PO Box 794
Baxley, GA 31515
478-401-0477
Fax: 888-375-0624
BAXLEY: baxleyclinic@yurhealth.com
MILLEN: clinicadmin@yurhealth.com

AUTHORIZATION TO RELEASE PATIENT INFORMATION & MEDICAL RECORDS

To: _____

_____

_____

Pursuant to O.C.G.A. §§ 31-33-1 and 31-33-2:

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including x-rays and photo static copies, abstracts or excerpts of all records and any other information he/she/they may request relating to any examinations, treatments, or opinions concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward the records and information to:

YURHEALTH, LLC
Post Office Box 794
Baxley, GA 31515
Phone: 478-401-0477
Fax: 888-375-0624

_____
Patient Signature

_____
Printed Patient Name

_____
Date of Birth

_____
Social Security Number

_____
Signature of Representative

_____
Relationship to Patient

NEW PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____

Sex: F / M SS#: _____ Race: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Text: Y / N

Email: _____

Occupation: _____ Employer: _____

Work Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Guardian/Spouse Name: _____ DOB: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Family Medical Doctor: _____

IF THIS SECTION IS NOT COMPLETED AND WE DO NOT HAVE A COPY OF YOUR INSURANCE CARD, WE CANNOT FILE ON YOUR INSURANCE AND YOU WILL BE RESPONSIBLE FOR YOUR VISIT.

Primary Insurance Plan: _____

Primary Insurance Member ID# : _____

Name of Policy Holder: _____ DOB: _____

Policy Holder Address (if different from above) _____

City: _____ State: _____ Zip Code: _____

Policy Holder Employer: _____ Policy Holder SS#: _____

Secondary Plan (if applicable) _____

Name of Policy Holder: _____ DOB: _____

REASON FOR TODAY'S VISIT? _____

_____

_____

Authorization For Insurance

I certify that I (or dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO *YURHEALTH, LLC* INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submission.

Patient's Signature: _____ Date: _____

Parent or Legal Representative Signature: _____ Date: _____

HEALTH HISTORY

Current Primary Care Provider: _____

_____ AIDS/HIV
_____ Alcoholism
_____ Allergies/Hay Fever
_____ Anemia
_____ Arthritis/Gout
_____ Asthma
_____ Bleeding Disorder
_____ Cancer
_____ Cataracts
_____ Chemical Dependency
_____ Chicken Pox
_____ Breast Lump
_____ Bulimia
_____ Diabetes
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Glaucoma
_____ Goiter/Thyroid
_____ Heart Disease
_____ Hepatitis
_____ Hernia
_____ Herniated Disc
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease
_____ MRSA Exposure
_____ Migraines
_____ Mono
_____ Osteoporosis
_____ Pacemaker
_____ Pinched Nerve
_____ Psychiatric Care
_____ Reflux/GERD
_____ Rheumatic Fever
_____ Scarlet Fever
_____ STD
_____ Stroke
_____ Ulcers

Family History:
(Parents, Siblings, Grandparents)
Please indicate, if applicable, who has had:

Heart Disease _____
High Blood Pressure _____
Stroke _____
Diabetes _____
Kidney Disease _____
Liver Disease _____
Psychiatric _____
Cancer(&type) _____
_____
OTHER _____

Are you currently under Pain Management or any medical care? _____ Yes _____ No

If yes, please explain. _____

_____

_____

Please list any allergies _____

Please list any surgeries, including dates: _____

_____

_____

Daily/Weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Tobacco _____ packs/day

If not currently, did you ever use tobacco? _____ # of years quit? _____
Do you live alone? _____ Or with others? _____
General stress level? Low _____ Med _____ High _____
Are you hard of hearing or deaf in one or both ears? _____
Are you legally blind in one eye? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information or withholding information can be dangerous to my health.

Patient Signature _____ Date _____

Parent/Legal Representative Signature _____

CHRONIC MEDICATION LIST

Name: _____

Date of birth: _____

Pharmacy: _____

Allergies: _____

_____

Medication	Dosage	Frequency

(WOMEN) OB/GYN History

Date of Last Pap Smear: _____ ☐ Abnormal

Date of Last Mammogram: _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____

Births: _____ Miscarriages: _____ C-Sections: _____

Current Birth Control Method: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
- ☐ Interested in being screened for STD's

CONSENT TO CARE

I, _____, authorize the healthcare providers of YurHealth, LLC to administer treatment as deemed necessary for care of the above named patient. This pertains to today's visit and any future visits involving treatment by the healthcare providers of YurHealth, LLC. I certify that I am the patient or the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the provider.

I have read and understand the foregoing:

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Representative's Signature (if required) Date

_____
Relationship to patient

HIPAA 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. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations (TFO) and for other purposes 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

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 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 to support the business activities of your physician's practice. These activities include quality assessment activities, employee review activities, training medical students, licensing, 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.

Your Rights

The following is a statement of your rights regarding 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 a 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 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 vour physician amend vour protected health information. If we deny your amendment request, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal 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 June 1, 2023.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices regarding protected health information. This letter will be reproduced for each family member's chart. Reproduction of this form shall serve as the original. 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: _____

A copy of this form is available upon request.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices for YurHealth, LLC regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the clinic and my respective rights contained therein.

I also understand that the Notice is furnished to me is subject to change at any time. I am aware that I may obtain a copy of this Notice at any time by contacting YurHealth, LLC.

My signature herein constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for YurHealth, LLC.

_____ _____
Patient Signature Date

_____ _____
Patient's Legal Representative Date

_____
Relationship to patient

I, the patient, hereby authorize YurHealth, LLC to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via telephone or in-person to the following family members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

****PLEASE NOTE: VALID PHOTO IDENTIFICATION WILL BE REQUIRED WHEN REQUESTING INFORMATION IN-PERSON.**

Late Policy

A grace period of **15 minutes** will be permitted at our medical office for unforeseen delays a patient may encounter while traveling to our office. **Each appointment slot is 15 minutes long and certain appointments require us to book multiple slots.**

With this policy, we are trying to avoid delaying and/or inconveniencing the patients who have arrived on time.

Please note that if you arrive more than 15 minutes late, you will be rescheduled at a later time or date.

** after 3 no-shows, you will be charged a $25 fee for each additional no show appointment **

Thank you for understanding.

- YurHealth, LLC Staff

I acknowledge that I have read and understand the late notice rules as described above.

_____ _____

Patient Signature **Date**