Athens Geriatrics & Internal Medicine, P.C.

May L. Bullecer, M.D. | Mark J. Paradela, M.D. | Lisa Swift, ANP-BC

Patient Information

Patient's Full Legal Name: _____

Date of Birth: ____/____/_____ Social Security Number: ____-____-_____

Physical Address: _____

Phone Number(s): Home_____ Cell_____

Email Address: _____

Name and Location of Pharmacy: _____

Mail Order Pharmacy (if available): _____

Parent or Responsible Party Information

Name: _____ Relationship to Patient: _____

Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

Physical Address: _____

Phone Number(s): Home_____ Cell_____

Employer _____ Work Phone Number _____

Emergency Contact Information

Name: _____ Number: _____ Relationship: _____

Name: _____ Number: _____ Relationship: _____

Insurance Information

Please give your identification card and your insurance card(s) to the front office at the time of arrival for your appointment.

Assignment of Benefits

I hereby assign all medical benefits to which I am entitled, including major medical, Medicare, Medicaid, private insurance, and any other health plan to Athens Geriatrics and Internal Medicine, P.C. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is considered as valid as an original. I understand that I am financially responsible for all charges that are NOT paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT TIME OF SERVICE

(CO-PAY LISTED ON CARD, 20% with Medicare if there is no secondary, deductible)

$37.00 fee for RETURNED CHECKS

If our office is forced to send you to collections, you will be charged an additional 40% recovery fee which will be billed on your account balance.

Signature: _____ Date: _____

1500 Oglethorpe Ave, Suite 3200, Athens, Ga 30606 | 696 Breedlove Dr, Suite A, Monroe, Ga 30655
Athens office: (706) 549-8931 | Monroe office: (706) 207-5677

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New Patient Paperwork

Reason for today's visit / Concerns you would like to discuss with the provider:

Previous Primary Care Physician: _____

Specialty Physicians (Name & Specialty):

Current Medication List *(If you bring all medication bottles or a medication list to the appointment, you don't need to fill out this section)*

Medication Name	Dosage	Directions

Medical History

Please list any past or present medical conditions i.e. diabetes, hypertension, COPD, GERD, IBS, etc.

Allergies to Medications

Medication Name	Reaction

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Surgical History

Type of Surgery	Date and Location

Hospitalizations

Reason for Hospitalization	Date and Location

Family History

Please fill out as much as possible. This information is important to us.

Family Member	Alive	Deceased	Age	Medical Problems or Cause of Death
Father				
Mother				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Siblings *Brothers*_____ *Sisters*_____				
Children *Sons*_____ *Daughters*_____				

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Patient Consent of Protected Health Information (PHI)

Patient's Name: _____ Date of Birth: ____/____/_____

I wish to be contacted in the following manner (Complete all that apply):

Home Phone: _____ Ok to leave message? Yes/no

Cell Phone: _____ Ok to leave message? Yes/no

Work Phone: _____ Ok to leave message? Yes/no

Other: _____ Ok to leave message? Yes/no

Please list the person(s) with whom we may discuss your medical information:

Name: _____ Number: _____ Relationship: _____

Ok to discuss: ( ) Appointments ( ) Test results ( ) Billing information

Name: _____ Number: _____ Relationship: _____

Ok to discuss: ( ) Appointments ( ) Test results ( ) Billing information

Name: _____ Number: _____ Relationship: _____

Ok to discuss: ( ) Appointments ( ) Test results ( ) Billing information

I, _____, have received a copy of Athens Geriatrics & Internal Medicine's notice of privacy practices and have read and understood its contents. I ultimately agree that Athens Geriatrics & Internal Medicine may disclose any and/or all of my PHI/medical records to any person and/or facility they deem necessary.

Patient's Name (print) _____

Patient's Signature _____ Date _____

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Medical Record Release Form

Patient's Name: _____ Date of Birth: ____/____/_____

I, _____, do hereby request my complete personal protected health information/medical records to be released in their entirety to Athens Geriatrics & Internal Medicine, P.C. (Dr. Bullecer, Dr. Paradela, Lisa Swift, and staff).

I understand that information in my health record may include information relating to confidential information and may include mental health, alcohol, and drug use information, and I authorize the release of this information.

I understand that by signing this authorization, I am giving Athens Geriatrics & Internal Medicine permission to release my complete personal protected health information/medical records. I understand that my complete health information may be related to any of the following but not limited to: specialty physicians, PCP, hospital (of choice), lab companies, pharmacy (of choice), home healthcare facility, nursing home, insurance company, and medical supply company (of choice).

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by the federal privacy laws.

I understand that authorization may be revoked at any time. This must be in writing to the office. This would not apply to information that has already been released prior to my written revocation.

I understand I may refuse to sign this authorization.

Patient's Signature _____ Date _____

Patient's Legal Representative Name _____

Patient's Legal Representative Signature _____ Date _____

Office Use Only

To: _____ Phone: _____ Fax: _____

Type of Records Requested: _____

_____

Office Contact: _____ Date Requested: _____

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Consent to Access External Prescription History

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTOOD THE FOLLOWING.

Patient Name (please print): _____

I, _____, whose signature appears below, authorize Athens Geriatrics & Internal Medicine, P.C., the affiliated providers, and staff to view the external prescription history.

I understand that a prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by the providers and staff of Athens Geriatrics & Internal Medicine, P.C. and may include past prescriptions from several years ago.

MY SIGNATURE CERTIFIES THAT I HAVE READ, UNDERSTOOD, AND AUTHORIZE THE ACCESS OF EXTERNAL PRESCRIPTION HISTORY.

Patient or Legal Guardian Signature _____

Print Name _____

Witness Signature _____

Date: _____

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Acknowledgement and Consent for Hepatitis B Virus and HIV Antibody Blood Test

I acknowledge that I have been informed by my physician that my blood will be tested in order to detect whether or not I have antibodies in my blood to the hepatitis B virus (HBV) and human immunodeficiency virus (HIV). HBV is the causative agent of Hepatitis B, and HIV is the probable causative agent of acquired immunodeficiency syndrome (AIDS).

I understand that the test is voluntary and that it is performed by drawing blood and using a substance to test it. I understand that I have the right to consent, or to refuse the test.

I acknowledge that I have been informed that the HIV test is new and that its accuracy and reliability are still uncertain because the test results may, in some cases, indicate that a person has antibodies to the virus when the person does not, giving a false positive. The test may also fail to detect that a person actually does have antibodies to the virus, giving a false negative. I also acknowledge that I have been informed that a positive blood test does not mean that I have or will develop AIDS.

I acknowledge that I have been informed that any questions I have regarding the nature of the blood test, its expected benefits, its risks, or alternate tests may be asked of by my physician before I consent to the blood test. I have had the opportunity to question my physician regarding this procedure and she has fully answered all of my questions.

I understand that the results of this blood test will only be released to the physician directly responsible for my care and treatment, and to the other persons only as required by law. I further understand that no additional release of the results will be made without my express written authorization.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of the results of the test I am about to receive. I hereby give my consent to the performance of a blood test to detect antibodies hepatitis B virus (HBV) and human immunodeficiency syndrome (HIV).

Please initial below.

_____ **Yes,** I consent to the tests.

_____ **No,** I am refusing the tests.

Patient or Legal Guardian Signature _____

Print Name _____

Witness Signature _____

Date: _____

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Notice of Privacy Practices – Confidentiality of Your Healthcare Information

This notice describes how your medical information may be used and disclosed as well as how you can access this information.

PLEASE REVIEW IT CAREFULLY AND SIGN THE UNDERSTANDING OF AGREEMENT ON THE PATIENT CONSENT OF PROTECTED HEALTH INFORMATION (PHI) PAGE.

This notice is required by law to tell you how Athens Geriatrics and Internal Medicine, P.C. (AGIM) protects the confidentiality of your healthcare information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's healthcare history, mental or physical condition, and treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or any other identification numbers, date of birth, date of treatment, treatment records, x-rays, and enrollment and claims records. AGIM receives, uses, and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

We must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may also request a copy of this notice anytime by contacting the address or phone number at the end of this notice. You should receive a copy of this notice at the time of enrollment as a patient at AGIM.

Permitted uses and disclosures of your PHI

We are permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to your protected health information, uses and/or disclosures for purposes of healthcare treatment, payment of claims, billing of premiums, and other healthcare operations. If your benefit plan is sponsored by your employer or another party, we may provide PHI to your employer or their sponsor for purposes of administering your benefits. We may disclose PHI to third parties that perform services for AGIM in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. You PHI may be disclosed to an affiliate that performs services for AGIM in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state laws.

We are also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for the purposes of health oversight by government agencies, judicial, administration, or other law enforcement purposes, information about decedents to coroners, medical examiners, and funeral directions, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veteran activities, for workers' compensation purposes, and for use in creating summary information that can no longer be traced to you. Additionally, with certain restrictions, we incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure but we attempt to keep incidental uses and/or disclosures to a minimum. We use administrative, technical, and physical safeguards to maintain the privacy of your PHI, and we must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose for the use and/or disclosure.

Examples of uses and disclosures of your PHI for treatment, payment, or healthcare operations such activity may include but are not limited to processing your claims, collecting enrollment information and premiums, reviewing the quality of healthcare you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers.

Additional examples include uses and/or disclosures of PHI in facilitating treatment, for payment, and for healthcare operations.

Disclosures without an authorization

We are required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U.S. Secretary of Health and Human Services to investigate or determine the compliance with law, and on other occasions when required by law. AGIM may disclose your PHI without prior authorization to the following:

- Court order
- Insurance company
- Order of a board commission, or administrative agency for purposes of adjudication pursuant to its lawful authority
- Subpoena in a civil action
- Investigative subpoena of a government board, commission, or agency
- Subpoena in an arbitration
- Law enforcement search warrant, or coroner's request during investigations

Disclosures Athens Geriatrics and Internal Medicine, P.C. makes with your authorization

You have the right to request an inspection of and obtain a copy of your PHI. You may access your PHI by contacting the appropriate AGIM office. You must include your name, address, telephone number, identification number, and the PHI you are requesting. AGIM may charge a reasonable fee for providing you with copies of your PHI. AGIM will only maintain that PHI that we obtain or utilize in providing your healthcare benefits.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the privacy office as noted below if you have questions about access to your PHI.

You have the right to request a restriction of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situation. You may not limit the uses and disclosures that we are legally required or allowed to make.

You have the right to request or receive confidential communications from us by alternative means or at a different address. We will agree to a reasonable request if you tell us that disclosure of your PHI could endanger you. You may be required to provide us with a statement of possible danger, a different address, or another method of contact or information as to how payment will be handled. Please contact the privacy office as noted below if you have questions about amending your PHI.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or healthcare operations or for

information we disclosed after we received a valid authorization from you (by signing this form, you will be giving us proper authorization). Additionally, we not need account for disclosures made to you, your family members or friends involved in your care, or for notification purposes. We do not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to December 2, 2007. Please contact the privacy office as noted below if you would like to receive an account of disclosures or if you have questions about this right.

You have the right to receive this via email. You have the right to get a copy of this notice by email, even if you have agreed to receive notice via email. You also have the right to request a paper copy of this notice.

You may complain to us if you believe that AGIM has violated your privacy rights. You may file a complaint with us by notifying the privacy office as noted below. We will not retaliate against you for filing a complaint. You may contact the privacy department at the address, telephone number, and email below for further information about any information contained in this notice.

You understand that I am providing healthcare services to you, and this practice will send any medical records requested by specialists (physicians we refer you to), hospitals, lab companies, pharmacies, and insurance companies in order to benefit you healthcare. I appreciate the opportunity to participate in your healthcare.

Athens Geriatrics and Internal Medicine

Patient Health Questionaire-9 (PHQ-9)

Patient's Details:

Today's Date:

Name of Assessor:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several day	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
3. Trouble falling asleep, or sleeping too much?	0	1	2	3
4. Feeling tired of having little energy?	0	1	2	3
5. Poor appetite or overeating?	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
8. Moving or speaking so slowly that other people could've noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way?	0	1	2	3
FOR OFFICE CODING:	0			

= TOTAL SCORE: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

NEW PATIENT ADULT ASSESSMENT FORM

Patient Name: _____ **DOB:** _____ **Exam Date:** _____

COGNITION: Intact Impaired 6CIT score (if applicable) _____

SENSORY: Hearing: Good Fair Poor ? Impaired: Deaf Hearing Device

Vision: Good Fair Poor? Impaired: Glasses Contacts Cataracts

Glaucoma Macular Degeneration DM Retinopathy Blind

Speech: Intact Impaired Stutter Non-verbal Language barrier

ADL's: Completely Independent: YES NO Has Caregiver: YES NO

Assistance: Hygiene Dressing Eating Meal prep Medications Finance

Housework Toileting / Incontinence Shopping Transport / Driving

GAIT: Independent: YES NO Normal Good Fair Falls in 12 months _____

Assistive Device: Cane Walker Wheelchair Rollator Scooter

FUNCTION: Currently working: YES NO Currently exercises: YES NO

QUESTIONAIRE: Depression: Y N PHQ-9 Score _____ Anxiety: Y N Sheehans' _____

PAIN: Location _____ Rating: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

SCREENS: Eye Exam _____. Mammogram (35-40 yrs.) Y N. Year____ Location _____.

Colonoscopy: Y N. Year ____ . Location: _____. Dexa: Year _____. Foot Exam: _____.

VACCINES: Influenza: Year____. Pneumovax 23: Year____. Prevnar 13: Year ___. Zostavax

DNR STATUS: Advanced Directive Y N. Living Will Y N. POA: Name: _____

MEDICATIONS REVIEWED: YES NO

PROVIDER SIGNATURE: _____