

# Rophé Adult & Pediatric Medicine

Yvonne Smith, M.D., P.C.

Patient's Name: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Father's Name: \_\_\_\_\_ Date \_\_\_\_\_

## PREGNANCY/BIRTH HISTORY

Term:  Full  Preterm Delivery:  Normal  C-Section Birth Weight: \_\_\_\_\_

Prenatal care:  Yes  No Month initiated \_\_\_\_\_ Source of care:  Doctor  Clinic

Problems: Prenatal, Delivery, Postnatal, At Birth \_\_\_\_\_

Maternal Use of: Medications \_\_\_\_\_ Cigarettes \_\_\_\_\_ Alcohol \_\_\_\_\_

Crack/Cocaine \_\_\_\_\_ Marijuana \_\_\_\_\_ Other drugs \_\_\_\_\_

## DEVELOPMENT: When did your child?

Sit alone \_\_\_\_\_ Stand \_\_\_\_\_ Walk \_\_\_\_\_

Say words \_\_\_\_\_ Say short sentences \_\_\_\_\_ Toilet train \_\_\_\_\_

School performance \_\_\_\_\_ Gets along with others \_\_\_\_\_

Problems \_\_\_\_\_

## NUTRITION

Breast \_\_\_\_\_ Frequency \_\_\_\_\_ Weaned \_\_\_\_\_

Formula \_\_\_\_\_ Amount \_\_\_\_\_ Present diet \_\_\_\_\_

Appetite \_\_\_\_\_ Stools \_\_\_\_\_ Urine output \_\_\_\_\_

Pica (craving) \_\_\_\_\_ Water:  City  Well Vitamins \_\_\_\_\_ Iron \_\_\_\_\_

Fluoride \_\_\_\_\_ Comments \_\_\_\_\_

## PAST MEDICAL HISTORY

Illnesses \_\_\_\_\_

Hospitalizations \_\_\_\_\_

Surgery \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Immunizations UTD \_\_\_\_\_

FAMILY HISTORY

Illness in immediate family (i.e., parents, grandparents, aunts, uncles, siblings)

- Hypertension \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Asthma \_\_\_\_\_
- Cancer \_\_\_\_\_
- Seizures \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Mental Illness \_\_\_\_\_
- Other \_\_\_\_\_

SOCIAL HISTORY

Household members \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary child caretaker \_\_\_\_\_ Phone \_\_\_\_\_  
Number \_\_\_\_\_

Day Care Provider \_\_\_\_\_ Phone \_\_\_\_\_  
Number \_\_\_\_\_

Housing conditions: House \_\_\_\_\_ Apt. \_\_\_\_\_ Trailer \_\_\_\_\_  
Year built \_\_\_\_\_ Heat \_\_\_\_\_

Smoking in house \_\_\_\_\_ Drug use in home \_\_\_\_\_ Need for Social Services \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Patient Data**

(Complete all fields clearly)

<b>Name:</b>		Todays Date:	
SSN:		Date of Birth:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male			
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Street Address:		City:	State: Zip:
Phone Numbers:			
Home:		Cell:	Work:
Primary No. is <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Reminder call to be made to <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
Email Address:		Preferred Contact Method: <input type="checkbox"/> Phone <input type="checkbox"/> Text	
Preferred time of day to be contacted <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening			
Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French			
Race/Ethnicity <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
<b>Employment</b>		<input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	
Employer:		Job title:	
<b>Emergency Contact</b>			
Spouse, companion, relative or friend living with you			
Name & Relationship:			
Preferred Number:			
Nearest relative or friend not living with you			
Name & Relationship:			
Preferred Number:			
<b>Insurance Information</b>			
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 responsible for co-payments, deductibles, co-insurance, and non-covered services.

Patient Signature:

Date:

# 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.

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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

## 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.

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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)

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