Covenant Medical Center, P.C.

(PLEASE PRINT CLEARLY)

Patient Name: _____
Last Name First Name Middle Initial

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

Sex: □M □F Date of Birth: _____ □ Single □Married □Widowed □Separated □Divorced

Social Security No: _____ Who Referred You: _____

Phone No. Home: _____ Work: _____ Mobile: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Who is responsible for this account? _____ Relationship to patient: _____

Address of responsible person: _____

Social Security No. of responsible person: _____ Phone: _____

Do you have Medicare? □Yes □No ID No: _____

Do you have Medicaid? □Yes □No ID No:

Responsible Person – Primary Insurance Co. Name: _____

ID No: _____ Group No: _____ Policy No: _____

Insurance Co. Address: _____ Phone No: _____

Secondary Insurance Co. Name: _____

ID No: _____ Group No: _____ Policy No: _____

Insurance Co. Address: _____

In the event of an emergency who should be notified? _____

Relationship: _____ Phone No. Day: _____ Phone No. Evening: _____

Insurance Authorization & Assignment

I hereby authorize Covenant Medical Center, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I acknowledge this authorization for assignment of benefits will continue indefinitely unless revoked by me in writing by me. I will be responsible for all collection fees incurred if an outside collection agency is used to recover past due balances. I have read and understand the above.

Signature: _____ Date: _____

Covenant Medical Center, P.C.

Patient History Form

Patient's Name: _____ Date of Birth: _____ Today's Date: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? □Yes □No If yes, date & reason: _____

Have you ever been tested for hepatitis A, B or C? □Yes □No Which Virus? _____

Have you been vaccinated for hepatitis B? □Yes □No When? _____

Have you been vaccinated for hepatitis A? □Yes □No When? _____

Last (TB) Tuberculosis Screening? _____ Result of screening? □Positive □Negative

If positive, date of last chest x-ray? _____ Result of chest x-ray? □Positive □Negative

Which of the following conditions are you currently being treated or have been treated for?

□Heart Disease/ Murmur/ Angina	□Shortness of breath	□Eye disorder/ Glaucoma	□Diabetes
□High cholesterol	□Asthma	□Seizures	□Kidney/ Bladder problems
□High blood pressure	□Arthritis	□Liver problems/ Hepatitis	□Stroke
□Low blood pressure	□Sinus problems	□Headaches/Migraines	□Lung problems/ cough
□Heartburn (reflux)	□Seasonal allergies	□Neurological problems	□Cancer
□Anemia or blood	□Tonsillitis	□Depression/ Anxiety	□Ulcers/colitis
□Swollen ankles	□Ear problems	□Psychiatric care	□Thyroid problems

Please list any current or past medical conditions not listed above

_____

_____

Please list your past surgeries and date of procedure

_____

_____

Please list any previous medications:

_____

_____

_____

Please list any current medications:

_____

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? _____

Any non/drug, latex or food allergies? _____

Social and Preventive History

Do you 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? _____

Family History

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

Females Only: Gynecological History

How many times have you been pregnant? _____

No. of vaginal birth: _____ C-section: _____ Miscarriage: _____ Termination: _____

Have you had an abnormal Pap Smear? _____ Diagnosis: _____

Date of last mammogram: _____ Results: _____

Have you ever had a breast 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.

Patient Signature: _____ **Date:** _____

Covenant Medical Center , P.C.
5014 Stone Mountain Hwy Suite C
Lilburn, GA 30047
(770)-564-6900

By signing this I _____ fully understand that I am being treated by Covenant Medical Center with the understanding that my medical insurance is active and will pay any medical expenses that I occur. However if there are many problems that my medical bill is not covered by insurance I_____ take full responsibility and will pay any expenses that have accumulated during the time of being treated at Covenant Medical Center.

Patient:_____

Witness:_____

Date:_____

Sincerely
Covenant Medical Center, P.C.

COVENANT MEDICAL CENTER, P.C.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health

insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

5. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

6. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Privacy Officer at (770) 564-6900** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the front desk or **Privacy Officer at (770) 564-6900 for further information.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Privacy Officer at (770) 564-6900.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Covenant Medical Center, P.C.
Attn: Privacy Officer
5014 Stone Mountain Hwy., Suite C
Lilburn, GA 30047
(770) 564-6900

Covenant Medical Center, P.C.

(PLEASE PRINT CLEARLY)

ACKNOWLEDGEMENT & AUTHORIZATIONS

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. The patient is responsible for all fees, regardless of insurance coverage unless the services are for properly authorized workmen's compensation, auto injuryor for services covered under a contractual agreement between this Medical Practice and your insurance carrier. I understand that I need to notify Covenant Medical Center, P.C. of tests or other treatments that may not be covered by my insurance policy. I realize that I am responsible for fees that are not covered by my insurance carrier. If hospitalization is indicated, the patient is responsible for ensuring Covenant Medical Center, P.C is informed of the necessary pre-certification requirements.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that Covenant Medical Center's policy is to notify patients of any abnormal labs or diagnostic test results. We will notify you as soon as possible. I indicate below which results may be released and to whom that information may be released. (You may choose more than one option).

□ Give my results to me personally. My daytime phone number is _____. If you are not available to speak to us, we will leave a message to call our office).

If you cannot reach me personally, I authorize Covenant Medical Center to release my results to another person specifically:

Name: _____ Relationship: _____ Number: _____

□ If my results are benign (or within normal limits), you may leave my results on my answering machine at (check all that apply):

□Home _____ □ Work _____ □Cell/ Other _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize Covenant Medical Center to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means, including, but not limited to Medicare.

CONSENT TO OBTAIN MEDICAL RECORDS: I authorize Covenant Medical Center to obtain medical records from any other physician or medical facility necessary in the course of my treatment & continued primary care.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

HIPPA COMPLIANCE NOTICE: I hereby acknowledge that I have read the COVENANT MEDICAL CENTER, P.C. - NOTICE OF PRIVACY PRACTICES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of this information for my records. Copies are available at our office and online. COVENANT MEDICAL CENTER, P.C. will abide by all HIPPA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient Name: _____

Guardian Name : _____
(If other than patient)

Patient/Guardian Signature: _____

Date: _____

Covenant Medical Center, P.C.

RECORDS TRANSFER REQUEST

Date:_____

To:_____
(Doctor/Hospital)

Address: _____

City:_____ **State:**_____ **Zip:**_____

Telephone: (____)_____

I hereby authorize the release of my medical records or copies of such and request that they are transferred to:

Cecilia O. Babalola, MD
5014 Stone Mountain Hwy., Suite C
Lilburn, GA 30047
Phone (770) 564-6900 Fax (770) 564-6030

Patient Name: _____

Guardian Name : _____
(If other than patient)

Patient/Guardian Signature: _____

Date: _____