I UNDERSTAND THAT NORTH OAK FAMILY MEDICINE DOES NOT PRESCRIBE NARCOTIC MEDICATION FOR THE TREATMENT OF PAIN. I ALSO UNDERSTAND THAT ANY COMPLAINTS OF PAIN THAT I HAVE MAY BE REFERRED TO A LOCAL PAIN SPECIALIST FOR FURTHER TREATMENT. I ACKNOWLEDGE AND ATTEST TO THIS NOTIFICATION FROM NORTH OAK FAMILY MEDICINE CLINIC.

Print
Name_____

Signature_____

Date_____

# North Oak FAMILY MEDICINE

## Authorization for Release of Information

I hereby authorize _____, to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Patient Name: _____ Date of birth: _____
Persons/organizations to receive the information: North Oak Family Medicine / David Jackson, NP

The specific information to be released/disclosed is specified below:

☐ Complete Medical Record

Or specify one or more of the following:

| | |
|---|---|
| ☐ Operative Reports | ☐ X-rays |
| ☐ Progress Notes | ☐ Billing or Claim Records |
| ☐ Laboratory | ☐ Other (Specify) |

This information is to be used/disclosed for the following purpose(s) only: _____

(No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)

This authorization will expire on _____ (state date or event).

Specific Authorization

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

☐ Yes
☐ No
Initials _____

_____ _____
Signature or patient or patient's representative (Form must be completed before signing) Date

Printed name of patient's representative (If applicable) _____
Relationship to the patient (If applicable) _____

*You are entitled to a copy of this document

# North Oak Family Medicine

2718 North Oak Street
Valdosta, Georgia 31602
(229) 242-5145

## PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ Sex: ( ) M ( ) F Age: _____
Last First Middle

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Date of Birth: _____ Marital Status: _____ Social Security No.: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

Home Phone No.: _____ Cell Phone No.: _____

E-mail Address: _____ Mobile Carrier: _____

How would you like to be notified of your next appointment? ☐ Phone ☐ Text ☐ E-mail

Employer's Name: _____ Work Phone No.: _____

Address: _____ City: _____ State: _____

Your Occupation/Job Title: _____

Emergency Contact: _____ Phone: _____

Address: _____ Relationship to Patient: _____

City: _____ State: _____ Zip Code: _____

## SPOUSE OR PARENT INFORMATION

Name: _____

Address: _____ Relationship to Patient: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security No.: _____

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

Employer Name: _____ Occupation/Job Title: _____

Address: _____ City: _____ State: _____

## INSURANCE INFORMATION:

Primary Plan Name: _____

Insured Name: _____ Social Security No. _____

Relationship to Patient: _____ Insurer's D.O.B. _____

Secondary Plan Name: _____

Insured Name: _____ Social Security No. _____

Relationship to Patient: _____ Insurer's D.O.B. _____

**PLEASE PRESENT INSURANCE CARD/S TO RECEPTIONIST!**

**(Co-Payments will be collected prior to treatment)**

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Patient name: _____

Current problem today is: _____

Have you been treated for this problem before? _____ Yes _____ No

If yes, then 1) Who was the doctor who treated you. _____

2) When did you see him/her? _____

3) What treatment was given? _____

Name of your family doctor or primary doctor: _____

What pharmacy do you use for prescriptions? _____

Were you referred to us? If so, who referred you? _____

Are you a diabetic? _____ Yes _____ No

Is your diabetes controlled with: (Please circle one) Insulin Pills Insulin and Pills Diet

Name of the doctor treating your diabetes: _____

Date diabetic doctor was last seen: _____

How did you hear about our office: (Please circle one)

Internet Phone-book Television Newspaper Family Friend

Is this a work-related injury? _____ Yes _____ No

## AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

### AUTHORIZATION OF TREATMENT

I the undersigned hereby authorize the physicians and staff of Southern Podiatry Group to render treatment and/or therapy to myself that they deem medically necessary in order to treat the condition and or conditions I have requested from the physicians and/or staff.

**SIGNATURE OF PATIENT/GUARDIAN:** _____

**RELATIONSHIP OF GUARDIAN TO MINOR CHILD:** _____

### LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage with the enclosed captioned, and hereby assign and convey directly to Southern Podiatry Group, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments and understand that these balances are due within 30 days from the date of insurance payment and/or denial. If outside collection attempts are necessary, I will be responsible for all collection and legal fees. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

**SIGNATURE OF INSURED/GUARDIAN** **DATE**

**RELATIONSHIP OF GUARDIAN TO MINOR CHILD:** _____

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# North Oak Family Medicine Patient History

(PAGE 1)

Patient Name _____ Date of Birth ____/____/____

**Your Medical History**

Are you allergic to any medications?: ☐ Yes ☐ No

If so, please list here: _____

Previous Primary Care Physician_____

Preferred Pharmacy_____Pharmacy Phone Number_____

Please check box if you are allergic to:
☐Tape ☐Latex ☐Shellfish ☐Iodine ☐Other

Have you ever had any of the following?

| | | | |
|---|---|---|---|
| Acid Reflux | ☐Y ☐N | Allergic Rhinitis | ☐Y ☐N |
| Anemia | ☐Y ☐N | Heart Attack | ☐Y ☐N |
| Arthritis | ☐Y ☐N | Heart Disease/Failure | ☐Y ☐N |
| Asthma | ☐Y ☐N | Hepatitis | ☐Y ☐N |
| Back Pain | ☐Y ☐N | HIV+/AIDS | ☐Y ☐N |
| Blood Clots | ☐Y ☐N | High Blood Pressure | ☐Y ☐N |
| • Leg | ☐Y ☐N | Kidney Disease | ☐Y ☐N |
| • Lung | ☐Y ☐N | Liver Disease | ☐Y ☐N |
| • Other | ☐Y ☐N | Mitral Valve Prolapse | ☐Y ☐N |
| Bronchitis/Emphysema | ☐Y ☐N | Neuropathy | ☐Y ☐N |
| Cancer | ☐Y ☐N | Sickle Cell Disease | ☐Y ☐N |
| Chronic Ear Infections | ☐Y ☐N | Sleep Apnea | ☐Y ☐N |
| | | Speech problems | ☐Y ☐N |
| Diabetes | ☐Y ☐N | Stomach Ulcers | ☐Y ☐N |
| Fibromyalgia | ☐Y ☐N | Stroke | ☐Y ☐N |
| Gout | ☐Y ☐N | Thyroid Disease | ☐Y ☐N |

Other
Conditions_____

_____

Please list all medications you are currently taking (Include prescriptions, over-the-counter meds and herbal supplements):

| Name | Dose | How often do you take? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

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# Patient History

(PAGE 2)

Patient Name _____ Date of Birth ____/____/____

Please list all prior surgeries:

| Type of surgery | Date | Type of surgery | Date |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

## Social History

Patient Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Yes ☐ No ☐ Occasional

Current use of recreational drugs: ☐ Yes ☐ No ☐ Type _____

Use of tobacco: ☐ Never ☐ Quit - How long ago? _____ ☐ Smoke ___ Packs/Day for ____ years

## Family History

Do you have a family history of: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Coronary Artery Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis

☐ Other _____

Please list the relative who had the disease or condition.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| • Diabetes: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |
| • Cancer: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |
| • Heart Disease: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |
| • High Blood Pressure: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |
| • Stroke: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |
| • Thyroid Disease: | Mother | ☐ Yes | ☐ No | Father | ☐ Yes | ☐ No | Sibling | ☐ Yes | ☐ No |

• Other: _____

_____

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North Oak Family Medicine

# SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
Our Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

**Uses and Disclosures of Health Information.** We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

**Uses and Disclosures Based on Your Authorization.** Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

**Uses and Disclosures Not Requiring Your Authorization.** In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

**Patient Rights.** As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive a detailed notice of our privacy practices (shall you request one).

**If you have a question, concern or complaint regarding our privacy practices, you may contact:**

**Office Manager: North Oak Family Medicine**
**Telephone: 229-242-5145 Fax: 229-253-8666**
**Address: 2718 N Oak Street**
**Valdosta GA, 31602**

**E-mail: info@NorthOakFamilyMedicine.com**

# North Oak Family Medicine
## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

### *Our Legal Duty*

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 2, 2023**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

## Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities,

training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

**Uses and Disclosures Based On Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

**Others Involved in Your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

**Marketing:** We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

**Research; Death; Organ Donation:** We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

**Public Health and Safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive

reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Required by Law:** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

**Process and Proceedings:** We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

**Law Enforcement:** We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

## Patient Rights

**Access:** You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **.80** for each page, **$20.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Accounting of Disclosures:** You have the right to receive a list of instances in which we or our business associates disclosed your <u>non-electronic</u> protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of <u>electronic</u> health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact

us using the information listed at the end of this notice for a full explanation of our fee structure.

**Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

**Confidential Communication:** You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

**Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

**Electronic Notice:** If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

**Notice of Unauthorized Disclosures:** If the Practice causes or allows your health information to be disclosed to an unauthorized person, and such may cause harm to you, the Practice will notify you of this and help you mitigate the effects.

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Name of Contact Person: Office Manager**
**Telephone: 229-242-5145 Fax: 229-253-8666**
**Address: North Oak Family Medicine**
**2718 N Oak Street, Valdosta GA 31602**
**E-mail: info@NorthOakFamilyMedicine.com**

# ACKNOWLEDGMENT OF RECEIPT

**OF**

# NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a summary of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose). A detailed copy will be given upon request.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature