

PATIENT INFORMATION RECORD

Name _____ SS # _____ PHONE (AC _____) _____

Address (Street) _____ (City) _____ (State) _____ Zip Code _____

MARITAL STATUS: S - M - W - D - SEP		DATE OF BIRTH:	AGE:	SEX:	RACE:
SPOUSE'S NAME:			PARENT / GUARDIAN NAME:		
ALLERGIES:			EMERGENCY CONTACT - (Not Living With You) NAME AND PHONE NO.:		
EMPLOYMENT INFORMATION					
PATIENT	EMPLOYER NAME:				
EMPLOYER ADDRESS:			BUSINESS PHONE:	MOBILE PHONE:	
GUARANTOR	IF OTHER THAN PATIENT	GUARANTOR NAME:		RELATIONSHIP TO PATIENT:	
SS#		EMPLOYER NAME			
EMPLOYER ADDRESS:			BUSINESS PHONE:		
MEDICAL INFORMATION					
CHIEF COMPLAINT:					IS THIS THE RESULT OF AN INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATE OF INJURY:		TYPE OF INJURY: <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> SPORT <input type="checkbox"/> OTHER			
HOW DID YOU HURT YOURSELF?			IF NOT AN INJURY, BUT AN ILLNESS, HOW LONG HAS PROBLEM BEEN GOING ON?		
HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS PROBLEM?			IF SO, PLEASE GIVE OTHER DOCTOR'S NAME, ADDRESS AND PHONE NO.:		
DID YOU GO TO AN EMERGENCY ROOM FOR THIS PROBLEM?		IF SO, WHICH ONE?		WHEN?	
WERE X-RAYS TAKEN? <input type="checkbox"/> Yes <input type="checkbox"/> No	ARE YOU SEEKING A SECOND OPINION? <input type="checkbox"/> Yes <input type="checkbox"/> No		FOR X-RAY PURPOSES, ARE YOU PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No		
WERE YOU REFERRED TO OUR OFFICE FOR THIS PROBLEM?	IF YES, BY WHOM?	<input type="checkbox"/> ANOTHER DOCTOR	<input type="checkbox"/> PATIENT	<input type="checkbox"/> FRIEND	<input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> OTHER
IF BY ANOTHER DOCTOR, PLEASE LIST DOCTOR'S FULL NAME, ADDRESS AND PHONE NUMBER:					
INSURANCE INFORMATION					
#1	NAME OF INSURANCE COMPANY:				
POLICY NUMBER:	GROUP NUMBER:		EFFECTIVE DATE OF POLICY:		
INSURED'S NAME:	INSURED'S SS#:		INSURED'S BIRTHDATE:		
PATIENT'S RELATIONSHIP TO INSURED:					
#2	NAME OF INSURANCE COMPANY:				
POLICY NUMBER:	GROUP NUMBER:		EFFECTIVE DATE OF POLICY:		
INSURED'S NAME:	INSURED'S SS#:		INSURED'S BIRTHDATE:		
PATIENT'S RELATIONSHIP TO INSURED:					
WORKER'S COMPENSATION INFORMATION					
DATE OF INJURY	EMPLOYER NAME		EMPLOYER PHONE		
EMPLOYER ADDRESS -	STREET & NO.	CITY	STATE	ZIP CODE	CONTACT PERSON

CONSENT FOR TREATMENT

I authorize The Hughston Clinic, P.C. to perform treatment deemed by the physician in exercise of professional judgement to be of appropriate kind and method on me / my dependent. I hereby authorize The Hughston Clinic, P.C. to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges.

X SIGNED _____ DATE _____

INSURANCE ASSIGNMENT

I hereby assign to and authorize payment to The Hughston Clinic, P.C. of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, workmen's compensation, and / or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including attorney's fee and waive my exemption under the constitution and laws of the states of Georgia and Alabama.

X SIGNED _____ DATE _____

CONSENT TO TREAT WITH ASSOCIATE PHYSICIAN AND/OR PHYSICIAN ASSISTANT

By my signature below I acknowledge that I have been informed that The Hughston Clinic, P.C. and/or my Physician may utilize an Associate Physician and/or a Physician Assistant for medical services rendered. I have further been informed that as a courtesy, my insurance will be billed for these services and any balance will be my responsibility.

X SIGNED _____ DATE _____



MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____ Chart# _____

Date of birth _____ Age _____ Sex _____ Height _____ Weight _____

Race _____ (For office use only: BP _____ Pulse _____)

Who referred you for this visit; if not referred, please indicate _____

Who is your Primary Care Physician? _____

Past Medical History

Do you have, or have you had, any of the following: (PLEASE CIRCLE)

Diabetes High blood pressure Heart condition Seizure Sleep apnea Ulcer Cancer Blood or bleeding disorder
Phlebitis or blood clots Stroke Asthma Emphysema Complication of anesthesia Kidney stone

List other medical conditions and/or illnesses not mentioned above _____

List reasons for hospitalizations and/or surgeries with dates and any complications _____

List any significant injuries you have sustained _____

List current medications _____

List any Drug Allergies _____ / Latex Allergy? Yes or No

Family History (if deceased, please provide age and cause)

Age(s) and overall health of parents _____

Age(s) and overall health of sibling(s) _____

List any significant family health problems _____

Social History

Marital status _____ Education (Years/Degrees) _____

Alcohol use (type/amount) _____ Tobacco use (amount/years used) _____

Employer _____ Occupation _____

Review of Systems (Circle positive symptoms and describe and/or add others, if needed.)

Constitutional: Fever, weight gain/loss, loss of appetite

Urologic: Pain when urinating, hesitancy, bleeding, incontinence

Psychiatric: Depression, anxiety, hallucinations, sleep disturbances

Eyes: Double vision, blurring, difficulty seeing

Skin: Rashes, lesions that do not heal, changes in moles

Endocrine: Excessive thirst, excessive urination, heat/cold intolerance

ENT: Deafness, sinusitis, hoarseness, vertigo

Gynecologic: Breast masses, pain, discharge, problems
Date of last gynecologic check-up

Blood and Lymph: Anemia, bleeding tendencies, swollen nodes

Cardiovascular: Chest pain, palpitations, irregular/rapid heartbeat, murmur

Date of last pap smear

Allergic and Immunologic: Hives, eczema, itching

Respiratory: Shortness of breath, wheezing, spitting blood, chronic cough

Neurologic: Seizures, loss of balance/coordination, paralysis, weakness, loss of memory

Musculoskeletal: Stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arm/leg

Digestive: Abdominal pain, constipation, diarrhea, bleeding

Other: _____

Patient Signature _____

Date _____

Physician Signature _____

Date _____



HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully.

Hughston Clinic is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Hughston Clinic is required by law to abide by the terms of this Notice.

How your medical information will be used and disclosed:

We will use your medical information as part of rendering patient care. For example, the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive may use your medical information.

We may also use and/or disclose your information in accordance with federal and state law without your consent for the following purposes:

- **Appointment Reminders** - May contact you to provide appointment reminders
- **Treatment Information** - Other alternative treatments or health-related services that may be of interest to you
- **Law Enforcement** - May disclose your information as required during an investigation
- **Legal Proceedings** - May disclose your information in the course of certain judicial or administrative proceedings
- **Public Safety** - May disclose your information to prevent or lessen a serious threat to the health or safety of the public
- **Military Activity and National Security** - May disclose information to military command for their military records or other federal officials conducting national security and intelligence activities for protective services for the President
- **Worker's Compensation** - May disclose information as authorized for worker's compensation or similar programs
- **Inmates** - May disclose information to the correctional facility or law enforcement official for your proper care
- **Abuse or Neglect** - May disclose information when it concerns abuse, neglect or violence in accordance with federal or state law
- **Coroner, Medical Examiner, or Funeral Director** - May disclose information for identification of a body or determine cause of death
- **Food and Drug Administration** - May disclose information to report adverse events, product recalls, to make repairs or replacements
- **Research** - May disclose information for certain research purposes if an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your information (GA Code Ann. § 31-7-6(b))
- **Disclosure to Department of Health and Human Services** - May disclose information for public health purposes to help control disease, injury, or disability, also to a person who may have been exposed to a communicable disease or at risk of contacting or spreading a disease or condition
- **Others Involved in Your Healthcare** - May disclose information to a family member, other relatives, close personal friends or other representative you authorize when medical information is directly relevant to that person's involvement in your care
- **Health Oversight Activities** - May disclose information for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee health care systems, government benefit programs, and other government regulatory programs and civil rights law.
- **Disaster Relief** - May disclose information to a public entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts
- **Facility Directory** - Unless you object, we will use and disclose in our facility directory your name, and the location at which you are receiving care. This information will be disclosed only when someone calls and asks for you by name
- **Business Associates** - May disclose information to a business associate that we have a contract with to provide services on our behalf. We require our business associates to appropriately safeguard the health information of our patients

AUTHORIZATIONS:

We will not use or disclose your medical information for any purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Your Personal Provider (Physician)
Hughston Clinic
6262 Veteran's Parkway
Columbus, GA 31908
(706)324-6661/1-800-331-2910



HIPAA NOTICE OF PRIVACY PRACTICES

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

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this Notice.
7. The right to file a complaint if you feel your privacy has been violated.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of The Hughston Clinic's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person named as the Privacy Officer. I further understand that The Hughston Clinic will offer me updates to this **NOTICE OF PRIVACY PRACTICES**, should it be amended, modified or changed in any way.

Patient or Representative Name (Please Print)

Patient or Representative Signature

Date

Patient refused to sign

Patient was unable to sign because-

Documented by _____



Affix Patient Label

AUTHORIZED PATIENT NOTIFICATION LIST
(Required of HIPAA) Health Insurance Portability and Accountability

I authorize all Hughston Clinic Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my orthopedic care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

_____	_____
_____	_____
_____	_____

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

PATIENT/OTHER PERSON AUTHORIZED TO SIGN

DATE

RELATION TO ABOVE SIGNATURE

DATE

WITNESS SIGNATURE

DATE



FINANCIAL POLICY

Thank you for choosing The Hughston Clinic, PC as your Orthopedic specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual and customary” charge. As your medical provider, we will only supply factual information to facilitate claim processing.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments and in some cases coinsurance, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

_____ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance may be due in full from you. If any payment is made directly to you for services billed by The Hughston Clinic, you recognize an obligation to promptly remit payment to The Hughston Clinic, PC.

_____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by The Hughston Clinic, PC, I will be responsible for all costs of collecting monies owed, including collection agency fees.

_____ 5. The above does not apply for those patients that are considered Workers’ Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.

____6. Our practice utilizes the services of Assistant Surgeons/Physician Assistants for medical services including surgical procedures. As with the other professional services we will bill your insurance for these services; however, should your insurance not cover the charges you may be held ultimately responsible.

____7. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore fees are your responsibility for payment. Hughston Clinic fees related to completion of these documents are expected to be paid upon presentation of forms for completion.

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. Our financial counselor is available to assist you or answer any questions you may have.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____

Signature of Patient or Responsible Party

Date

Relationship if other than the patient