\_\_\_\_  
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE      \_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT OR LEGAL REPRESENTATIVE PRINTED NAME

- Acknowledgment NOT obtained because:
- Patient or Legal Representative declined Notice of Patient Privacy Practices
- Other (Briefly describe) \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF EMPLOYEE      \_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF EMPLOYEE



### Authorization for Release of Medical Information

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
FIRST M.I. LAST

Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
STREET CITY STATE ZIP

I authorize Smyrna Family Medicine to:

- obtain information from:
- release information to:

Name of provider/facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Fax number: \_\_\_\_\_

Specific description of information to be released:

- Complete Medical Records
- Progress Notes
- Labs Reports
- Radiology/Xray Reports

I authorize the release of records that my include diagnosis and treatment of HIV, alcohol & drug usage and/or mental health records). I understand that I may cancel this authorization at any time by submitting a written request to Smyrna Family Medicine except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT (IF NOT PATIENT)

**Releasing provider or facility: Please return this form to**

**Smyrna Family Medicine  
3903 S. Cobb Dr., Suite 200 • Smyrna, GA 30080**

**or fax to (770) 437-6911**



**EMORY HIE (HEALTH INFORMATION EXCHANGE) OPT-IN OR OPT-OUT FORM**

Smyrna Family Medicine is a part of the Emory Healthcare Network of physicians. The Emory Health Information Exchange (HIE) is a secure, electronic way for your participating healthcare providers to improve patient care collaboratively by sharing patient health information. The HIE assists your participating healthcare providers with viewing certain health information about you in a timely manner to effectively coordinate your healthcare needs. You may decide to **OPT IN** or **OPT OUT** of allowing your health information to be viewable by my participating healthcare providers via the Emory HIE. Before deciding, these are some facts you should consider:

1. By **Opting In**, you agree to allow other providers in the Emory Healthcare Network access to **all** of your medical information in our electronic health record. It is either all-or-none agreement (we cannot choose which information to include or exclude). This includes doctor visit notes, lab results (including HIV results), radiology reports, medical history and diagnoses, and a list of your medications.
2. **Opting Out** of the HIE may delay access by my participating healthcare providers to important medical information.
3. I understand that by **Opting Out**, my health information will still be able to be sent to the Emory HIE with my permission in the future but it will not be **VIEWABLE** electronically from the HIE. Instead, my healthcare providers will continue to share information via previously established methods, such as phone, fax, or mail.
4. You may change your mind later and choose to **Opt-In** or **Opt-Out** in the future. However, if you decide to **Opt-Out** in the future, the information that was previously shared remains with the providers who accessed information before the **Opt-Out** goes into effect.
5. My decision today will remain in effect unless I change it in writing and this request can take up to 3-5 business days to take effect.

After reviewing the information above I choose to:

**Opt In**     **Opt Out**

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (Check One)

Parent     Legal Guardian     Other (Specify Relationship) \_\_\_\_\_ for the person named above.

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## NEW PATIENT INTAKE

*Welcome to Smyrna Family Medicine. Please take this time to answer some questions about your health and medical history (front & back pages) to help us get to know you. Hand this to the nurse when she calls you back.*

PRIOR AND CURRENT MEDICAL ISSUES:

PAST SURGERIES/PROCEDURES AND YEAR:

FAMILY MEDICAL HISTORY: *First-degree relatives only.*

MEDICATIONS—DOSES & HOW MANY TIMES YOU TAKE IT:

DRUG ALLERGIES: *Name of drug(s) and what happens when you take it?*

PHARMACY: *Name of your pharmacy, phone and address:*

HEALTH MAINTENANCE:

When was your last tetanus immunization? \_\_\_\_\_

When was your last yearly physical? \_\_\_\_\_

SOCIAL HISTORY:

Occupation:

Do you smoke? If yes, how much?

Do you drink alcohol? How much & how often?

Are you married/single/divorced?

Children & ages:

Hobbies:

Do you exercise? What activity & how often?

CHIEF COMPLAINT:

What is the main reason you want to see the physician today?

ONLINE ACCESS TO YOUR LAB RESULTS AND HEALTH RECORDS:

*If you would like to receive your tests results online as well as having secure access to your medical health record online, please provide your email address.*

Email: \_\_\_\_\_

*Thank you for taking the time to fill out this form!*