Heart of Georgia
Primary Care, LLC

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

911 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 LIMIATION AS INDICATED BELOW:

ENRITE 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

Brianna J Crummey, FNP-C

Provider Signature: Caley C Allen, FNP-C

Caley C Allen, FNP-C

Patient Signature _____

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Brianna J. Crummey, FNP-C Caley C. Allen, FNP-C

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: _____