Intown Primary Care

2215 Cheshire Bridge Road Unit A Atlanta GA 30360

Phone: 404-541-0944 Fax: 855-364-4949

Authorization to Release Medical Information

Release To:

INTOWN PRIMARY CARE
2215 CHESHIRE BRIDGE RD
UNIT A
ATLANTA GA 30324

Release From:

____

____

____

____

You are hereby authorized to release a copy of my medical records to include any record that may contain information regarding psychiatric treatment, drug/alcohol usage and/or treatment, and HIV/AIDS information.

Name: ______________________ **Date of Birth:** ______________

Signature: ______________________ **Date:** ______________

Medical Information Release Form

(HIPPA Release Form)

Name: ______________________________ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be release to:

[ ] Spouse______________________________

[ ] Child(ren)______________________________

[ ] Other______________________________

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell number ______________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other ______________________________

The best time to reach me is (day) ________________ between (time) ______________

Signed:______________________________ Date: ____/____/____

Witness:______________________________ Date: ____/____/____

Pharmacy Information

Pharmacy Name:____

Phone#:____

Address: ____

____

Please update pharmacy information before leaving the office to make sure prescriptions are sent to the appropriate pharmacy within a timely manner.

____

Print Patient's Name

____

Patient's Signature

____

Date

****Without appropriate, up to date information, prescriptions can be delayed, which is outside of the control of the office.**

Gynecological/Obstetrical History

Age of onset of periods_______ Length of periods_________ Frequency of periods_________

Pregnancies________ Births _______ Miscarriages________ Abortions ________

Have you had an abnormal PAP? YES NO Date of last PAP_________________________________

Findings: ____

Have you had an abnormal Mammogram? YES NO Date of last Mammogram? __________

Findings: ____

Do you perform self-breast exams? YES NO How often? _____________________________

Immunization History

Have you received any of the following immunizations?

Hepatitis A	Yes	No	Don't know	Date_______________
Hepatitis B	Yes	No	Don't know	Date_______________
Influenza	Yes	No	Don't know	Date_______________
Measles/Mumps/Rubella	Yes	No	Don't know	Date_______________
Pneumovax	Yes	No	Don't know	Date_______________
Prevnar	Yes	No	Don't know	Date_______________
Polio	Yes	No	Don't know	Date_______________
Gardasil	Yes	No	Don't know	Date_______________
Tetanus/Diptheria	Yes	No	Don't know	Date_______________

Family History

Mother: ____ Living _______Deceased – cause ________________________________ age __________

Father: _____Living _______Deceased – cause ________________________________ age __________

Please check if your parents or siblings have had any of following:

_______Cancer _______Heart Disease ________ Lung Disease

_______Depression _______ High Cholesterol ________ Stroke

_______Diabetes _______ Hypertension

Other____

Health Prevention/Promotion

Do you smoke? YES NO Packs per day _______________

Have you ever smoked in the past? YES NO Packs per day___________ Quit date ____________________

Do you drink alcohol? YES NO Amount per week_____________

Do you drink caffeine? YES NO Cups per day_________________

Do you do recreational drugs? YES NO Marijuana_____ Cocaine_____ Ecstasy _____ GHB_____

Crystal Meth______ Ketamine_______ Other____

Do you wear glasses/contacts? YES NO

Do you wear a hearing aid? YES NO

Do you wear dentures? YES NO

Do you have a Living Will? YES NO (please provide office with a copy if possibly)

Appointment Cancellation Policy:

Intown Primary Care is committed to providing all of our patient with exceptional care. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from being seen.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $75 fee for Preventive/Physical visits and a $50 fee for Non Preventive/Physical visits; this will not be covered by your insurance company.

If a patient is 15 minutes past their scheduled appointment time we will have to reschedule the appointment.

_______________________________ ______/______/______

Print Name DOB

_______________________________ ______/______/______

Patient/Guardian Signature Date

Intown Primary Care, P.C.
Patient Registration
(Please Print)

Date_____/______/_______

Name____
First Middle Last

Date of Birth________/________/_______ Social Security Number______________________

Sex: Female________ Male_________ Other______

Ethnicity: Hispanic or Latino________ Not Hispanic or Latino_______

Race: American Indian/Alaska Native_______ Asian_____ Black or African American_______
Native Hawaiian or Other Pacific Islander_______ White______

Preferred Language: English______ Other_____ please specify ______________

Address____

____
City State Zip

____ Home Phone________________________________ Work Phone________________________

____Cell Phone____________________________________ *please place a check by your preferred method of contact

____Email Address___________________________________

Marital Status: Single_____ Married______ Partnered_____ Divorced_____ Widowed_____

Sexual Orientation: Heterosexual_____ Homosexual_______ Bisexual_____ Other_______

Employer____

Occupation____

Significant Other____

Emergency Contact____
Name Relationship

Emergency Contact____

Address

____

City State Zip Phone Number

Insurance Information

Primary Carrier____

Policy Number____

Effective Date_______/_______/_______ Copay Amount____________________

Carrier Address____

____

City State Zip

Phone Number____

Secondary Carrier____

Policy Number____

Effective Date_______/_______/_______ Copay Amount____________________

Carrier Address____

____

City State Zip

Phone Number____

I authorize the release of any medical or other information necessary to process this claim, including information related to HIV/AIDS, mental health, and substance abuse. I also request payment of government benefits whether to myself or to the party who accepts assignment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional service rendered.

________________________________ ____________________

Responsible Party Signature Date

Intown Primary Care, P.C.
Patient Registration
(Please Print)

Date____

Name____
First Middle Last

Female_______ Male_______ Other_______ Date of Birth____________________ Current Age___________

Occupation____

Marital Status: Single_______ Married________ Partnered_______ Divorced_______ Widowed__________

Please list all know drug allergies:____

Past Medical History

Please check all past or current medicals conditions:

_____Allergies
_____Anemia
_____Anxiety
_____Arthritis
_____DVT
_____Asthma
_____Alcohol Abuse
_____Breast Cancer
_____Colon Cancer
_____Diabetes Type 1 / 2
_____Depression
_____Bipolar Disorder
_____Drug Abuse
_____Eating Disorder
_____Enlarged Prostate

____Kidney Stones
____Genital Warts
____Gout
____Coronary Artery Disease
____COPD
____Heartburn/GERD
____Hepatitis A/B/C (circle)
____Herpes oral/genital (circle)
____High Cholesterol
____HIV/AIDS
____Hypertension
____Seizures
____Hyperthyroid
____Hypothyroid
____Insomnia

____Chronic sinusitis
____Low Back Pain
____Hemorrhoids
____Obesity
____Erectile Dysfunction
____Valvular Disorders
____Prostate Cancer
____Pneumonia
____Irritable Bowel Syndrome
____Fibromyalgia
____Syphillis
____Sleep Apnea
____Stroke
____Tuberculosis
____Headache

Other:____

Please list all past
Surgeries/hospitalizations:____
____

Please list current
Medicines/supplements:____
____

Intown Primary Care

Acknowledgement of Receipt of Notice of Privacy Practices

____

Signature

____

Date

Personal & Family Cancer History

Name: ______________________________ Date of Birth: __________ Age: _____

Provider: __________________________ Date: ____________

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides.** Specify which relatives were affected with cancer and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

Circle		CANCER HISTORY	You	Siblings/ Children	List Relatives on Mother's Side	List Relatives on Father's Side	Age of Diagnosis
No	Yes	BREAST CANCER at age **49 or younger**					
No	Yes	3 or more BREAST CANCERS on one side of family, **any** age					
No	Yes	OVARIAN or PANCREATIC CANCER at **any** age					
No	Yes	ENDOMETRIAL CANCER at age **49 or younger**					
No	Yes	COLON CANCER at age **49 or younger**					
No	Yes	3 or more COLON or ENDOMETRIAL on one side of family, **any age**					

Patient Signature ______________________________________

Office Use Only - If there is one correct Yes, patient is a candidate for testing

Appropriate for testing? Yes/No **Accepted Testing?** Yes/No **Provider Initials** ____________

Patient Portal Registration Form

We know you're busy. That's why Intown Primary Care is offering a way for you to manage your healthcare online.

The IPC Patient Portal is a convenient, time saving and easy to use online system that allows you to:

- Communicate with your doctor's office
- Request prescription refill
- Review lab results
- Request appointments
- Review your personal health information

The IPC Patient Portal, sponsored by Azalea Health, is encrypted, password protected and HIPPA compliant. Therefore, your health data remains secure.

Sign up and make managing your healthcare a little easier. To get started, simply check the accept box and complete the info below.

☐

I Accept

____

Print Patient's Name

____

Patient's Date of Birth

____

Patient's E-mail Address

____

Patient's Signature

*If you decline, please check the box below and sign. Also, please note that by declining there may be a slight delay in receiving test results via phone call.

☐

I Decline	____________________	____________________
	Print Patient's Name	Patient's Signature

Notice of Privacy Practices and Understanding the Use of Your Health Record

Each time you visit Intown Primary Care, a record of your visit is made. Generally, this includes your symptoms, the examination findings, test results, diagnosis (es) and treatment or plan of care. This information is referred to by Intown Primary Care as your medical record and serves as:

- The basis for planning your care, treatment and follow-up
- Communication among the healthcare professionals who contribute to your care
- A legal document detailing the care you received
- A means by which you or a third-party payor may verify that the services billed were provided
- A tool to educate Intown Primary Care providers
- A potential resource for medical research data
- A source of information for public health officials chosen to improve the health of the nation
- A resource for marketing and planning by Intown Primary Care
- A tool for Intown Primary Care to access and continuously improve the care rendered

Understanding your health record and how its information may be used to assist you:

- Ensure its accuracy
- Better understanding who, what, when, where and why others may assess your record
- Help in making informed decisions when authorizing disclosures to others

Your Heath Information Rights:

Your health record is the physical property of Intown Primary Care, however the information in it belongs to you. You have the right to:

- Request a restriction on certain uses or disclosures of your information
- Obtain a paper copy of this notice of information upon request
- Request to view and have a copy of your medical records (fees may be applied)
- Request an amendment of your medical record
- Request communications of your records by alternative means or at alternative sites
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibility:

Intown Primary Care is required by law to:

- Maintain the privacy of your health Information
- Provide you with a notice as to our legal duties and privacy practices with respect to the information we collect and maintain about you
- Abide by the term within this notice
- Notify you of any restrictions concerning certain requests of uses
- Accommodate reasonable requests for communication of your medical record to be alternative means and/or alternative locations.

*We reserve the right to change, modify and make new provisions effective for all protected health information we maintain. We will not use or disclose your protected health information without your authorization, except as described in this notice.

***For more information or to report a problem, you may contact the practice administrator, Marion Johnson at 404-541-0944.**