

# PATIENT INFORMATION SHEET

**Buford-Norcross Primary Care, P.C.**

Phone: 770-246-6100

Fax: 770-246-6142

<b>Patient Information Only</b>	First Name	Middle Name	Last Name
	Street Address		
	City	State	Zip Code
	Date of Birth (mm/dd/yyyy)	Sex Male / Female	Social Security Number
	Home Phone Number	Work Phone Number	Cell Phone Number
	Marital Status Single / Married / Separated / Divorced / Widowed		
	Email Address		
	If patient is a minor (under 18 years old) and/or patient is not the primary insurance card holder, please complete the following:		
<b>Guardian / Policy</b>	First Name	Middle Name	Last Name
	Social Security Number	Date of Birth (mm/dd/yyyy)	Relation to Patient
	Name of Employer	Employer Address	Occupation

## CONSENT FOR TREATMENT and PAYMENT

I hereby authorize the physicians/associates of Buford-Norcross Primary Care, P.C. to provide me with medical treatment. **I understand that I am ultimately responsible for all fees for services rendered.** I hereby authorize the release of any medical information necessary to file a claim with my insurance company.

Medicare/Insurance: I request that payment of authorized Medicare or Insurance benefits be made either to me or on my behalf to Buford-Norcross Primary Care, P.C. furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above medical practice any information regarding my Medicare claims under Title XVIII of the Social Security Act.

I hereby volunteer consent to my treatment by the physicians/associates of Buford-Norcross Primary Care, P.C. at the office and authorize such treatments, examinations, medications and diagnostic procedures (including but not limited to the use of radiographic and laboratory studies) as ordered by attending physicians. **I understand that payment is due at the time of service and that I am responsible for any amount not paid by insurance.** I have read this consent, am aware of its contents and fully understand the same. I also understand that no assurances or promises have been given to me concerning the results which may be obtained by such treatments and/or procedures ordered by the attending physicians.

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

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

# HIPAA Notice of Privacy Practices

**Buford-Norcross Primary Care, P.C.**  
**777 West Peachtree Street, Norcross, Georgia 30071**  
**Phone: 770-246-6100 Fax: 770-246-6142**

## **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **1. Uses and Disclosures of Protected Health Information**

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**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. 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.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. 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.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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**Buford-Norcross Primary Care, P.C.**  
**777 West Peachtree Street, Norcross, Georgia 30071**  
**Phone: 770-246-6100 Fax: 770-246-2142**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_