Welcome!

Thank you for choosing TheraMed Health, LLC, to become a member of your Health Care Team. During your firs t visit, you will meet our staff, complete a few brief forms and, of course, meet your health care provider.

As family physicians, we will try to solve your current medical problem and detect or prevent other health problems. We hope to make the first visit not just an opportunity to deal with any medical concerns you may have but also a time to get acquainted with you.

Attached, you will find our new patient information packet. Please take the time to review and complete the information prior to your initial visit. In addition, we will need **copies of a government-issued picture identification card and the front and back of all current/active health insurance cards *(required)***. We are unable to initiate services without a completed packet, copies of all insurance cards, and, if applicable, a copy of the Power of Attorney. Please help us prevent a delay in care by having all the necessary paperwork completed prior to the first date of service.

Should you need assistance with completing the packet, please let one of our providers know during your visit.

Please fax the completed packet along with attachments to 888.857.4685. We will initiate services upon receipt of all required documentation and signed consent.

After the examination, your health care provider will suggest a treatment plan and future visits, if necessary. We hope that after your visit, you will feel confident that you've made a wise decision by choosing our practice. If you have any questions or concerns, please feel free to contact our office at 404.857.9575

Thank you

Date_____

Community Name _____ ***Room #*** _____

Pharmacy _____

o Assisted Living (AL)
o Memory Care (MC)
o Independent Living (IL)

Patient General Information

Full Name: _____ _____ _____
Last First M.I.

SSN: _____D.O. B: _____/_____ /_____ Sex: OMale OFemale

*Email Address: _____

Street Address _____Apt/Unit #_____

City _____ State _____ Zip Code_____

Home: _____ Cell: _____ Work: _____

Marital Status: OSingle OMarried ODivorced OWidowed OPartner OLegally Separated

Name of Spouse or Partner: _____

Additional Demographical

Race: o Asian o Black o Hispanic o White o Other, please specify: _____

Ethnicity: o Hispanic o Non-Hispanic o Other, please specify: _____

Language: o English o Spanish o Other, please specify: _____

Primary Contact

Please provide the names of individuals with whom TheraMed Health, LLC may share your medical and account information. This may include family members, caregivers, or legal representatives. If applicable, please include a copy of the Power of Attorney documentation with this packet

Full Name: _____ Full Name: _____

Email: _____ Email: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

Is this person Medical POA: o Yes o No Is this person Medical POA: o Yes o No

New Patient Medication Form

Full Name_____ DOB: _____

Please list all the medications you are currently taking. If you need more space, you may continue on the back of this sheet or attach a current medication list to this packet.

Name of Medication	MG/DOSE	How Often Taken

Do you have any Allergies? O YES O NO If YES, please list all allergies below:

_____

_____

Circle any you may currently have or have had in the past (leave blank if none):

Anxiety/ Depression	Congestive Heart Failure	Hearing Loss	Kidney Disease
A-Fib	COPD	Heart Disease	Mental Illness
Arthritis	Dementia	Hepatitis (B, C)	Scoliosis
Asthma	Diabetes	High Cholesterol	Skin Disease
Cancer	Drug/Alcohol Dependency	Hypertension	Stroke

Other: _____

_____

Height: _____ft _____ in **Weight: _____ lbs.**

Full Name_____ DOB:_____

Specialist:

Specialist Name: _____ For: _____

Specialist Name: _____ For: _____

Specialist Name: _____ For: _____

Surgical History:

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Social History:

Tobacco use? O YES O NO Cigarettes or Cigars? Qty/day: _____

Alcohol Use? O YES O NO Wine, liquor, beer? Approx. amount/week: _____

Caffeine use? O YES O NO Coffee, tea, soda? Cups/day: _____

Rate the following on a scale of 1 to 10 (1 being the lowest/least, 10 being the highest/best):

Stress:	1	2	3	4	5	6	7	8	9	10
Energy:	1	2	3	4	5	6	7	8	9	10
Mood:	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10

Insurance Information:

Primary Insurance
Insurance Name:
Policy or ID Number:
Group Number:
Main Policy Holder:
Relationship with Patient:

CONSENTS

Patients Name: _____ **DOB:** _____

CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to receive medical and mental/behavioral health evaluation and treatment by TheraMed Health, LLC. I authorize attending physicians, nurse practitioners, mental health professionals, and other qualified staff to administer treatments, examinations, medications, and laboratory tests as deemed necessary for my care. This consent is valid until I choose to revoke it in writing. I give consent to have TheraMed Health, LLC, bill my insurance company and to release all information necessary to secure payment. I understand that I am responsible for all charges not paid by insurance.

Initials: _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I, the undersigned, acknowledge that I have received and reviewed a copy of TheraMed Health, LLC's "Notice of Privacy Practices" on the date noted below. I confirm that I have discussed this document, have had the opportunity to ask questions, and have received any needed clarification. Additionally, I consent to allow TheraMed Health, LLC, to leave relevant medical information in the manner specified and with the individuals designated as primary contacts on page 2 of this document.

Initials: _____

MEDICARE PART B BILLING AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. When we accept the assignment of insurance benefits for payment of your bill, we are, in effect, acting as the insurance company's agent or provider. It is also important for you to understand that when you sign authorization to release medical information to your insurance company, we may be asked to discuss, in a verbal or written report, information related to your case with a case manager or other insurance representative. This contract may be necessary to facilitate continuing payment for medical services rendered. I understand and have discussed the above conditions. I am willing to accept treatment under these conditions and authorize TheraMed Health, LLC, to release clinical information necessary to warrant the need of services rendered. I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize payment directly to TheraMed Health, LLC.

Initials: _____

Chronic Care Management (CCM) Consent

I, the undersigned, consent to the Chronic Care Management (CCM) services that may be provided by TheraMed Health, LLC. I authorize the electronic communication of my medical information with my healthcare provider, and I understand that my health data will be stored securely and confidentially. If applicable, my information may be shared with other treating providers for coordination of care. I acknowledge that CCM is a monthly service, and cost-sharing may apply. I understand that I may be billed for a portion of the CCM services. Only one practitioner can furnish CCM services during the calendar month. I understand that I can withdraw my consent to participate in CCM at any time, with withdrawal being effective at the end of the current thirty (30) day service period. I may revoke this agreement either verbally or in writing.

Initials: _____

By signing below, I confirm that I have read, understood, and consented to all terms described above.

Patient/Guardian Print_____ Is this person Medical POA: o Yes o No

Patient/Guardian Signature _____ **Date** _____

Office or Other Witness Signature _____ **Date** _____

If MEDICAL Power of Attorney is signing on behalf of the patient, documentation must be submitted along with this packet.

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

* **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
* **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
* **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this alternatively i.e. electronically.
- We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for information:
TheraMed Health, LLC
3950 Cobb Parkway #401
Acworth, GA 30101
Ph: 404.857.9575
Fax: 888.857.4685
www.TheraMedHealth.com

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
(202) 619-0257
Toll free: 1-800-368-1019