DeKalb Medical Physicians Group
Atlanta Neurosurgical Associates

Patient's Name _____
LAST MIDDLE FIRST

SSN ___ - ___ - ___ DOB ___ - ___ - ___ Age _____ Sex _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ ☐ Do Not Have Email

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Caucasian/White
☐Hispanic or Latino ☐Native Hawaiian or Pacific Islander ☐Other

Preferred Language: ☐Chinese ☐English ☐French ☐German ☐Italian ☐Japanese ☐Russian ☐Spanish
☐Other _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Interests/Hobbies: _____

Patient's Employer _____ Phone _____

Employer's Address _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Pharmacy Name _____ Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Address _____

Primary Insurance _____

Member/Policy ID# _____ Group # _____

Policy Holder _____ Relationship _____

Social Security # _____

DOB _____ Phone _____

Secondary Insurance _____

Member/Policy ID # _____ Group # _____

Policy Holder _____ Relationship _____

Social Security # _____

DOB _____ Phone _____

INSURANCE AUTHORIZATION & ASSIGNMENT: I hereby authorize Atlanta Neurosurgical Associates/ DeKalb Medical Physicians Group to furnish information to my insurance carriers concerning my illness & treatment. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependants. I understand that I am responsible for any amount not covered by insurance. ALL copays, deductibles, and coinsurances are due at time of service and/or prior to surgery.

Signature _____ Date _____

DeKalb Medical Physicians Group

ATLANTA NEUROSURGICAL ASSOCIATES
MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Nutritional Status:
Appetite: ☐ Good ☐ Fair ☐ Poor
Are you on any special diet? ☐ Yes ☐ No If yes, what type? _____
Do you currently use herbs or nutritional supplements in your diet? ☐ Yes ☐ No
Have you had any unintentional weight loss/gain in the last 6 months? ☐ Yes ☐ No Pounds: _____
Do you wear dentures? ☐ Yes ☐ No
Please check if you have ever had any:
☐ Difficulty swallowing ☐ Difficulty chewing

Gynecologic / Obstetric History:
Age onset of menstrual period: _____ Length of menstrual period: _____ Frequency: _____
Pregnancies: _____ Births: _____ Marriages: _____ Abortions: _____
Age at first pregnancy: _____ Are you pregnant at this time? ☐ Yes ☐ No
Date of last pap smear: _____ Have you had an abnormal pap smear? ☐ Yes ☐ No
If yes, please describe finding: _____
Date of last mammogram: _____ Have you had an abnormal mammogram? ☐ Yes ☐ No
If yes, please describe finding: _____
Do you perform a self breast exam? ☐ Yes ☐ No If yes, how often? _____

Immunization / Preventive Screening History:

Pneumovax	____	Yes	Date _____	____	No	_____ Don't know
Hepatitis B	____	Yes	Date _____	____	No	_____ Don't know
Hepatitis A	____	Yes	Date _____	____	No	_____ Don't know
Influenza	____	Yes	Date _____	____	No	_____ Don't know
Tetanus	____	Yes	Date _____	____	No	_____ Don't know
Measles, Mumps, Rubella	____	Yes	Date _____	____	No	_____ Don't know
Polio	____	Yes	Date _____	____	No	_____ Don't know

Date of last cholesterol: _____ Date of last stool check for blood: _____
Sigmoidoscopy, if over age 50: _____ Date of last prostate exam: _____

Family History: Please check & describe if any member of your family (*including parents, siblings and grandparents*) ever had:

_____ Cancer _____ _____ Hypertension _____
_____ Heart Disease _____ _____ Diabetes _____
_____ Stroke _____ _____ Mental Illness _____
_____ Addiction _____ _____ Glaucoma _____
_____ Blood Disorder _____ _____ Other _____

Prevention:
Do you smoke? ☐ Yes ☐ No Packs per day _____
Do you drink alcohol? ☐ Yes ☐ No Amount/week _____
Do you wear a seatbelt? ☐ Yes ☐ No
Do you wear a bike helmet? ☐ Yes ☐ No
Do you drink caffeine? ☐ Yes ☐ No
Do you use drugs (including Marijuana, Cocaine, etc.)? ☐ Yes ☐ No Describe: _____
Do you engage in activity which places you at risk for acquiring AIDS? ☐ Yes ☐ No Describe: _____
Do you wish to be tested for AIDS? ☐ Yes ☐ No
Do you work with any occupational hazards such as chemicals, paints, asbestos, etc.? ☐ Yes ☐ No
Are you in a relationship in which you have been physically hurt? ☐ Yes ☐ No
Do you ever feel afraid of your partner? ☐ Yes ☐ No
Is there a gun in your home? ☐ Yes ☐ No
Do you have a Living Will? ☐ Yes ☐ No
Would you like information on a Living Will? ☐ Yes ☐ No

DeKalb Medical
Physicians Group
Murray D. Robinson, M.D.

ATLANTA NEUROSURGICAL ASSOCIATES
MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ M S D W Date: _____

Height: _____ Weight: _____ lbs. Sex: M F Occupation: _____

Onset of Symptoms (date): _____ MVA Trauma: _____

Present Symptoms: _____

_____

_____

Therapy: _____

_____

Injections (dates): _____

_____

Present Medications: _____

_____

Medication Allergies: _____

_____

Previous Surgeries: _____

_____

Hospitalizations other than Surgery (last 5 years): _____

_____

Do you smoke? ___ Yes ___ pks/day ___ No Do you drink? ___ Rare ___ Minimal ___ Moderate

Do you have any of the following?

	YES	NO		YES	NO
Chest Pain	___	___	Bleeding Disorder	___	___
Heart Attack	___	___	Diabetes	___	___
Hepatitis	___	___	Kidney Disease	___	___
Seizures	___	___	Ulcer Disease	___	___
Rheumatic Fever	___	___	Lung Disease	___	___
Colitis	___	___	Fractures	___	___
High Blood Pressure.....	___	___	T.B.	___	___
Thyroid Disease	___	___	Asthma	___	___

Any travel outside the USA past one year? ___ Where? _____

MRI _____ EMG _____

Catscan _____ Other _____ Misc. _____

DeKalb Medical
Physicians Group

PATIENT CONSENT FORM

CONSENT FOR ROUTINE PROCEDURES & TREATMENTS

We are required by law to obtain a 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 or Treatments.

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

(1) **Needle Sticks**, such as injections (shots), intravenous lines, or 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 of 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 alternatives 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 that 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;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks 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 DeKalb Medical and its staff the right to access my electronic pharmacy and prescription information.

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

Printed Name of Patient: _____

Reason Patient Unable to Sign (if applicable): _____

Date Signed: _____

[redacted]

Acknowledgement of Receipt of Notices of Privacy Practices (HIPAA): 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.

_____

Patient Signature

Notice of Privacy Practices in the Use and Disclosure of Personal Health Information

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. This Notice applies to DeKalb Regional Health System (and all affiliates) and their medical staffs, employees and other health professionals who are approved to provide services at its facilities. Please note that physicians may have different privacy practices for services provided at their offices.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and/or receive a copy your health record (a fee may be applied)
- obtain and/or receive a copy of your health record in electronic form if readily producible in such form (a fee may be applied)
- request an amendment or correction to your health record
- request that PHI be be provided directly to another individual
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

The organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- provide you notification in the event your information is breached.
- obtain your written authorization for any subsidized communications that market a health-related product or service.
- We will use or disclose your information consistent with 45 C.F.R. 164.514.4 (F) (i-vi). Such information shall be the minimum necessary to accomplish the desired purpose and may include: Demographic information relating to you including your name, address, other contact information, age, gender, and date of birth; Dates of health care provided to you; The department where you received services; Name of treating physician; Outcome information; and Health insurance status.
- provide you the opportunity to opt out of any fundraising communications

We are not required to agree to most restrictions you request on the use or disclosure of your information. However, we must agree to a restriction on disclosure of your information to a health plan for purposes of carrying out payment or health care operations if the information relates solely to a health care item or service for which you or your guarantor have paid us out of pocket in full. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose psychotherapy notes, use or disclose your information for marketing purposes, or use or disclose your information for purposes not described in this Notice without your written authorization.. DeKalb Regional Health System will not sell your information. A decedent's information is no longer protected under the HIPAA privacy law upon 50 years following death.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
Information obtained by, or treatment ordered or provided by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine your course of treatment.. . We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

We will use your health information for payment.
A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

- *Quality Improvement*: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in you health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- *Business Associates*: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate **and applicable subcontractors** so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- *Directory*: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to people who ask for you by name.
- *Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location and general condition.
- *Communication with family*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- *Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- *Funeral Directors*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- *Organ procurement organizations*: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- *Marketing*: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fund raising*: We may contact you as part of a fund-raising effort.
- *Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution*: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement*: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- *Federal oversight agency*: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

For More Information or to report a Problem

If you have a question and would like additional information, you may contact the Privacy Officer at 404-501-5990. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Please submit your question or complaint in writing and mail to: Privacy Officer, DeKalb Medical Center, 2701 North Decatur Road, Decatur, Georgia 30033

Effective Date: September 23, 2013

For More Information or to report a Problem

If you have a question and would like additional information, you may contact the Privacy Officer at 404-501-5990. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Please submit your question or complaint in writing and mail to: Privacy Officer, DeKalb Medical Center, 2701 North Decatur Road, Decatur, Georgia 30033.
Effective Date: September 23, 2013

DeKalb Medical
Physicians Group

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print **patient's** full name)

_____ Birth date (Mo/Day/Yr)

_____ (Street address)

_____ Social Security Number

_____ (City, state, zip code)

_____ Phone (Home)

At the request of the individual, I _____, do hereby authorize _____
(Patient Name) (Practice Name)
_____to release:

_____Medical History
_____Progress Notes
_____Laboratory Reports
_____Radiology Reports
_____EKG Results
_____Other Ancillary Reports
_____Immunization Records
Other_____
_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL
OTHER (SPECIFY)_____

Please provide a DAYTIME telephone number in the event we need to contact you:_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 DAYS from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ **Signature of individual (or guardian or Personal Representative of patient's estate)**

_____ **Date**

MEDICAL INFORMATION RELEASED

Medical History_____
Progress Notes_____
Lab Reports_____
Radiology Reports_____
EKG Results_____
Other Ancillary Rpts____
Immunization Records_____
Other_____
_____

_____
ROI SPECIALIST

_____
DATE

A PHOTOCOPY OF THIS RELEASE IS VALID AS THE ORIGINAL.

DeKalb Medical Physicians Group

DeKalb Medical Physicians Group Patient Notice

HIPAA stands for the Health Insurance Portability and Accountability Act. This federal law has brought many changes to the healthcare industry, specifically in areas such as:

- Protecting and ensuring the privacy of patient's health information
- Regulation to protect electronic health information
- 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 compete this form to ensure that we can contact you.

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

Home telephone #: _____ (please circle answer) Yes No May we leave messages on your home answering machine? Yes No

Work telephone #: _____ (please circle answer) Yes No May we leave messages on your work voice mail? Yes No

Cell phone #: _____ (please circle answer) Yes No May we leave messages on your cell phone voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people:

- All test results Yes No
- The entire medical record Yes No
- Today's chart note Yes No
- Any healthcare provider or facility Yes No
- Spouse: Yes No Name: _____
- Parent(s): Yes No Name: _____
- Children: Yes No Name: _____
- Other: Please give name and relationship (aunt, uncle, cousin, partner, etc.)

Name:_____

_____

Patient/parent/guardian signature: _____

Dated signed: _____

DeKalb Medical Physicians Group

DeKalb Medical Physicians Group
Atlanta Neurosurgical Associates

PRESCRIPTION POLICY

During the course of your treatment, it may be necessary for the physician to prescribe medications. The following policy will be strictly enforced. Your signature at the bottom of this page indicates that you understand and will abide by this policy.

All medications prescribed will be with the approval of our licensed physicians. All narcotic (pain) medication will be prescribed based on the following:

- The patient will obtain the prescribed medication from an ANA physician/PA only. If it is discovered that the patient is obtaining the same prescription from another source, no refills will be given. It is the patient's responsibility to notify our practice if they are receiving another narcotic from a different physician.
- The patient will take the prescribed medication exactly as prescribed by the physician. Should the patient feel they require more pain medication than has been prescribed, they must contact the physician for approval to change the dosage.
- The patient understands no prescription will be refilled early. NO ALLOWANCES will be made for lost prescriptions or medication taken in a manner other than exactly as prescribed.
- Under no circumstances will a prescription be refilled if the physician has not seen the patient within a three-month period. You will be required to make an appointment to see the doctor and he will determine at that visit if additional medication is needed.
- Under no circumstances will the physician/PA write a prescription for a family member, friend, etc., without seeing them first as a patient. You should never allow another individual to take your medication.
- Once the physician determines the medication is no longer necessary to manage your pain, no refills will be issued.
- You are required to keep track of your prescription refills and notify the office 48 hours in advance for renewal of a prescription. **All refill requests should be sent through the Patient Portal.** For the few patients that do not have an email address you can call the office and leave a message on the prescription line, but please be aware that selecting this alternative may delay response to your request by an additional 24 hours. NO refills will be given after business hours or on weekends. NO EXCEPTIONS. Certain medications cannot be refilled or called in to your pharmacy. These prescriptions will have to be picked up in the office or mailed. Please allow 3-5 business days for these type medication requests.

_____ _____

PATIENT NAME DATE

DeKalb Medical Physicians Group
Atlanta Neurosurgical Associates

NO SHOW POLICY

Due to the fact that our office continues to have an unacceptable No-Show rate, we have no option but to institute a No Show Policy. No-shows result in loss of revenue to our practice as well as valuable time wasted where the physician could be seeing another patient.

You will be considered a No-Show if you miss an appointment and do not notify our office 24 hours in advance of your scheduled appointment time. There will be a twenty five dollar ($25.00) fee for all No-Shows.

If you are unable to keep your scheduled appointment, please contact our office to cancel or reschedule your appointment. This can be done by calling our office at 770-979-8080.

If you fail to keep a scheduled appointment without notifying our office, you will NOT be allowed to schedule another appointment until the No-Show fee is paid. Three No-Shows will result in dismissal from our practice.

Please sign below indicating you have read and understand the policy.

Signature of Patient: _____ Date: _____

Print Name: _____