



911 Plaza Ave., Ste. C, Eastman, GA 31023  
478-374-5774 (fax) 478-374-9112  
Amy Cravey, FNP-C • M. Todd Peacock, MD • Brianna Crummey, FNP-C  
Caley Allen, FNP-C

### PATIENT REGISTRATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI ( \_\_\_\_\_ )  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Language: \_\_\_\_\_ Martial Status \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Title \_\_\_\_\_ Business Number \_\_\_\_\_

### INSURANCE INFORMATION

*Primary Insurance* \_\_\_\_\_ Policy Number \_\_\_\_\_ Group \_\_\_\_\_  
Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_  
*Secondary Insurance* \_\_\_\_\_ Policy Number \_\_\_\_\_ Group \_\_\_\_\_  
Policy Holder \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

### IN CASE OF EMERGENCY

Emergency Contact \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Phone # \_\_\_\_\_

### PHARMACY INFORMATION

Pharmacy \_\_\_\_\_ City \_\_\_\_\_ Phone #: \_\_\_\_\_

### AUTHORIZATION AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance information benefits be paid directly to the physicians. I understand that I am financially responsible for any balance. I also authorize Heart of Georgia Primary Care LLC or insurance company to release any information necessary to process my claims.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I AUTHORIZE *HEART OF GEORGIA PRIMARY CARE*  
*977 PLAZA AVE SUITE C*  
*EASTMAN GA 31023*

*Phone number: 478-374-5774 Fax: 478-374-9112*

TO OBTAIN MY MEDICAL INFORMATION FROM:

(MEDICAL OFFICE, INSURANCE COMPANY)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOR THE PURPOSES FOR REVIEW/ EXAMINATION, I FURTHER AUTHORIZED YOU TO PROVIDE SUCH COPIES THEREOF AS MAY BE REQUESTED. THE FOREGOING IS SUBJECT TO SUCH LIMINATION AS INDICATED BELOW:

ENRTE RECORD OR

SPECIFIC INFORMATION: \_\_\_\_\_

I GIVE SPECIAL PERMISSION TO RELEASE ANY INFORMATION REGARDING : (PLEASE INITIAL)

SUBSTANCE ABUSE \_\_\_\_\_

PSYCHIATRIC / MENTAL HEALTH INFO \_\_\_\_\_

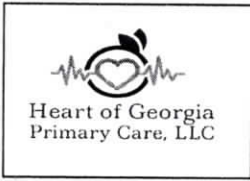
HIV INFORMATION \_\_\_\_\_

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE WHEN PATIENT IS EITHER DISCHARGED FOR IS DECEASED OR OTHERWISE NO LONGER A PATIENT OF *HEART OF GEORGIA PRIMARY CARE, LLC*, EXCEPT AS REQUIRED BY LEGAL JUDGEMENT OR STATUTE. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN TO RELIANCE THEREON.

REASON FOR REQUEST: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_



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## CONSENT TO RELEASE MEDICAL INFORMATION TO FAMILY AND FRIENDS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Many of your patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family members you must sign this form. Signing this form will only give information to family members/friends indicated below.

I authorize Heart of Georgia Primary Care to release my medical and/or billing information to the following individual(s):

1. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

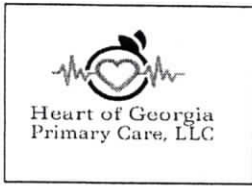
### Patient information

I understand I have the right to revoke this authorization at anytime and that I have the right to inspect or get a copy of this protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature \_\_\_\_\_ Date: \_\_\_\_\_



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## NOTICE OF PRIVATE PRACTICE

**EFFECTIVE 08/28/2018**

We may make your medical information available electronically through state, regional, or national information exchange services which help make your medication information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

Physician Signature: \_\_\_\_\_

M. Todd Peacock, M.D., P.C.

Provider Signature: \_\_\_\_\_

Amy H. Cravey, FNP-C

Provider Signature: \_\_\_\_\_

Brianna J Crummey, FNP-C

Provider Signature: \_\_\_\_\_

Caley C Allen, FNP-C

Patient Signature \_\_\_\_\_



### HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NOPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

- The right to inspect and copy your information.
- The right to request corrections to your information.
- The right to request that your information be restricted.
- The right to request confidential communications.
- The right to a report of disclosures of your information.
- The right to a paper copy of this Notice.
- The right to file a complaint if you feel your privacy has been violated.
- The right to opt-out of fundraising communications. (The Heart of Georgia Primary Care does not contact patients for fundraising.)
- The right to restrict certain disclosures of your protected health information to a health plan when you have paid out of pocket in full for the healthcare item or services.
- The right to be notified following a breach of unsecured protected health information.

We want to assure you that your medical/protected health information is secure with us.

#### Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Heart of Georgia Primary Care's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the Privacy Officer.

\_\_\_\_\_  
Patient or Representative Name (Please Print)

\_\_\_\_\_  
Patient or Representative Signature

\_\_\_\_\_  
Date

- Patient refused to sign  
 Patient was unable to sign because \_\_\_\_\_

Documented by: \_\_\_\_\_