Dear Patient,

Let us take this opportunity to thank you for choosing Dalton Family Practice to provide your healthcare needs.

Please fill out the enclosed paperwork, including a list of all medications and copies of front and back of insurance cards.

You can return the forms back to us by any of the following ways:

Mail to:

Dalton Family Practice

1114 Professional Blvd, Dalton, GA 30720 or

Fax to:

706-226-6586 or

Email all forms to the two emails below:

khensley@daltonfamilypractice.com

clafferty@daltonfamilypractice.com

If you have any questions, we invite you to call us at 706-278-0138 and we will be happy to assist you.

Once again, thank you for your consideration.

Sincerely,

The Physicians and Staff at Dalton Family Practice

Dalton Family PRACTICE

Name:	Date of Birth: / /
Cell number: ( )	Email:
Ethnicity: Not Hispanic Hispanic	
Race: African American/Black American Indian Asian White Other	
Employer:	Work Phone: ( )
Employment Status: Full-time Part-time Retired Student Other	
Name of Emergency Contact:	
Relationship to Emergency Contact: Spouse Parent Child Other	
Emergency Contact Numbers:	Home: ( )
Cell: ( )	Work: ( )

Dalton Family PRACTICE

Date:

Patient Name: Last First Middle		
SS#	Age	Sex M F
Date of Birth / /	Marital Status S M W D	Race
Home ( )	Cell ( )	Work ( )
Address:		
City:	State:	ZIP:

Primary Insurance Coverage	PPO?
Policy Holder Name	Relation to Patient
If thru employer, employer's name	
Policy or contract number	Group Number
Secondary Insurance Coverage	PPO?
Policy Holder Name	Relation to Patient
If thru employer, employer's name	

Policy or contract number	Group Number
Third Insurance Coverage	PPO?
Policy Holder Name	Relation to Patient
If thru employer, employer's name	
Policy or contract number	Group Number
Were you referred by another physician?	If so, physician's name
If married, spouse's name	Spouse's employer
Spouse's SS#	Spouse's Date of Birth
Are you allergic to any medication? Y N	If so, what?
In case of emergency, please list number other than numbers above	

In case of hospitalization, please sign the authorization below.

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

PATIENT'S SIGNATURE IF CHILD, PARENTAL SIGNATURE

Dalton Family PRACTICE

How did you hear about Dalton Family Practice?	
Are any members of your family a patient here?	YES NO
If yes, list names and relationship to you.	
Please list your medical conditions:	
Last doctor that treated you and when?	
What is your reason for changing doctors or seeking a new physician?	
Do you understand and agree that any copays are due when treated and any balance due by you after your insurance is due in full with the first statement?	YES NO

SIGNATURE

DATE

Dear Patient,

We would like to explain our insurance and pay policy.

We will file with your carrier. All co-pays, deductibles, and patient portions will be due at the time of service.

If we participate with your plan, we will file with your carrier. All co-pays, deductibles, and patient portions will be due at the time of service.

If your account is placed with a collection agency for nonpayment, you will be responsible for any collection fees in addition to the balance being placed for collection.

If you have questions, please ask the receptionist.

PATIENT'S SIGNATURE IF CHILD, RESPONSIBLE PARTY

MEDICAL HISTORY		
Are you allergic to any food or drugs? If so, list		
Are you now taking any prescribed medicines? If yes, list medications and doctor's name who prescribed medication		
For what condition are you taking these medicines?		
Do you or your family have, or ever had arthritis, diabetes, cancer, TB, high blood pressure, heart trouble, or epilepsy?	YES	NO
If yes, please list:		
Do you smoke? YES NO	If yes, I smoke	packs per day
Do you drink? YES NO	If yes, I drink	drinks per week

List any time you have ever been hospitalized in your life			
Date	Hospital	Doctor's Name	Reason for hospitalization

PATIENT'S SIGNATURE
IF CHILD, PARENT'S SIGNATURE

DATE

Dalton Family PRACTICE

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, there will be a revised copy available in our waiting room.

By signing below, you acknowledge that you have received a copy of our notice of privacy practices on the date indicated below.

_____

Patient Name

_____

Patient/Responsible Party Signature

_____

Date

Dalton Family
PRACTICE

Patient Privacy Notice

Dalton Family Practice, P.C.

1114 Professional Boulevard
Dalton, Georgia 30720
(706) 278-0138
FAX (706) 278-0347

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Jennifer Duckett the Privacy Officer or designee.

WHO WILL FOLLOW THIS NOTICE.

This notice describes our practice's procedures and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments and units of our practice.
- Any members of a volunteer group we allow to help you while you are in our practice.
- All employees, staff and other practice personnel.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION.

We understand that information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. We need these records to provide you with quality care to comply with certain legal requirements. This notice applies to all of the records of your care generated by our practice doctors and/or personnel working for the practice.

This notice will tell you the ways in which we may use and disclose medical information about you. We also describe your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose will fall within one of the categories.

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care or you. For instance, we may need to share information about your condition with another doctor if you have complications and need a specialist. Our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions and lab work.

For Payment. We may use health information about you so that the treatment and services you receive at our practice may be billed, and that payment may be collected from you, an insurance company or another third party. For example, we may need to give your health plan information about services that you received at our practice so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for the practice's health care operations. These uses and disclosures are necessary to run our practice and to make sure that all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services our practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, and technicians, medical students, residents, and other practice personnel for review and training purposes. We may also disclose your information, in conducting and arranging other business activities of the practice. We may disclose information as part of a sale, transfer, merger, or consolidation of our practice to another entity covered by the Privacy Rule. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from the set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may disclose information, if necessary, to contact you to remind you about appointments.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information about you to tell you of health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be informed about your condition and location.

As Required By Law. We will disclose information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety.
We may use and disclose medical information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

SPECIAL SITUATIONS

Research. We may also do certain kinds of research using your records, but only if a legally authorized review board gives us permission to use your information provided that the researcher says he/she will use safeguards to protect your information.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose information to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

Workers' Compensation. If applicable, we may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report deaths;
- to report reactions to medications or problems;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required by law.

Health and Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with applicable civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovers request, or other lawful process by someone else involved in the dispute, but only if we receive satisfactory assurances that the party seeking the information has made efforts to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena (after we attempt to notify you), a warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under the circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our offices; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Jennnifer Duckett, Privacy Officer. All complaints must be submitted in writing.

You will not be penalized in any way for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

We may deny your request for any amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment ;
- Is not part of the medical information kept by or for our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer or designee. Your request must state a time period which may not start more than six years in the past and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation purposes. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of our practice to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records in certain cases.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer or designee. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer or designee. In addition, you must provide a reason that supports your request.

Dalton Family PRACTICE

FAMILY HEALTH INFORMATION ACCESS FORM

_____
Date

_____
Patient Name ID#

I, _____, authorize Dalton Family Practice to release any of my individual identifiable health information to:

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

I understand, if the party/parties authorized to receive this information are not a health plan or a health care provider, the released information may be redisclosed and may no longer be protected by federal privacy regulations.

I understand this authorization will remain in effect until I revoke it in writing to Dalton Family Practice, 1114 Professional Blvd, Dalton, GA 30720. Attn: Privacy Officer.

_____
Signature of Patient or Patient's Legal Representative