ATLANTA CENTER FOR MEDICINE
PATIENT REGISTRATION FORM

____Steven J. Anander, M.D. **____Ellen M. Ferguson, D.O.** **____D. Timothy Daugherty, M.D.**
____Thomas J. Mizell, M.D. **____Larry G. Ray, M.D.** **____Jitendra P. Singh, M.D.**

PLACE AN "X" IN THE SPACE TO THE LEFT OF THE DOCTOR WHO YOUR APPOINTMENT IS WITH TODAY.
IN THE SECTION BELOW, PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF:

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Other _____ **Sex:** ☐Male ☐ Female

Name (Last, First, MI)_____ Nick Name:_____

Physical Address (No PO Box)_____ Apt #_____

City:_____ State_____ Zip_____

Mailing Address if different than above (PO Box is allowed)_____

☐Home Phone _____ ☐Cell Phone_____ ☐Work Phone_____Ext_____
(Place a check mark next to the preferred number above where may we leave voice mail messages for Appointment Reminders, Normal Blood Tests, Normal Diagnostic Results and Medication Info.) **May we text reminders to you?** ☐Y ☐N

Date of Birth_____ Marital Status _____ Social Security # _____-_____-_____

Patient's Employer Name & Address _____

Emergency Contact _____ Phone _____ Relationship _____

Primary Insurance Carrier _____

Primary ID#_____ Group #_____ Group/Plan Name _____

Insured Name Primary insurance_____ Their Birth Date_____ Relationship_____

Secondary Insurance Carrier _____

Secondary ID#_____ Group #_____ Group/Plan Name _____

Insured Name Second Insurance _____ Their Birth Date_____ Relationship_____

Email address _____ Do you want access to patient portal ☐Yes ☐No

RACE (Please circle): Asian; African-American; Hispanic; White; Refuse to report; Other (specify): _____

ETHNICITY (Please circle): Hispanic/Latino; Not Hispanic/Latino; Refuse to report **LANGUAGE:**_____

Pharmacy Name _____ Pharmacy Phone _____

Pharmacy Address _____

***By signing this consent form you are agreeing that Atlanta Center for Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers (for treatment purposes only.)*
The above information is true to the best of my knowledge. I authorize Atlanta Center for Medicine (ACM) to release any information required to process my claims. I understand that my co-payment is due at the time of service. I authorize my insurance benefits to be paid directly to ACM and I understand that I am financially responsible for any remaining balance. I understand that ACM does not file insurance for Motor Vehicle Accidents (MVA) and I agree to be self-pay for MVA. I understand that I may be charged a fee for any missed appointment unless I cancel with at least 24 hours advance notice. I understand that ACM reserves the right to dismiss patients who fail to keep their account current or after reasonable attempts to collect payment have been made, and I agree to pay all reasonable fees if my account is sent to collections.

**Patient (or Guardian) Signature _____ Date_____

Responsible Party _____ Relationship to Patient _____

ATLANTA CENTER FOR MEDICINE
COMPREHENSIVE PATIENT HISTORY DATABASE

TODAY'S DATE:_____

NAME:_____BIRTH DATE:_____

ADDRESS:_____

TELEPHONE: (HOME)_____(CELL) _____(WORK)_____

EMERGENCY CONTACT:_____PHONE: _____

ALTERNATE PHONE # WHERE DOCTOR CAN LEAVE MESSAGE:_____

WITH WHOM MAY WE DISCUSS YOUR MEDICAL INFORMATION?_____

_____

PHARMACY: _____PHONE:_____

DRUG ALLERGY HISTORY: List all drugs you are allergic to as well as the type of allergic reaction it causes:

NAME OF DRUG	TYPE OF REACTION
_____	_____
_____	_____
_____	_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME	DOSAGE	TIMES TAKEN DAILY

PERSONAL MEDICAL HISTORY

INSTRUCTIONS: Please check or circle any condition that applies to you now, or has applied to you in the past. Include any lab abnormalities or any problem you have taken medication for. Read each section carefully. You may write-in your condition if it is not listed.

CARDIAC

High Blood Pressure
Rheumatic Heart Disease
Anginal Chest Pain
Atrial Fibrillation
Ventricular Tachycardia
Hyperlipidemia
Hypercholesterolemia

Heart Failure
Heart Attack
Heart Murmur
Aortic Stenosis
Mitral Valve Prolapse
Hypertriglyceridemia

Name: _____ **Date:** _____

PULMONARY

Chronic Bronchitis	Emphysema
Tuberculosis	Asthma
Pulmonary Embolism	Pneumonia
COPD	

GASTROINTESTINAL

Irritable Bowel	Ulcerative Colitis
Diverticulitis	Diverticulosis
Gastritis	Liver Cirrhosis
Type B Hepatitis	Crohn's Disease

RENAL

Acute Renal Failure	Kidney Stones
Nephritis	Chronic Kidney Disease
Pyelonephritis	Urinary Tract Infections

SKELETAL AND RHEUMATIC

Arthritis, Fingers	Arthritis, Hand
Arthritis, Shoulder	Arthritis, Neck
Arthritis, Back	Arthritis, Hip
Arthritis, Knee	Arthritis, Ankle
Arthritis, Foot	Arthritis, Toes
Rheumatoid Arthritis	Polymyalgia, Rheumatica
Fibrositis Syndrome	Spondylitis
Spondylosis	Osteoporosis
Back Fracture	Hip Fracture
Wrist Fracture	Humerus Fracture
Tibia-Fibula Fracture	Sciatica
Ruptured Disk	TMJ Syndrome

SKIN

Eczema	Sunburn
Common Warts	Venereal Warts
Acne	Rosacea
Plantar Warts	Malignant Melanoma
Psoriasis	Other Skin Cancer

NEUROLOGICAL

Tension Headaches	Seizures
Epilepsy	Migraine Headaches
Cluster Headaches	TIAs (Small Strokes)
Stroke	Guillian Barre
Syncope (Fainting)	Myasthenia Gravis
Cerebro-Vascular Disease	Deafness

PSYCHIATRIC

Anxiety	Depression
Alzheimer's Disease	Panic Attacks
Anorexia Nervosa	Bulimia
Dementia	Hyperventilation

Name: _____ **Date:** _____

ENDOCRINE

Diabetes (Insulin)	Diabetes (Non-Insulin)
Chronic Cortisone Use	Gout
Hypothyroidism	Hyperthyroidism
Thyroid Goiter	Thyroid Nodule
Hyperparathyroidism	High Blood Calcium

INFECTIOUS DISEASE

Meningitis, Bacterial	Meningitis, Viral
Sinusitis, Acute	Sinusitis, Chronic
Chronic Ear Infection	Cellulitis
Gonorrhea	Syphillis
Herpes, Genital	Fever Blisters
Athletes Foot	Jock Itch
Nail Bed Fungus	Shingles
HIV/AIDS	Pneumocyctic Pneumonia
Hepatitis	

HEMATOLOGIC

Anemia	Chronic Lymphocytic Leukemia
Iron Deficiency	Chronic Myelogenous Leukemia
Lymphoma	Hodgkin's Disease
Lymphadenopathy	Pernicious Anemia

ALLERGY

Hives	Allergic Rhinitis
Hay Fever	Bee Sting
Angioedema	Food

GYNECOLOGICAL, FEMALE URINARY TRACT AND BREASTS

Irregular Menstruation	Amenorrhea
Menopause	Yeast Infections
Pelvic Inflammatory Disease	Ovarian Cyst
Infertility	Vaginitis
Painful Menstruation	Pelvic Pain
Abnormally Heavy Periods	Incontinence
Fibrocystic Breast Disease	

MALE URINARY TRACT

Enlarged Prostate	Acute Prostatitis
Chronic Prostatitis	Urinary Obstruction
Prostrate Nodule	Varicocele
Hydrocele	

CANCER

Skin	Mouth	Tongue
Larynx	Esophagus	Stomach
Colon	Lung	Bladder
Blood	Kidney	Cervical
Breast	Uterine	Rectal
Thyroid	Ovarian	Brain
Lip	Prostate	Salivary Gland

Name: _____ **Date:** _____

PAST SURGICAL HISTORY

Tonsillectomy	Appendectomy	Gallbladder
Hernia	Stomach Ulcer Surgery	Hysterectomy
Ooporectomy	Tubal Ligation	Vasectomy
Hemorrhoids	Heart Valve	Lung
Kidney	Brain	Abdomen
Prostate (TURP)	Bladder	Colon
Back	Coronary Artery Bypass Graft	Breast Biopsy
Mastectomy		

Please list in the space below any surgery you had in the past not listed above:

FAMILY HISTORY

INSTRUCTIONS: Please check or circle the conditions below **found among your family members:**

Hypertension	Heart Disease	Diabetes
Stroke	Atherosclerosis	Kidney Disease
Tuberculosis	Thyroid Disease	Stomach Caner
Colon Cancer	Skin Cancer	Osteoporosis
Arthritis	Breast Cancer	Alcoholism
Malignant Melanoma	High Cholesterol	High Triglycerides
Heart Attacks	Heart Failure	Cancer
Obesity	Depression	Suicide

FAMILY HISTORY

		YEAR OF	Alive?	
Family Member	First Name	BIRTH	Y or N	List their Medical Diseases
Father				
Mother				
Brothers				
Sisters				
Children				

SOCIAL HISTORY

Current occupation_____ Retired? Yes No

Previous occupation if retired_____

Employer_____

Have you ever been exposed to any dangerous fumes, chemicals, cotton dust, or radiation sources? Yes No

Name: _____ **Date:** _____

TOBACCO

Have you used tobacco products? Yes No Never (please circle one)
How many years have (or did) you use tobacco? _____
In what year did you begin to use tobacco? _____
Cigarettes: Packs smoked each day: ½ 1 2 3 4 (please circle one)
Cigars: Number of cigars smoked each day _____
Pipe: Number of ounces of tobacco each week _____
Smokeless tobacco: Ounces used each week_____
If you stopped using tobacco, in what year did you do so? _____

YOUR SEXUAL PREFERENCE:

Heterosexual (straight) Bisexual Homosexual (gay or lesbian) (Please circle one)

DRUGS AND ALCOHOLIC BEVERAGES

Do you now use alcoholic beverages on a regular basis? Yes No Never (Please circle one)
Beer: Number of cans per week _____
Wine: Number of glasses per week: _____
Whiskey/Liquor: Number of ounces consumed weekly _____
In your opinion, do you now or have you ever had a drinking problem Yes No Never (Please circle one)
If you drank alcoholic beverages in the past but no longer consume them, in what year did you stop drinking alcohol? _____
Do you use recreational drugs? Yes No Never (Please circle one)

COMPREHENSIVE REVIEW OF SYSTEMS

INSTRUCTIONS: Please check or circle any symptoms you are **CURRENTLY** experiencing:

GENERAL	Weakness	Fatigue	Lack of Appetite
	Weight Loss	Weight Gain	Chills
	Fever	Insomnia	Night Sweats
SKIN	Rash	Itchiness	Moles
	Warts	Non-healing Ulcers	Acne
	Dryness	Hair Loss	Ring Worm
	Eczema	Abnormal Sweating	
HEAD	Lumps on the Scalp	Headaches	Sore Spots on the Scalp
EYES	Double Vision	Decreased Vision	Burning Eyes
	Cataracts	Pain in the Eyes	Rings around Lights
	Red Eyes	Infected Eyes	
EARS	Decreased Hearing	Ringing in the Ears	Pain in the Ears
	Discharge from the Ears		
NOSE	Nose Bleeds	Stuffy Nose	Constant Runny Nose
	Nasal Obstruction	Broken Nose	Nasal Polyps
	Sinus Infection	Can't Smell	Post Nasal Drip
THROAT	Sore Throats	Strep Throats	Chronic Hoarseness
	Vocal Cord Polyps	Colds Sores on Lips	Mouth Ulcers
	Bleeding Gums	Cavities	Dentures
	Non-Healing Tongue or Mouth Sore		

Name: _____ **Date:** _____

NECK	Chronically Swollen Glands	Neck Pain	Neck Stiffness
	Crick in the Neck	Neck Swelling	

PULMONARY

Breathlessness on Exertion	Breathlessness at Rest	Wake from Sleep Breathless
Cold Air Causes Wheezing	Daily Smokers Cough	Chronic Dry Cough
Daily Coughing of Phlegm	Coughing Up Blood	Pain in Chest with Cough
Exposure to Tuberculosis	Snoring	

BREAST	Breast Lump(s)	Nipple Discharge	Breast Pain
	Breast Cysts		

CARDIAC Chest Pain/Tightness on Physical Exertion

Chest Pain at Rest	Heart Pounding	Heart Racing
Irregular Heart Rate	Ankle Swelling	Leg Pain on Exertion

GASTROINTESTINAL

Nausea	Vomiting	Abdominal Bloating
Indigestion	Lump in the Abdomen	Stomach Cramps
Vomiting Blood	Rectal Bleeding	Black Sticky Stools
Heartburn	Frequent Antacids	Food Allergy
Diarrhea	Constipation	Stomach Burning
Painful Swallowing	Food Sticks on Swallowing	

ENDOCRINOLOGY

Hot Flashes	Cold Intolerance	Heat Intolerance
Frequent Urination	Increased Appetite	Increased Thirst
Weight Loss	Weight Gain	No Sex Interest
Menopause	Loss of Body Hair	Increased Hair Growth

GYNECOLOGIC (WOMEN ONLY)

Age periods began ____	Date of Last Period ____	Vaginal Discharge Yes No
Severe Menstrual Cramps	Pelvic Pain	Are Periods Regular? Yes No
Abnormal Vaginal Bleeding	Painful Intercourse	Decreased Sexual Desire
Vaginal Spotting	Frequent Vaginal Infections	
Vaginal Bleeding After Menopause		

URINARY	Burning on Urination	Frequent Urination	Urinary Retention
	Can't Start Urine Stream	Decreased Urine Stream	Enlarged Prostate
	Genital Ulcers or Blisters	Urinary Tract Infection	Genital Infections
	Can't Hold Urine (Incontinence)	Urine Leakage when you Cough or Sneeze	

NEUROLOGICAL

Headaches	Seizures	
Convulsions	Body Numbness	Body Tingling
Poor Memory	Mental Confusion	Periodic Facial Drooping
Slurring of Words	Arm or Leg Weakness	Blackout Spells
Dizziness	Vertigo	Paralysis of Arm or Leg
Loss of Balance	Difficulty Speaking	

PSYCHIATRIC

Depressed Mood	Crying Spells	Very Nervous/ Anxious
Can't Sleep Well	Personality Change	Hearing Voices
Angry often	Mental Breakdown	I'm thinking about suicide
I've lost interest in things I used to enjoy		

Name: _____ **Date:** _____

Are you aware of the importance of safe sex in the prevention of sexually transmitted diseases? Yes No

Do you always practice safe sex? Yes No Not applicable to my situation

Do you wear seat belts at all times? Yes No

Do you have a smoke detector in your household? Yes No

Do you have a firearm in your household? Yes No If yes, is it locked up? Yes No

Do you exercise regularly? Yes No # of days per week? _____ **If yes,** please list what you do for exercise:_____

VACCINATIONS:

When was your last Tetanus vaccination? _____

When was your last pneumonia vaccination? _____

When was your last Gardasil/HPV vaccination? _____

When was your last shingles vaccination? _____

TESTS:

When was your last cholesterol check? _____

Have you ever had a colonoscopy? Yes No **If yes,** when? _____

Have you ever had a bone density scan (DEXA scan)? Yes No **If yes,** when? _____

FOR INDIVIDUALS BORN 1945 - 1965 <u>ONLY</u>

Have you ever been tested for hepatitis C? Yes No **If yes,** when? _____

FOR MALES <u>ONLY</u>

Are you aware of the importance of testicular self examination? Yes No

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FOR FEMALES <u>ONLY</u>

Approximate date of last PAP smear? _____

Birth Control Method: Abstinence Condoms Birth Control Pills Vasectomy Tubal Ligation Other:___

Last menstrual cycle? Approx Date _____ (or check here if not applicable to your situation ___)

Last mammogram? Approx Date _____ (or check here if you have never had one ___)

Are you aware of the importance of breast self-examination in detection of breast cancer? Yes No

Do you perform monthly self examination of your breasts? Yes No

Protecting your Health Information

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

1. Give patients more control over their health information;
2. Set boundaries for the use and release of health records;
3. Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
4. Hold violators accountable, with civil & criminal penalties; and
5. Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with our Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information. A copy of this Notice is posted by the waiting room, and a copy is available for you, if desired, at the check-in window.

Please sign below that we have made available a copy of the Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

Additionally, by signing below I allow anyone who comes into the examination and/or consultation room with me to participate in examination(s) and or discussion regarding my health care while in my presence.

I acknowledge that I have received a copy of Atlanta Center for Medicine Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name (please print) _____

Signature _____**Date:** _____

If Personal Representative, relationship to patient:

_____

Atlanta Center for Medicine

Financial Policy

Thank you for choosing Atlanta Center for Medicine (ACM) for your medical needs. Our staff is committed to providing you with the best care possible. Your clear understanding of the Financial Policy, which is an agreement between the practice and the patient or guarantor, is important to our professional relationship. We require a signature to document that you have read and understand this policy.

INSURANCE/PAYMENT: Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. On arrival, please sign in at the front desk and **present your current insurance card and photo identification as well as any other forms that may assist us in processing your claims correctly at every visit**. It is the responsibility of the patient to provide *accurate* and *timely* insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. If your plan requires, you must name ACM as your primary care physician prior to your first appointment. If an ACM physician is not named on your insurance as your primary care physician, your appointment will need to be rescheduled. According to your contractual agreement with your insurance plan, **you are responsible for your co-payment, coinsurance, and/or deductible at the time of service.** It is important for you to be an informed consumer who understands the specifications of your insurance policy regarding doctor visit coverage, referral/authorization requirements for specialty care, imaging studies, laboratory tests, emergency hospital care, etc. You should refer to information from your insurance company or call them if you have questions about your coverage.

BILLING: We accept cash, checks, MasterCard, Visa, and Discover. **Outstanding balances are due within 30 days unless prior arrangements have been made with the billing department.** For balances over 60 days, you will receive a final request for payment letter. Balances not paid in full within 10 days of the date on the final request letter will be forwarded to a collection agency. **You will be responsible for any costs incurred if your account is turned over to a collection agency,** which will include collection agency fees equaling **25%** of the outstanding balance, and in addition, court costs and attorney fees.

The guarantor is responsible for full payment at the time of service. We realize that temporary financial problems may affect timely payment on your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Should your account balance become uncollectible due to bankruptcy, we will continue to see you on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

Please call if you have a question about your bill. Most problems can be settled quickly and easily and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

IF WE PARTICIPATE WITH YOUR INSURANCE COMPANY: All services performed in our office will be submitted as a courtesy to your insurance. **All co-payments, deductibles, and coinsurance are due at the time of service.** All insurance carriers have a fee schedule from which they will reimburse. Not all services provided by this office are covered benefits in all contracts. Therefore, any balance not covered by insurance becomes the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY: We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with a bill so that you may submit the charges to your insurance company for reimbursement. **Payment for service is due in full at the time of service.**

IF YOU DO NOT HAVE INSURANCE: If you are not covered by insurance at the time of service, please be advised that **you will be responsible for all charges incurred at the time of service**.

NON-EMERGENCY APPOINTMENTS: We may reschedule non-emergency appointments if there is an overdue balance on your account or if a co-payment is not made at the time of service.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, a 24 hour notice prior to the appointment is requested. However, we understand emergencies arise, so please call us if you must miss an appointment. **We reserve the right to charge a $25.00 fee for missed appointments without proper notification ($150.00 for missed physicals).**

RETURNED CHECKS: A **$35.00 fee** will be charged for all returned checks. If you write a check that is returned, your account will be placed on a cash only basis, meaning we will only accept cash or credit card payments.

AFFIDAVITS/LEGAL MATTERS: Each Provider charges a fee for affidavits, letters, or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service.

FORMS: We require at least 48 hours to complete all forms. An appointment may be required depending on the nature of the form and information requested.

MEDICAL RECORDS: If you request a copy of your medical records, you will be required to sign a medical record release form and pay a medical record fee prior to having your records copied (fee details stated on release form). Please allow up to 14 days for this request to be processed.

REFERRALS: If your insurance plan requires a written referral for you to see a specialist, for procedures, or laboratory tests, you must allow no less than 3 business days to complete the appropriate form(s) prior to obtaining services. You may have to reschedule your appointment if enough notice is not given to prepare your referral. Emergency referrals will be completed on the same day. Retroactive referrals cannot be written and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted about first.

REFUNDS: If you have a credit on your account, we will gladly refund the amount within thirty (30) days of your request (and if cleared by the Billing Department). You must provide a correct mailing address for your refund to be sent.

DISMISSAL PROCESS: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to ACM's narcotic policy
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty (30) days of the date of the letter, one of our providers will be available for advice. After the thirty (30) days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

You may review this Financial Policy at http://acmdocs.com/

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT.

Patient Acknowledgement: *I, _____ (print name), have read, understand, and agree to the Atlanta Center for Medicine Financial Policy. I agree to pay at the time of service. I also understand that Atlanta Center for Medicine reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor.*

_____

Patient's or Responsible Party's Signature Date

_____

Witness Signature Date

Atlanta Center for Medicine Opt-Out Form for the Emory Health Information Exchange

Please complete the form below and give to the receptionist only if you do NOT want us to share your medical record with your other health care providers on the Emory Health Information Exchange (EHIE.) Otherwise you will be automatically opted in, and your data may be shared on the EHIE to facilitate improved patient care.

I elect to opt out of the Emory HIE:

*Name: _____ *Date of Birth: _____

*Street Address: _____ *City: _____

*State: _____ *Zip: _____ *Phone: _____

e-mail: _____ *Required Field

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.

After considering my option of participating in the Emory HIE, ***I have decided to OPT OUT*** and ***NOT*** allow my health information to be viewable by my participating healthcare providers via the Emory HIE. By choosing to **OPT OUT** of allowing my health information to be viewable via the Emory HIE, I hereby acknowledge and agree as follows:

1. Opting out of the HIE may delay access by my participating healthcare providers to important medical information.

2. **I understand that by Opting Out, my health information will still be sent to the Emory HIE but it will not be VIEWABLE from the HIE. Instead, my healthcare providers will continue to share information via previously established methods, such as phone, fax, or mail.**

3. My health information will NOT be shared with other HIEs in which Emory Healthcare may participate including the Georgia Health Information Network (GaHIN). By opting out of the Emory HIE, I am also opting out of the GaHIN.

4. Any information that is shared before I submit this HIE Opt-Out form may remain with providers who accessed information before this Opt-Out went into effect.

5. My **HIE Opt-Out** selection will remain in effect unless I change it in writing; and

6. This request can take up to 3-5 **business days** to take effect.

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: _____

Signature: _____

ACM Staff: Please fax this completed and signed HIE Opt-Out Form to the Emory HIE at 404-712-2980 so that this patient can be properly opted out.

Revised 11/11/19

Atlanta Center for Medicine

Steven J. Anander, M.D.
D. Timothy Daugherty, M.D.
Ellen M. Ferguson, D.O.
Thomas J. Mizell, M.D.
Larry G. Ray, Jr., M.D.
Jitendra Singh, M.D.

Authorization For The Use And/Or Disclosure of Protected Health Information

I authorize the use and/or discloser of my protected health information as described below. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

- Type of health information to be released:_____
- Release of information dated:_____

I authorize Atlanta Center for Medicine to make the authorized disclosure of my protected health information to the following entity or persons (spouse, friend, relative, etc):

_____

_____

_____

I understand, that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.

I understand, that I have a right to revoke this authorization at any time. My revocation must be in writing to Atlanta Center for Medicine. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand, that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr._____, nor will it affect my eligibility for benefits.

I certify that I have received a copy of this authorization. This authorization expires upon my written notice to Atlanta Center for Medicine

_____ _____

Full Name **Date of Birth**

_____ _____

Signature **Date**

_____ _____

Name of Personal Representative **Relationship to Patient**