

911 Plaza Ave., Ste. C  
Eastman, GA 31023  
478-374-5774  
(Fax) 478-374-9112



## Heart of Georgia Primary Care, LLC

150 E. Peacock St., Ste A  
Cochran, GA 31014  
478-271-3200  
(Fax) 478-271-3205

M. Todd Peacock, MD  
Brianna Crummey, FNP-C

Amy Cravey, FNP-C  
Caley Allen, FNP-C

### PATIENT REGISTRATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI(\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Sex \_\_\_\_\_ Race \_\_\_\_\_ Language \_\_\_\_\_ Marital 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 \_\_\_\_\_ 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 to 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 \_\_\_\_\_

### CONSENT TO RELEASE MEDICAL INFORMATION TO FAMILY AND FRIENDS

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

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

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

1. \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

2. \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

3. \_\_\_\_\_ Phone # \_\_\_\_\_

Relationship \_\_\_\_\_

**Patient Information**

I understand I have the right to revoke this authorization at any time 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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**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  
478-374-5774  
FAX: 478-374-9112

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COCHRAN GA 31014  
478-271-3200  
FAX: 478-271-3205

TO OBTAIN MY MEDICAL INFORMATION FROM  
(MEDICAL OFFICE, INSURANCE COMPANY)

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

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

ENTIRE 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 JUDGMENT 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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## 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.

A handwritten signature in black ink, appearing to read "M. Todd Peacock".

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

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

A handwritten signature in black ink, appearing to read "Amy H. Cravey".

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

Amy H. Cravey, FNP-C

A handwritten signature in black ink, appearing to read "Brianna J. Crummey".

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

Brianna J Crummey, FNP-C

A handwritten signature in black ink, appearing to read "Caley C. Allen".

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

Caley C Allen, FNP-C

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

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## 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 unable to sign because \_\_\_\_\_

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

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### REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my healthcare visits. I understand that free interpretive services may not be immediately available and Heart of Georgia Primary Care may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternative choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Heart of Georgia Primary Care.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies are required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Heart of Georgia Primary Care's *Notice of Health Information Privacy Practices*. I understand that confidentiality may be broken if I cannot be contacted when a life-threatening condition is suspected or detected. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Heart of Georgia Primary Care, LLC provide appropriate evaluation, testing, and treatment.

**I hereby acknowledge receipt of Heart of Georgia Primary Care's Notice of Health Information Privacy Practice.**

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

I witness the fact that the patient received the above mentioned information and she/he read and understood the same and had the opportunity to ask questions.

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_ CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BY LAW

**Signature of any other person consenting** \_\_\_\_\_ **Date** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_

I witness the fact that the patient's legal guardian (or person consenting on her behalf) received the above mentioned information and said she read and understood the same

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ (Parent/Guardian) gives phone consent on \_\_\_\_\_ (date) to Heart of Georgia

Primary Care, LLC to treat \_\_\_\_\_ (patient)