PATIENT INFORMATION

Last Name _____ First Name _____ Middle Int. _____ Sex

__ Street Address _____Apt# _____City _____State _____ Zip_____

Employer/School _____ Position_____

Home Phone _____Work Phone _____Cell Phone # _____ Date

of Birth _____SSN # _____ E-Mail Address _____ Spouse

_____Work Phone # _____Cell Phone # _____ Spouse's

Employer _____Address _____Phone # _____ Parent/

Guardian _____ Address _____Phone # _____

Emergency Contact Name: _____Phone # _____Cell Phone # _____

Pharmacy Name/ Location _____

Do you have a living will/durable power of attorney? YES/NO If so would you like a copy in your chart? YES/NO

**** If you answered yes please give the receptionist a copy*.**

INSURANCE POLICY HOLDER INFORMATION

(You must provide an insurance card and picture identification for verification purposes.)

***PRIMARY INSURANCE**

Are you the Policy Holder? _____Yes ___No
Please check: _____Spouse _____Dependent
Insurance: Aetna□ BCBS□ Cigna□ Coventry□ MEDICARE□ United Healthcare□ No Insurance□ Other: _____
Policy ID # _____ Effective Date _____

Policy Holder Last Name _____**First Name** _____M**iddle Int.**_____

Street Address _____**City**_____ **State:** _____**Zip**_____

SSN # _____**D.O. B**_____ **Employer** _____

***SECONDARY INSURANCE: Aetna· BCBS· Cigna· Coventry· MEDICARE· United Healthcare· Other:** _____
Policy ID # _____**Group #** _____ **Effective Date:**_____

***TERTIARY INSURANCE: Aetna· BCBS· Cigna· Coventry· MEDICARE· United Healthcare· Other:** _____
Policy ID # _____**Group #** _____ **Effective Date** _____

Financial Responsibility: Hillandale Primary Care will submit medical claims to your insurance company on the patient's behalf; however, patients are ultimately responsible for payment if the insurance company doesn't pay the claim. Patients are required to pay the **estimated** amount due at the time of service, however the final determination will be based on the insurance company. If insurance benefits are denied, applied the deductible or coinsurance the patient will receive a bill for the balance due. All patient balances must be paid 2 weeks from the date of service. Any remaining balance after 14 days from the date of service will be subject to a $10 late fee monthly until paid in full. **After 90 days all unpaid balances will be turned over to an outside collections agency and patient will be subject to termination from the practice.**

PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

We accept Cash, Checks, Credit (AMEX is charged 2.5% processing fee)
Patient (Print) _____
Patient/Guardian Signature _____ Date: _____

Office Policies & Consent Form 2021
Routine Physical Exam Billing Policy

Unfortunately, most insurance companies will no longer cover evaluation & treatment for sick (symptomatic) office visits and routine physical examinations and on the same date of service. Due to this recent change, Hillandale Primary Care will require patients to schedule these visits separately. Going forward, all patients that require a sick visit or that are on maintenance medications will have to be seen for their advised visit prior to being seen for their routine physical examination. We realize the inconvenience this may cause and regret that the insurance company's payment policy has led us to make such a decision. Please ask the front desk receptionist to clarify this policy if you have any questions.

Missed Appointment Policy

When an appointment is scheduled, a time slot is reserved for your visit. As a courtesy, we will try to make a reminder call. However, it is ultimately the patient's responsibility to remember the time and date of the appointment. It is also patient responsibility to know your co-pay/deductible amount, and to be prepared to pay at the time of service.

In an effort to provide quality care and service to our patients, a 24-hour prior notice is required when canceling or rescheduling an appointment. Missed appointments or cancellations will result in the following fees: $75 missed without any notice, and $50 cancelled without 24-hour notice. No further appointments will be scheduled until the fee is paid. Please call 770.322.9660 if you need to cancel or reschedule an appointment. Cancellation messages left by voice message will be honored if received 24 hours prior to the appointment.

Consent for Treatment

The undersigned hereby consents to examination and treatment of the patient by Hillandale Primary Care physician(s) and to the performance of any diagnostic procedure and/or laboratory test which is deemed necessary.

Authorization to Release Information

I hereby authorize the release of medical information including prescription history for the purpose of medical treatment. This information may be obtained from other physicians, previous medical facilities, pharmacies, and insurance companies.

Financial Responsibility

I understand that I am responsible for payment of services at the time they are rendered. It is my responsibility to know my benefits and be prepared to pay the applicable copay, coinsurance, and/or deductible amount at the time of service. As a courtesy, Hillandale Primary Care will bill my insurance provider, if insurance benefits are denied or there is a patient balance, I will be responsible for the balance. There will be no additional services including office visits, referrals, or prescription refills until the balance is paid. The balance due will accrue a late fee of $10 if not paid in full (14) days from the date of service. Thereafter, the balance will accrue a monthly late fee of $10. After 90 days all balances will be forwarded to an outside collection agency.

I have read and understand the above policies:

Patient (Print): _____

Patient/Guardian Signature: _____ Date: _____

I was given the PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION to read from Hillandale Primary Care:

Patient: _____Patient/Guardian Signature: _____ Date: _____

HILLANDALE PRIMARY CARE
PATIENT HISTORY FORM

Patient's Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____AGE: ____
Previous Physician's name/phone #: _____Date of last appointment: _____

REASON FOR YOUR VISIT TODAY: _____

PRIMARY MEDICAL CONCERNS: _____
Allergies
Are you allergic to penicillin or any other drugs? □Yes □No
Please list: _____
Have you ever been hospitalized? □Yes □No If yes, what for? _____
Vaccination History
Pneumonia □Yes □No If yes, date vaccine was received_____
Shingles □Yes □No If yes, date vaccine was received_____
Tetanus (Td or Tdap) within 10 years? □Yes □No If yes, date vaccine was received_____
Influenza vaccine this season? □Yes □No If yes, date vaccine was received_____

Have you had a Bone Density Test (DEXA Scan) in the last 2 years? (For Women 65+ years and men 70+ years?)
□Yes □No If yes, when and where_____
Have you had a colonoscopy? □Yes □No If yes, when and where_____
Have you had a sexually transmitted disease? □Yes □No
Diagnosis:_____
Which of the following conditions are you currently being treated or have been treated for in the past (please check)
□Heart disease / Murmur / Angina □Shortness of breath
□Eye disorder / Glaucoma
Glaucoma screening within the last year? □Yes □No If yes, when and where_____
□Diabetes
Diabetic foot exam within the last year? □Yes □No If yes, when and where_____
Diabetic eye exam within the last year? □Yes □No If yes, when and where_____
□High cholesterol □Asthma □Seizures □Kidney / Bladder problems
□High blood pressure □Lung problems / cough □Stroke □Liver problems / Hepatitis
□Low blood pressure □Sinus problems □Headaches / Migraines □Arthritis
□Heartburn (reflux) □Seasonal allergies □Neurological problems □Cancer
□Anemia or blood problems □Tonsillitis □Depression / Anxiety □Ulcers/colitis
□Swollen ankles □Ear problems □Psychiatric care □Thyroid problems Please describe any current or past medical treatment not listed above:

Please list your past surgeries:

_____
_____

Medications (Include Supplements and Vitamins)
Please list:

_____
_____
_____
_____
_____
_____
_____

Social and Preventive History
Do you currently smoke or chew tobacco? □Yes □No If no, have you in the past? □Yes □No
How many packs per day? _____

Do you drink alcohol, beer, or wine? □Yes □No If no, have you in the past? □Yes □No
How many drinks per week? _____

Do you currently drink coffee and/or tea? □Yes □No If yes, how many cups per day?
_____
Do you exercise daily/weekly? □Yes □No
Do you use seatbelts while driving? □Yes □No Do you wear a helmet while riding a bike? □Yes □No

Family History
Living Age (or age at death) List serious illnesses
Mother □Yes □No _____
Father □Yes □No _____
Sisters □Yes □No _____
Brothers □Yes □No _____

Has any member of your family (including children and parents) had any of the following illnesses? Illness, which family member?
Anemia or Blood disease_____
Cancer _____
Diabetes _____
Glaucoma _____
Heart disease _____
High blood pressure_____
HIV disease / AIDS _____
Mental Illness / Depression _____
Stroke _____
Other serious illness _____

Females: Gynecological History

How many times have you been pregnant? _____Date of last Pap Smear: _____
Have you had an abnormal Pap Smear? □Yes □No Diagnosis: _____ Follow up: _____
Have you had a sexually transmitted disease? □Yes □No Diagnosis: _____
Date of last mammogram: _____ Mammogram results: _____
Have you ever had a breast biopsy? □Yes □No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate. I also authorize Hillandale Primary Care to obtain my medical history from other physicians and pharmacies to aid in my treatment.

Patient/Legal Guardian Print: _____
Patient/Legal Guardian Signature: _____Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hillandale Primary Care is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.
I acknowledge that I have received a copy of the Notice of Privacy Practices of Hillandale Primary Care

Name: _____

Signature: _____

Name of Personal Representative (if appropriate):

_____

Signature of Personal Representative (if appropriate):

_____

Date: _____

_____

(FOR USE OF HPC ONLY)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____ This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Hillandale Primary Care

Saira Tariq Niaz, M.D.

2523 Panola Road
Lithonia, GA 30058

1950 Riverside Parkway, Suite 100
Lawrenceville, GA 30043

Phone: 770.322.9660
Fax: 770.322.1981

NEW PATIENT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize: _____ to release healthcare information of the patient named above from:

Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date Signed: _____

Patient/Guardian Print/Signature: _____

_____