



# DeKalb Medical Physicians Group

PATIENT INFORMATION - PLEASE PRINT				
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		APT#	CITY, STATE ZIP	
HOME PHONE	CELL PHONE	PREFERRED PHONE	EMAIL ADDRESS	
EMERGENCY CONTACT NAME		TELEPHONE NUMBER	RELATIONSHIP TO PATIENT	
PRIMARY EMPLOYER		WORK PHONE		
ADDRESS		CITY, STATE ZIP		
RESPONSIBLE PARTY INFORMATION (If Different than above)				
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		CITY, STATE ZIP	SECONDARY /BILLING ADDRESS (If Applicable)	
HOME PHONE	CELL PHONE	PREFERRED PHONE	CITY, STATE ZIP	
EMPLOYER		RELATIONSHIP TO PATIENT		
PRIMARY INSURANCE				
NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT		
		\$		
CITY, STATE ZIP	PHONE	DEDUCTIBLE		
		\$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	
SECONDARY INSURANCE (If Applicable)				
NAME OF INSURANCE COMPANY		POLICY#		
NAME OF INSURED		GROUP#		
ADDRESS OF INSURANCE COMPANY		COPAY AMT		
		\$		
CITY, STATE ZIP	PHONE	DEDUCTIBLE		
		\$		
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE	

I authorize the release of any medical or other information necessary to process this claim, including information related to AIDS, Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE



## Patient Demographic Information

Name: \_\_\_\_\_ Date of Birth: \_\_ / \_\_ / \_\_\_\_ Date: \_\_ / \_\_ / \_\_\_\_

Please select only one answer in each of the categories below by placing a mark in the box provided.

### Gender

- Male
- Female
- Undifferentiated

### Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino

### Race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other Race

### Language(s)

Please indicate which language or languages you speak by placing a mark in the corresponding box.

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> Arabic        | <input type="checkbox"/> Bulgarian                 | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Central Khmer | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> English       | <input type="checkbox"/> French                    |                                     |
| <input type="checkbox"/> German        | <input type="checkbox"/> Haitian or Haitian Creole |                                     |
| <input type="checkbox"/> Hebrew        | <input type="checkbox"/> Hindi                     |                                     |
| <input type="checkbox"/> Italian       | <input type="checkbox"/> Japanese                  |                                     |
| <input type="checkbox"/> Korean        | <input type="checkbox"/> Polish                    |                                     |
| <input type="checkbox"/> Russian       | <input type="checkbox"/> Spanish                   |                                     |

**Patient Medical History Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Language(s) spoken: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Name of Primary Care physician: \_\_\_\_\_

**1. What is the purpose of today's visit?** \_\_\_\_\_

**2. Please list all current medications: (including prescription, over the counter, vitamins, herbs, supplements, etc.)**

Medication (name)	Dose (strength) mg, mcg	Frequency (How often you take med. Ex: 1 tab 2 times a day)	Medication (name)	Dose (strength) mg, mcg	Frequency (How often you take med Ex: 1 tab 2 times a day)

**Please Circle preferred pharmacy:**

Local pharmacy: \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address: \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address: \_\_\_\_\_

**3. Allergies: (Medications, X-ray Dyes, Other Substances):**

Name of Medicine:	Type of Reaction:	Name of Medicine:	Type of Reaction:

**4. Past Medical History:**

*Please check if you have had problems with or been diagnosed with any of the following:*

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Heart Valve Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis/Liver Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes/Sugar	<input type="checkbox"/> Myocardial Infarction/Heart attack
<input type="checkbox"/> Asthma	<input type="checkbox"/> Elevated Lipids/Cholesterol	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> GERD/Acid Reflux	<input type="checkbox"/> Renal/Kidney Disease or Stones
<input type="checkbox"/> Blood Clots/DVT/PE	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer:(Type) _____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke/ TIA
_____	<input type="checkbox"/> Other: _____	_____

**5. Past Surgical/Hospitalization:**

Please list any surgery or hospitalization which you have had and include the date(s): \_\_\_\_\_

**6. List other Providers you see?**

Provider \_\_\_\_\_ Reason \_\_\_\_\_  
Provider \_\_\_\_\_ Reason \_\_\_\_\_  
Provider \_\_\_\_\_ Reason \_\_\_\_\_  
Provider \_\_\_\_\_ Reason \_\_\_\_\_

**7. Preventive Screening History:**

Date of last physical? \_\_\_\_\_ Eye Exam? \_\_\_\_\_  
Colonoscopy? \_\_\_\_\_ Prostate exam? \_\_\_\_\_ Mammogram? \_\_\_\_\_ DEXA Scan/ Bone Density? \_\_\_\_\_

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

	Cancer (Type)	Heart Disease	Hypertension	Diabetes	Other
Mother					
Father					
Grandparents					
Brother(s)					
Sister(s)					

**9. Safety/Social History:**

Do you use tobacco? \_\_\_ Yes \_\_\_ No \_\_\_ Former Tobacco Type(s)? \_\_\_\_\_  
Packs/Units per day? \_\_\_\_\_ Number of years used? \_\_\_\_\_  
Do you drink alcohol? \_\_\_ Yes \_\_\_ No \_\_\_ Former If yes, how many drinks per week? \_\_\_\_\_  
Highest Level of Education Completed: \_\_\_\_\_ Marital Status \_\_\_\_\_  
Do you have any children? \_\_\_ Yes \_\_\_ No \_\_\_ # of sons \_\_\_ # of daughters  
What is your source of heat in your home? \_\_\_\_\_  
Do you have a smoke detector? \_\_\_ Yes \_\_\_ No Do you have a carbon monoxide detector? \_\_\_ Yes \_\_\_ No  
Do you wear a seatbelt? \_\_\_ Yes \_\_\_ No Have you had any falls in the last year? \_\_\_ Yes \_\_\_ No  
Do you use drugs (including Marijuana, Cocaine, etc.)? \_\_\_ Yes \_\_\_ No  
If yes, describe: \_\_\_\_\_  
Do you wish to be tested for AIDS? \_\_\_ 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  
If yes, is it out of the reach of children, locked and unloaded? \_\_\_ Yes \_\_\_ No  
Do you have a living will or Advanced Directive? \_\_\_ Yes \_\_\_ No

**10. Immunization:** Have you received any of the following:

Flu Date: \_\_\_\_\_ Shingles (Age 50 & over) Date: \_\_\_\_\_  
Pneumonia Date(s): \_\_\_\_\_  
Tetanus Date: \_\_\_\_\_ HPV ( Age 12-26) Date: \_\_\_\_\_

**11. Gynecologic/Obstetric History:**

Age onset of menstrual period: \_\_\_\_\_ Length of Menstrual period: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Number of Pregnancies: \_\_\_ Births \_\_\_ Full-term \_\_\_ Premature  
\_\_\_ C-Section \_\_\_ Miscarriages \_\_\_ Abortions  
Age at first pregnancy: \_\_\_\_\_ Are you pregnant at this time? \_\_\_ Yes \_\_\_ No  
Date of last Pap smear: \_\_\_\_\_ Have you ever had an abnormal pap smear? \_\_\_ Yes \_\_\_ No  
If yes, please describe the finding and when: \_\_\_\_\_

**12. Lifestyle:** Are you on any special diet? \_\_\_ Yes \_\_\_ No If yes, what type? \_\_\_\_\_  
Do you exercise? \_\_\_ Yes \_\_\_ No If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_



## 2018 Financial Policies

### Assignment of Benefits

I authorize the release of any medical or other information necessary to process this claim.  
I authorize payment of medical benefits to the physician or supplier for all services rendered.  
I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company.

### Financial Responsibility

Payment in full is expected at the time services are received. Insured patients are required to pay identified co-payment, deductible, and estimated co-insurance at time services are rendered. The amount is determined by the contractual fees with your insurance carrier.  
Accounts with balances over 90 days, may be turned over to an outside agency for collections, unless prior payment arrangements have been made with the business office. We will file your claim as a courtesy; it is your responsibility to provide us with current insurance at time of service and to follow up with your insurance company if claims are not paid within 60 days.

### Appointment Cancellation

We require 24 hour notification to cancel an appointment. Missed appointments or those cancelled with less than 24 hour notice, are considered 'no-show'. You may be charged a fee of \$30 for office visit, \$90 for preventive visits, and \$120-\$150 for a missed surgery. We make every effort to provide courtesy reminders prior to your appointment, but failure to receive this reminder does not excuse a missed appointment charge.

### Preventive Visits

Most insurance plans allow annual preventive exams. There can be frequency limitations based on patient age. Routine EKG and labs are also plan specific. You are encouraged to check with YOUR specific plan to know what is covered in a preventive visit. By receiving these services, it is ultimately your financial responsibility for any services not covered by your plan.  
An office visit charge will also be added to your preventive visit for management of chronic conditions or treatment plan of any problems addressed during the visit.

I authorize DeKalb Medical Physicians Group and its representatives, to contact me regarding my medical information, appointment reminders, as well as billing information by means of home phone, cell phone and/or email. I authorize DeKalb Medical to leave messages for me when I am unavailable. I will also be responsible for contacting this office should this information change.

**I have read and understand the above policies and agree to the terms.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Risk Assessment for Hereditary Cancer Syndromes

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

*Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins  
Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather*

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
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Y N Breast cancer before age 50			
Y N Ovarian cancer			
Y N Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y N Male breast cancer			
Y N Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y N Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y N Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
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Y N Uterine (endometrial) cancer before age 50			
Y N Colorectal cancer before age 50			
Y N Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(\*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
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Y N 10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			
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MELANOMA	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
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Y N Two or more melanomas in an individual or family			
Y N Melanoma and pancreatic cancer in an individual or family			
Y N Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

\_\_\_\_\_  
Patient's Signature Date

FOR OFFICE USE ONLY	
<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing: <input type="checkbox"/> HBOC <input type="checkbox"/> Lynch <input type="checkbox"/> Polyposis <input type="checkbox"/> Melanoma <input type="checkbox"/> Information given to patient to review <input type="checkbox"/> Follow-up appointment scheduled Date: _____	<input type="checkbox"/> Patient offered genetic testing: <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> <p style="text-align: center; margin-top: 5px;">Healthcare Professional's Signature Date</p>

\*For a better understanding of triple negative breast cancer, please ask your healthcare provider. Assessment criteria based on medical society guidelines. For these individuals society guidelines go to [www.myriadtests.com/patient\\_guidelines](http://www.myriadtests.com/patient_guidelines). Myriad, and the Myriad logo are either trademarks or registered trademarks of Myriad Genetics, Inc. in the United States and other jurisdictions. ©2011 MDRA/12-11 PS-1241 (01/17/2017)

## Surgery Patient Health Assessment

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

DOB: \_\_\_\_\_

### Patient Review of Symptoms Checklist

**Constitutional**

- Neg Pos
- Chills
  - Fatigue
  - Fever
  - Malaise
  - Night sweats
  - Weight gain
  - Weight loss
  - Other

**HEENT**

Head\Eyes\Ears\Nose\Throat

- Neg Pos
- Ear drainage
  - Ear pain
  - Eye discharge
  - Eye Pain
  - Hearing loss
  - Nasal drainage
  - Sinus pressure
  - Sore throat
  - Visual changes
  - Other

**Respiratory**

- Neg Pos
- Chronic cough
  - Cough
  - Know TB exposure
  - Shortness of breath
  - Wheezing
  - Other

**Cardiovascular**

- Neg Pos
- Chest pain
  - Claudication
  - Edema
  - Palpitations
  - Other

**Gastrointestinal**

- Neg Pos
- Abdominal pain
  - Blood in stools
  - Change in stools
  - Constipation
  - Diarrhea
  - Heartburn
  - Loss of appetite
  - Nausea
  - Vomiting
  - Other

**Genitourinary**

- Neg Pos
- Dysuria
  - Hematuria
  - Polyuria
  - Urinary frequency
  - Urinary incontinence
  - Urinary retention
  - Other

**Reproductive**

- Neg Pos
- Abnormal pap
  - Dysmenorrhea
  - Dyspareunia
  - Hot Flashes
  - Irregular menses
  - Vaginal Discharge
  - Other

**Integumentary**

- Neg Pos
- Breast discharge
  - Breast lump
  - Brittle hair
  - Brittle nails
  - Hair loss
  - Hirsutism
  - Hives
  - Pruritis
  - Mole changes
  - Rash
  - Skin lesion
  - Other

**Neurological**

- Neg Pos
- Dizziness
  - Extremity numbness
  - Extremity weakness
  - Gait disturbance
  - Headache
  - Memory loss
  - Seizures
  - Tremors
  - Other

**Psychiatric**

- Neg Pos
- Anxiety
  - Depression
  - Insomnia
  - Other

**Metabolic / Endocrine**

- Neg Pos
- Cold intolerance
  - Heat intolerance
  - Polydipsia
  - Polyphagia
  - Other

**Musculoskeletal**

- Neg Pos
- Back pain
  - Joint pain
  - Joint swelling
  - Muscle weakness
  - Neck pain
  - Other

**Hematologic/Lymphatic**

- Neg Pos
- Easy bleeding
  - Easy bruising
  - Lymphadenopathy
  - Other

**Immunologic**

- Neg Pos
- Contact allergy
  - Environmental allergies
  - Food allergies
  - Seasonal allergies

**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.
- (5) **Administration of Medications** whether orally, rectally, topically or through 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.
- (6) **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: \_\_\_\_\_

**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.



## 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 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 your 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**

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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                      \_\_\_\_\_ Radiology Reports                      \_\_\_\_\_ Immunization Records  
\_\_\_\_\_  
Progress Notes                      \_\_\_\_\_ EKG Results                      Other \_\_\_\_\_  
\_\_\_\_\_  
Laboratory Reports                      \_\_\_\_\_ Other Ancillary Reports                      \_\_\_\_\_

\_\_\_\_\_  
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 \_\_\_\_\_ Radiology Reports \_\_\_\_\_ Immunization Records \_\_\_\_\_  
Progress Notes \_\_\_\_\_ EKG Results \_\_\_\_\_ Other \_\_\_\_\_ ROI SPECIALIST  
Lab Reports \_\_\_\_\_ Other Ancillary Rpts \_\_\_\_\_  
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 complete 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 #: \_\_\_\_\_

May we leave messages on your home answering machine?      Yes      No

Work telephone #: \_\_\_\_\_

May we leave messages on your work voice mail?      Yes      No

Cell phone #: \_\_\_\_\_

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, parent, etc.)

Name: \_\_\_\_\_

Patient/parent/guardian signature: \_\_\_\_\_

Dated signed: \_\_\_\_\_