Rophe Adult and Pediatric Medicine

14 and older

Patient Data

(Complete all fields clearly)

Name:	Todays Date:		
SSN:	Date of Birth:		
Gender: ❑Female ❑Male			
Marital Status: ❑Married ❑Single ❑Widowed ❑Divorced			
Street Address:	City:	State:	Zip:
Phone Numbers: Home: Cell: Work:			
Primary No. is ❑Home ❑Cell ❑Work	Reminder call to be made to ❑Home ❑Cell ❑Work		
Email Address:	Preferred Contact Method: ❑Phone ❑Text		
Preferred time of day to be contacted ❑Morning ❑Afternoon ❑Evening			
Preferred Language ❑English ❑Spanish ❑French			
Race/Ethnicity ❑Black/African American ❑White ❑Hispanic or Latino ❑American Indian/Alaskan Native ❑Asian ❑Native Hawaiian/Other Pacific Islander ❑Other ❑Unknown			
Employment ❑Unemployed ❑Retired			
Employer:	Job title:		
Emergency Contact			
Spouse, companion, relative or friend living with you			
Name & Relationship: Preferred Number:			
Nearest relative or friend not living with you			
Name & Relationship: Preferred Number:			
Insurance Information			
Primary Insurance: _____ Name of Insured & Relationship:_____ Insurer's Address:			
Secondary Insurance: _____ Name of Insured & Relationship:_____ Insurer's Address:			
Tertiary Insurance: _____ Name of Insured & Relationship:_____ Insurer's Address:			

Preferred Pharmacy	
Pharmacy Name:	Pharmacy Phone:
Pharmacy Address:	
I authorize Rophe Adult and Pediatric Medicine to obtain my prescription history electronically ❑Yes ❑No	

I certify that the above information is correct. I consent to be treated by the staff and providers of RAPM and its affiliates. I authorize payment of medical benefits to RAPM and its affiliates, and authorize them to release any medical information necessary to process claims.
I understand that I am responsibilities for co-payments, deductibles, co-insurance, and non-covered services.

Patient Signature: Date:

Health History Form	
Name:	**Date of Birth:**
Current Medication(s) (List Below)	
Drug Name, Strength, Frequency	Drug Name, Strength, Frequency
Food/Drug Allergies (List Below)	

Past Medical History (check all that apply)				
❑Alcohol Dependence	❑Congestive Heart Failure	❑Gallstones	❑Hyperthyroidism	❑Pancreatitis
❑Adrenal disease	❑COPD	❑Glaucoma	❑Irreg. Heart Rhythm	❑Peptic Ulcer
❑Asthma	❑Crohn's Disease	❑Goiter	❑Insomnia	❑Peripheral Vascular Disorder
❑Blood Clots	❑Depression	❑Gout	❑Irritable Bowel Syndrome	❑Prostate Disorder
❑Blood Thinner use	❑Diabetes Type I	❑Heart Attack	❑Headache	❑Reflux
❑Cancer/Type:		❑Other Heart Disease:	❑Kidney Disease:	❑Renal Disorders
❑Chronic Bronchitis	❑Diabetes Type II	❑Hyperlipidemia	❑Liver Disease	❑Sciatica
❑Chronic Fatigue	❑Diarrhea	❑Heart Failure	❑Migraines	❑Stomach Ulcer
❑Chronic Kidney Disease	❑Disc Degeneration	❑Hepatitis	❑Low Blood Pressure	❑Thyroid Disease
❑Chronic Neck Pain	❑Duodenal Ulcer	❑High Blood Pressure	❑Obesity	❑Tuberculosis
❑Chronic Sinusitis	❑Easy Bleeding	❑High Cholesterol	❑Osteoarthritis	❑Venereal Disease
❑Circulatory Disease	❑Emphysema	❑HIV	❑Osteoporosis	
❑Colitis	❑Esophageal Reflux	❑Hypertension	❑Palpitations	
❑Other:				

❑Yes ❑No Have you had a blood transfusion? When? Where? Reaction?

Hospitalizations (List Below)	
Diagnosis	Date

PATIENT NAME:_____ **DATE:**_____

FEMALE HISTORY				
Last Period	❑Light bleeding	Flow Duration	❑Regular Cycles	Last Pap Smear:
Pads used in 24 hr:__	❑Heavy Bleeding	Age of first period:__	❑Irregular Cycles	❑Past Abnormal Pap
❑Tampon use	Pregnancies (Gravid):__	Deliveries (Para):__		Menopause

SURGICAL HISTORY (please check all that apply) ❑No Prior Surgeries				
❑Abd Aortic Aneurism	❑Bypass, Coronary Art	❑Gastric Bypass	❑Knee Replacement	❑Pacemaker
❑Angioplasty	❑Carpal Tunnel Release	❑Gall Bladder Removal	❑LASIX	❑Small Bowel Resection
❑Angioplasty w/stent	❑Cataract Extraction	❑Heart Surgery	❑ Liver Biopsy	❑Sinus Surgery
❑Appendectomy	❑Cholecystectomy	❑Heart valve Repair	❑Open Reduction	❑Thyroidectomy
❑Arthroscopy knee	❑Colectomy	❑Hip Replacement	❑Orthopedic Surg	❑Tonsillectomy
❑Back surgery	❑Colostomy	❑Hernia Repair		
❑Other				

FEMALE SURGICAL HISTORY (Please check all that apply) ❑None				
❑Breast Augmentation	❑Breast Lumpectomy	❑Hysterectomy (Total Abd)	❑Myomectomy	❑Salpingo Oophorectomy
❑Bilateral Tubal Litigation	❑Cesarean Section	❑Mastectomy	❑Reduction Mammoplasty	❑Vaginal Hysterectomy
❑Breast Biopsy	❑D and C	❑Other:		

MALE SURGICAL HISTORY (Please check all that apply) ❑None			
❑Prostate Surgery/Biopsy	❑TURP	❑Vasectomy	❑Other:

IMMUNIZATIONS (Include Date)				
❑Flu	❑Pneumococcal Vaccine:	❑Hep B	❑Meningococcal	❑ Tetanus
❑PPD (Tuberculosis Test)	❑Other			
PREVENTATIVE HEALTH (Include Date)				
Mammogram				
Bone Density				
Colonoscopy				

PATIENT NAME:_____ **DATE:**_____

GENERAL HEALTH & HABITS (Check all that apply)			
Presented Health Status: ❑Excellent ❑Very Good ❑Average ❑Poor Weight: 10 yrs ago? ___ 5yrs ago? ___ Weight now?___			
Regular exercise? ❑Yes ❑No	Do you smoke? ❑Yes ❑No	Alcohol use? ❑Yes ❑No	Caffeine use? ❑Yes ❑No
How long regularly? ___yrs	❑Cigarettes ❑Pipes ❑Cigars	# Drinks per Day/Week__	# Cups of coffee/day?__
Type:	Packs per day:__	Stopped? ❑Yes ❑No	# Cups of tea/day?__
Frequency__wk__time	Yrs smoked:___ Quit:__		# Cans/Glasses?__

PERSONAL HISTORY			
Where Born?	Areas Lived?	Occupation:	
Education Level:		Worked in medical field? ❑Yes ❑No	Inhaled chemicals? ❑Yes ❑No

PATIENT NAME:_____ **DATE:**_____

Rophe Adult and Pediatric Medicine

FAMILY HISTORY										
Age:	Father ____	Mother ____	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased at age:	❑_	❑_	❑_	❑_	❑_	❑_	❑_	❑_	❑_	❑_
ADD/ADHD	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Alzheimer's Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Blood disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Cancer Type?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
High Cholesterol	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Stroke (CVA)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Epilepsy/Seizures	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Migraines	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Peripheral Vascular Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑Other	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑Adopted: Family History Unavailable										

Rophe Adult and Pediatric Medicine
4910 Jonesboro Road, Bldg. 700, Suite 1 • Union City, GA 30291
Phone (770) 964-7736 • Fax (770) 306-1726

EFFECTIVE DATE APRIL 1, 2004

NOTICE OF PRIVACY PRACTICES

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, with this notice, you authorize our practice to leave voicemail reminders or messages regarding your appointment.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Rophe Adult and Pediatric Medicine
4910 Jonesboro Rd, Bldg. 700 Suite 1• Union City, GA 30291
Phone (770) 964-7736 • Fax (770) 306-1726

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact: Rophe Adult & Pediatric Medicine Adult & Pediatric Medicine's Privacy Officer at 4910 Jonesboro Road, Bldg 700 Union City, GA 30291. (770) 964-7736. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received and/or reviewed the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative Date

Rophe Adult and Pediatric Medicine
4910 Jonesboro Rd, Bldg. 700, Suite 1• Union City, GA 30291
Phone (770) 964-7736 • Fax (770) 306-1726

Patient Financial Policy

Thank you for selecting our practice as your healthcare provider. We are committed to providing you with compassionate and quality medical care. Please understand that payment is expected for services rendered. The following is a statement of our financial policy. Please read, sign and date this policy prior to treatment. Please provide the receptionist any current medical insurance cards that should be used to cover services rendered. For your convenience, our practice accepts Visa, MasterCard, Discover, American Express, Cash and Personal Checks.

Insurance

We accept assignment for benefits for most insurance plans. However, we do require that all co-payments, co-insurance and deductibles be paid at the time of service.

Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. Should your insurance company fail to pay the insurance claim for services rendered by Rophe Adult & Pediatric Medicine, you may be responsible for the entire charges submitted to the insurance carrier. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the claim was submitted.

You are also responsible for determining what services your insurance company covers. Therefore, if your insurance coverage is verified and certain procedures are not covered, you will be required to sign a waiver indicating that you understand that your policy does not cover this service and you will be responsible for the charges associated with this service.

Co-insurance and any balances that remain the responsibility of the patient, according the insurance carrier terms, should be remitted to the practice upon notice of balance due. *Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any accounts turned over to an outside collection agency will incur the collection agency fees and these fees will become the responsibility of the patient.*

Non-Insured Patients

Patients that are not covered by an insurance plan are responsible for services rendered at the time of service. For patients unable to pay for services in full, a minimum of 50% of the charges are due at the time of service. Payment for any remaining balance is payable within 30 days of the date of service. Failure to remit payment may result in the patient's account being turned over to an outside collection agency. Any fees associated with the collection agency will become the financial responsibility of the patient.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, please kindly give a 24 hour notice. Failing to provide notice of cancellation for two or more consecutive visits, will result in a $ 25.00 missed appointment charge. This charge is the responsibility of the patient and it is not covered by most insurance carriers.

Rophe Adult and Pediatric Medicine
4910 Jonesboro Rd, Bldg. 700, Suite 1• Union City, GA 30291
Phone (770) 964-7736 • Fax (770) 306-1726

Forms

Disability, Life Insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the physicians and completion of detailed medical history questionnaires. Please allow 3 -5 days for completion of any requested forms. The charge for this service is $20.00. This charge is payable upon submission of the forms, therefore forms will not be completed unless pre-payment is collected.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and agree to abide by the financial policy of Rophe Adult & Pediatric Medicine.

X _____ _____
Signature of Patient or Responsible Party Date

Rophé Adult & Pediatric Medicine

Yvonne Smith, M.D., P.C. • Dwight Blake, M.D. • Nardia Watson, FNP-C • Stephanie Miller, FNP-C

Request for Limitations and Restriction of
Protected Health Information (PHI)

PATIENTS PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUEST.

Patient Name: _____ Date: _____

Patient Address: _____

_____

City, St, Zip: _____, _____, _____

Type of PHI to be restricted or limited: (Please check all that apply)

- o Home phone#
- o Patient history
- o Home address
- o Occupation
- o Name of employer
- o Office address
- o Office phone#
- o Spouse's name
- o Notes from visits
- o Hospital notes
- o Other:_____

How would you like your PHI restricted?

_____

_____

_____

We have your permission to speak to the following individual(s) regarding your PHI:

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Guardian Patient's Name

_____ _____

Print Name of Patient or Legal Guardian Date