Welcome!

Thank you for choosing TheraMed Health, LLC, to become a member of your Health Care Team. During your first 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 and copies of all insurance cards. Please help us prevent a delay in care by having all 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 consents.

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 _____

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 #_____

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: _____

Emergency Contacts

Please list at least ONE additional person we may contact in an emergency situation. This person will be notified of medical information in the event of an emergency ONLY.

Full Name: _____ Full Name:_____

Email: _____ Email: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

New Patient Medication Form

Full Name_____ DOB: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING
If you need additional space, please continue on back side of sheet.

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	Congestive Heart Failure	Heart Disease	Mental Illness
A-Fib	COPD	Hepatitis (B, C)	Scoliosis
Arthritis	Dementia	High Cholesterol	Skin Disease
Asthma	Depression	HIV/AIDS	STI/STD
Bleeding Tendency	Diabetes	Hypertension	Stroke
Cancer	Drug/Alcohol Dependency	Kidney Disease	Tuberculosis

Surgical History:

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Surgery: _____ Year: _____

Height: _____ft _____in **Weight:** _____lbs

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 to Patient:

CONSENT FOR TREATMENT

Patient Name: _____ **DOB:** _____

Community: _____

I acknowledge receipt of the Notice of Privacy Practices. I hereby voluntarily consent to medical and mental/behavioral health evaluation and treatment by TheraMed Health, LLC, and authorize such treatments, examinations, medications (including, but not limited to lab work) as ordered by attending physicians and mental health professionals. This assignment will remain in effect until revoked by me 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.

Patient/Guardian Signature _____ Date _____

Office or Other Witness Signature _____ Date _____

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 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 contact 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.

Patient/Guardian Signature _____ Date _____

Patient's Medicare Number: _____

Office or Other Witness Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I,_____, D.O.B: ____/____ / _____ acknowledge that I have received and discussed a copy of TheraMed Health, LLC's "NOTICE OF PRIVACY PRACTICES" on the date set forth below and acknowledge that the resident has received a copy of the document for review. I have read this document and have been given the opportunity to ask any questions and receive any clarification. Permission is given to leave medical information in the specified manner and to the specified person(s).

PLEASE CHECK ALL BOXES THAT APPLY

O You may share medical and account information with:

Name: D.O.B: Phone:

Name: D.O.B: Phone:

Patient/Guardian Signature _____ __Date _____

Office or Other Witness Signature _____ __Date _____

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