Creekside Medical Clinic LLC, 3104 Creekside Village Dr, #201, Kennesaw GA 30144

**PATIENT INFORMATION**

**Name**: _____ _____ _____
(First name) (Last name) (Middle name)

**Gender**: Male / Female. **S S N** #: XXX-XX-_____. **Marital status** ☐ Married ☐ Single **DOB**: ____/_____/_____
M/F ☐ Divorced ☐ Widowed

**Address**: _____

**City**: _____ **State**: _____ **ZIP**: _____

**Email**: _____

**Primary Phone**: _____**(Home / Cell).** Secondary Phone: _____ **(Home / Cell).**

**Work Phone**: _____. Preferred Contact Method: **Home Phone / Cell Phone / Email**

**Place of Work**: _____ Home/Cell/Email

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**

**Name**: _____ _____ _____
(First name) (Last name) (Middle name)

**Gender**: Male / Female. **S S N** #: XXX-XX- _____. **Marital status**: ☐ Married ☐ Single **DOB**: _____/_____/_____
M/F ☐ Divorced ☐ Widowed

**Address**: _____

**City**: _____ **State**: _____ **ZIP**: _____

**Email**: _____

**Primary Phone**: _____ **(Home / Cell).** Secondary Phone: _____ **(Home / Cell).**

**Work Phone**: _____. Preferred Contact Method: **Home Phone / Cell Phone / Email**

**Place of Work**: _____. Relationship to Patient: _____

**Primary Insurance Company**: _____

**ID#** _____ **Group#** _____

**Name on Card**: _____

**Secondary Insurance Company**: _____

**ID#** _____ **Group#** _____

**Name on card**: _____

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my physician. Regulations pertaining to the medical assignment of benefits apply. I understand that I am financially responsible for charges not covered by this agreement or that which is above the usual and customary as determined by my insurance company.

Patient/Guardian Signature_____ Date____/____/____

# Creekside Medical Clinic Privacy/Billing/Sharing Procedures Authorization and Acknowledgement

Name: _____Date of Birth:___/____/____

_____
Name of Patient Representative Signing for Patient and Relationship to Patient
(Required if the patient is a minor or an adult who is unable to sign this form)

Name and relationship of people with whom your information can be shared

_____

_____
These authorizations / acknowledgements cover all services rendered to the above patient for today and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us of your decision to revoke.

**Acknowledgement of receipt of notice of privacy practices:** We reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices for the patient outlined above.

**Authorization to Treat and Bill:** I give consent for the patient to be treated by Creekside Medical Clinic and its physicians. I authorize the release of any medical and demographic information necessary to process all claims. I authorize payment of medical benefits to Creekside Medical Clinic for all services performed and billed by Creekside Medical Clinic. Creekside Medical Clinic will submit a claim for services rendered to my insurance carrier and do so as a courtesy.

I understand that if I do not provide complete and accurate billing/insurance information at the time of service and this prevents Creekside Medical Clinic from collecting from my insurance company, I will be responsible for the full charges. I understand I will be held responsible for any balance that remains on the account after the insurance company has paid according to contract including services that my insurance company considers non-contracted, non-covered or preventative.

I understand that Creekside Medical Clinic may send lab specimens to an outside laboratory. I give permission for those outside laboratories to bill my insurance for their services. I understand that I may incur additional charges as *a* result of those outside laboratory tests.

I understand that Creekside Medical Clinic is not responsible for payment to those laboratories. I understand that if my account remains unpaid, it will be sent to collections and collection costs of up to 35% or $20, whichever is higher will be added to the account balance and become my responsibility.

Signature: _____Date:_____

**NOTICE OF PRIVACY PRACTICES FOR CREEKSIDE MEDICAL CLINIC LLC**
**3104 CREEKISDE VILLAGE DR #201 KENNESAW GA 30144. TEL: 7706273986 FAX: 7708720517**
**Email: doctor@creeksidemedicalclinic.com**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below and describes how we and our Business Associates, and their subcontractors may use and disclose your Protected Health Information. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy notice at any time. We will keep your health information confidential, using it only for the following purposes:

**Treatment**: We use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure**: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you including business associates and their subcontractors. These professionals will have a privacy and confidentiality policy like this one. We require these companies sign business associate or confidentiality agreements before we disclose your PHI to them but do not control the business, privacy, or security operations of our business associates. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. If you are a minor (generally an individual under 18 years old), we may disclose your PHI to your parent or guardian unless otherwise prohibited by law. The form you sign as part of the registration process includes your consent to the release of substance use disorder information, information regarding treatment of communicable diseases and mental health information for the purposes specified in this notice. If you do not wish for this information to be disclosed, you must notify us in writing, and we will determine if it is feasible for us to accept your request. However Federal and state laws provide special protection for certain types of health information, including psychotherapy notes, information about substance use disorders and treatment, mental health and AIDS/HIV or other communicable diseases, and may limit whether and how we may disclose information about you to others.

**Payment**: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies**: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations**: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. We may disclose your PHI to a medical examiner/ coroner to identify a deceased individual or to identify the cause of death, for worker's compensation in compliance with worker's compensation laws and through various secure patient portals that allow you to view, download and transmit certain medical and billing information and communicate with certain health care providers in a secure manner. When you provide us with any contact information during any administrative process we will assume that the information is accurate and that you consent to our use of this information to communicate with you for treatment, payment for service and health care operations. We reserve the right to utilize third parties to update your personal information for our records as needed.

**Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities**: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services**: We will not use your health information for marketing purposes.

**National Security**: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

**Health Information Exchange/Email**: To securely share your health information electronically, Creekside Medical Clinic participates in several HIEs, including, but not limited to, Surescripts, Georgia health Connect. This is subject to change. If you agree to have your medical information shared through HIE you do not need to do anything. If you want to opt-out of participating in HIE, please use the Opt-Out Request Form. Please note, your opt-out does not affect health information that was disclosed through HIE prior to the time that you opted out. If you email us medical or billing information from a private email address your information may not be secure in transmission and we are not responsible for the privacy or security of your PHI if you communicate with us through an unsecure medium. In addition, we are not responsible if your PHI is redisclosed, damaged, altered or otherwise misused by an authorized recipient or if you share an account with another person or if you choose to store, print, email, or post your PHI.

**Telemedicine**: Our healthcare providers may use video communication in a manner that is consistent with our HIPAA obligations. The virtual visit technology does not store or access the PHI of users and uses encryption that is designed to protect the video streams during transmission so that no unauthorized parties can access a video conference while in session. Further, the technology does not permit either the patient or provider to record the videoconferencing sessions.

YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. You may also request access by sending us a letter to the address at the top of this Notice. Once approved, an appointment can be made to review your records. A reasonable fee will be charged to locate and copy your health information.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures. Therefore, these are not available. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years. Information prior to that date would not have to be released. We will notify you of the costs involved with any additional request and you may withdraw your request before you incur any costs. Despite our efforts to protect your privacy, your PHI may be overheard or seen by people not involved in your care. For example, other individuals at your provider's office could overhear a conversation about you or see you getting treatment. Such incidental disclosures are not a violation of HIPAA.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations and is not for purposes of carrying out treatment and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full. Please contact our us if you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach Notification Requirements:** In the event unsecured protected information about you is 'breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

**COMPLAINTS:** You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. We support your right to the privacy of your information and 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. 12/1/ 2020