NORTHSIDE HOSPITAL

Full Name:_____ Date of Birth _____
(First) (Middle) (Last)

Gender (circle) Male Female **Marital Status (circle)** Single Married Divorced Widowed

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____

*Email_____

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Other ☐ Unknown/Declined

Preferred Language ☐ English ☐ Spanish ☐ Chinese(Cantonese) ☐ Chinese(Mandarin) ☐ French ☐ German
☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Other

Employer _____ Employer Phone_____

Preferred Communication for Appointment Reminders: ☐ Phone Call ☐ Automated Text ☐ Automated Email

If this practice lacks the capability for text or email reminders, may we use the phone number for reminders ☐ yes ☐ no.

Pharmacy Information

Pharmacy Name _____ Phone_____ Fax_____

Pharmacy Address _____

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name _____ Date of Birth _____Relationship to Patient_____

Address_____City_____ State_____ Zip_____

*Preferred Phone Number ☐ home ☐ cell _____ *Email _____

***Note:** *By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.*

Emergency Contacts Information and Relationship to Patient:

Name _____Relationship _____Phone_____

Name _____Relationship _____Phone_____

Referring Physician Information:

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Primary Care Physician Information (if different than referring physician):

Physician Name_____ Specialty _____Office Name_____

Address: _____ Phone_____ Fax _____

Does your insurance require a referral? ____YES ____NO; **if yes,** please provide the referral to the receptionist

	Primary Insurance	**Secondary Insurance**
Name of Insurance	_____	_____
Name of Policy Holder	_____	_____
Date of Birth of Policy Holder	_____	_____
Policy/Member ID Number	_____	_____
Group/Plan Number	_____	_____
Phone Number	_____	_____
Effective Date of Policy	_____	_____

Patient/Guarantor Signature _____ **Date** _____

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

English - Spanish

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: In consideration of the services provided at Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. If admission is for pregnancy, assignment of benefits will also apply to any newborn child.

PRECERTIFICATION: I understand that my insurance policy may require compliance with a utilization review program to make certain that health care benefit funds are expended when justified. **I understand** that it is the utilization review program's responsibility to review proposed elective admissions and anticipated courses of treatment. **I understand** that if the utilization review program determines that admission is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, health care benefits may be withheld. **I understand** that precertification may be the responsibility of the patient or financially responsible party and his or her physician. **I understand** that Northside Hospital is willing to admit as requested by my physician. **I also understand** that I may be financially responsible for all hospital charges incurred as a result of admission should the utilization review program refuse to certify that the admission is appropriate, or should the certification effort occur too late to be valid. **I understand** that to protect myself from unnecessary personal financial losses, I must provide insurance coverage at time of registration, review my obligations with my insurance company, utilization review program, and personal physician without delay.

ABOUT YOUR BILLING:

Hospital and Provider-Based Services — In addition to a bill received from Northside Hospital, a bill will be received for the professional component of treatment. Although Northside Hospital may be a provider in an insurance network, the physician or professional service group may or may not be a covered provider of service. If the care received is outpatient care, the insurance carrier will process the claim(s) on an outpatient basis. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits.

Physician Practice Locations — If services are received in a physician practice, which is not a provider-based outpatient location of Northside Hospital, insurance benefits will be processed as a physician office visit.

FINANCIAL RESPONSIBILITY: Payment in full is expected at the time services are received. Accounts more than 30 days past due will accrue interest at the rate of 8 percent a year. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible, and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made. This provision does not apply, and payment will not be requested, prior to emergency screening and stabilizing treatment as required by federal law.

_____ I authorize Northside Hospital, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at Northside Hospital or payment for the services I received at Northside Hospital, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services at Northside Hospital.

_____ I do not agree with the above statement and do not wish to be contacted by the use of any automatic dialing system; by pre-recorded forms of voice/messaging systems; by electronic mail or by receiving voice messages on my cell phone, except for clinical issues

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Interpreter Signature _____

Note: If phone interpretation used, record interpreter ID #

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receipt of the Notice of Privacy Practices from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice of Privacy Practices provides information about how Northside Hospital and the Northside Hospital medical staff members may use and disclose my health information. I have been encouraged to read the notice in full.

I understand that Northside Hospital and its Medical Staff members operate as an "organized health care arrangement" and have presented me with a joint notice of privacy practices. Although the Hospital and Medical Staff members have established an organized health care arrangement for purposes of complying with privacy laws, some or all of the health care professionals performing services in this hospital or its outpatient centers are not employees or agents of the Hospital and remain independent contractors. Independent contractors are responsible for their own actions and Northside Hospital shall not be liable for the acts or omissions of any such independent contractors.

I understand that the Notice of Privacy Practices is subject to change. If Northside Hospital changes its notice, I may obtain a copy of the revised Notice at Northside's website (www.northside.com).

_____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

INABILITY TO OBTAIN ACKNOWLEDGEMENT FOR RECEIPT OF PRIVACY PRACTICES

☐ **Patient/Representative refused to sign** ☐ **Patient not competent to sign and legal representative not present** ☐ **Other** _____

Interpreter Signature _____

Note: If phone interpretation used, record interpreter ID #

ANNUAL ACKNOWLEDGEMENT

Not a part of the Permanent Medical Record

NORTHSIDE HOSPITAL AFFILIATED MEDICAL PRACTICE
ANNUAL ACKNOWLEDGEMENT – CLINICAL ISSUES

Patient Name:_____ Date of Birth _____

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

Consent To Routine Procedures. I consent to medical care and procedures while I am a patient at a Northside Hospital affiliated medical practice ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals The Minor Procedures are performed by a physician or qualified midlevel provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

Testing And Disposition Of Specimens, Devices, Foreign Objects. I consent to the Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

Consent To Download Prescription Records. The Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

Testing For Blood-Borne Pathogens. Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

Students. The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

Medications From Outside Source . I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to the Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.

BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:

The practice of medicine is not an exact science. No guarantees have been made to me as to the result of any treatment or examination in the Practice;

The healthcare professionals participating in my care will rely on my medical history and other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures; therefore, I agree to provide accurate and complete information about my medical history and conditions;

I consent to participation in and assistance with the Procedure(s) by Practice employees, medical personnel under the direct supervision and control of the Physician, and other medical personnel involved in my care; and

If a health care worker is exposed to my blood as a result of care provided at this practice, my blood may be tested for HIV/AIDS.

I have read or had all pages of this form read to me and understand its contents. All statements that I do not approve of were stricken before I signed this form. If I am signing this form on behalf of another person, to the best of my knowledge, I am legally authorized to consent on that person's behalf.

_____

Signature of Patient or Legal representative Date Time

_____ _____

Relationship to patient reason patient can't sign

_____

Interpreter (Note: if phone interpretation used, record interpreter ID#)

CURRENT COMPLAINT

PATIENT NAME: DOB: PATIENT ACCT#:

PRIMARY COMPLAINT:

What is your primary complaint? (Please answer all questions):

Location:

☐ Right ☐ Left

☐ Great toe ☐ Lesser toe ☐ Ball of foot ☐ Top of foot

☐ Arch ☐ Heel ☐ Ankle ☐ Leg

Nature of the Pain: (Please answer all questions):

☐ Sharp ☐ Dull ☐ Aching ☐ Burning

☐ Radiating ☐ Stabbing ☐ Itching ☐ Other

Pain Scale:

Low 0 1 2 3 4 5 6 7 8 9 10 **High**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Swelling:

☐ None ☐ Mild ☐ Moderate ☐ Severe

PREVIOUS TREATMENT:

Have you had previous treatment for this problem?

☐ Yes ☐ No

If yes, what treatments? Please list doctor's name

Do you have any other complaints or problems?

☐ Yes ☐ No

If yes, please list:

ONSET:

When did the problem start:

☐ Suddenly ☐ Gradually

Duration:

☐ Days ☐ Weeks ☐ Months ☐ Years

COURSE:

Is this problem related to an injury?

☐ Yes ☐ No

If yes, when?

Work related?

☐ Yes ☐ No

Activity causing injury:

☐ Getting worse ☐ Improving

☐ Stays the same ☐ Comes and goes

What make it better?

Makes it worse?

☐ Standing ☐ Walking ☐ Running

☐ Daily activities ☐ Exercise ☐ Work

☐ Shoes

Does this problem affect your daily activity?

☐ Yes ☐ No

If yes, how?

PREVIOUS ILLNESS

PATIENT NAME: DOB: PATIENT ACCT#:

Illness
- ☐ Alcoholism
- ☐ Cancer
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypo (low) thyroid
- ☐ Liver Disease/Cirrhosis
- ☐ Lyme Disease
- ☐ Lymphoma
- ☐ Malignant Hyperthermia
- ☐ Rheumatic Fever

Cardiac
- ☐ Angina
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Cardiac Arrest (heart attack)
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Fainting / Syncope
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction
- ☐ Pacemaker / Defibrillator

Vascular
- ☐ Blood Clots
- ☐ Cellulites
- ☐ DVT (deep vein thrombosis)
- ☐ Greenfield Filter
- ☐ Leg Swelling
- ☐ Leg Ulcers
- ☐ Lymphedema
- ☐ Peripheral Artery Disease
- ☐ Phlebitis
- ☐ Poor Circulation
- ☐ Pulmonary Embolism
- ☐ Raynaud's
- ☐ Spider Veins
- ☐ Varicose Veins
- ☐ Vasculitis
- ☐ Vein Problems

Blood / Hematologic
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Previous Transfusion
- ☐ Sickle Cell Disease

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ CPAP
- ☐ Cystic Fibrosis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sarcoidosis
- ☐ Sleep Apnea
- ☐ Tuberculosis

EENT
- ☐ Blindness
- ☐ Cataract
- ☐ Eye Disease
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Macular Degeneration
- ☐ Migraine Headaches
- ☐ Nasal Polyps
- ☐ Sinus Headaches
- ☐ Sinus Infection
- ☐ Tinnitus

GI (Gastrointestinal)
- ☐ Acid Reflux/GERD
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Duodenal Ulcer
- ☐ Gallbladder Disease
- ☐ Gastric By-Pass Surgery
- ☐ Gastric Ulcer
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome

GU (Gentourinary)
- ☐ Bladder Infections
- ☐ Cystic Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Renal Insufficiency
- ☐ Renal / Kidney Failure
- ☐ STD
- ☐ Syphilis

Musculoskeletal
- ☐ Achilles Tendonitis
- ☐ Amputation - Foot / Toes
- ☐ Amputation - Leg
- ☐ Ankle Sprain
- ☐ Back Pain
- ☐ Bunion
- ☐ Bursitis
- ☐ Chacot Foot Deformity
- ☐ Club Foot
- ☐ Difficulty Walking
- ☐ Dislocation - Foot / Ankle
- ☐ Dropfoot
- ☐ Fibromyalgia
- ☐ Foot Sprain Fracture
- ☐ Ankle Fracture - Toes / Foot
- ☐ Fracture
- ☐ Ganglion
- ☐ Gout
- ☐ Hammertoe
- ☐ Heel Spur
- ☐ Joint Instability
- ☐ Joint Stiffness
- ☐ Lupus (SLE)
- ☐ Muscle Spasms
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Plantar Fascitis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Rupture - Achilles Tendon
- ☐ Shin Splints
- ☐ Tailor's Bunion
- ☐ Tendontitis, Other
- ☐ Unequal Leg Length

Neuro / Psych
- ☐ Alzheimer's Disease
- ☐ Anorexia
- ☐ Anxiety Disorder
- ☐ Bi-Polar Disorder
- ☐ Brain Injury
- ☐ Cerebral palsy
- ☐ Charcot-Marie-Tooth Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetic Neuropathy
- ☐ Drug Abuse
- ☐ Drug Dependency
- ☐ Epilepsy
- ☐ Hemiplegia
- ☐ Idiopathic Neuropathy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Pain Management
- ☐ Panic Disorder
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Poor Balance
- ☐ Psychotherapy/Medications
- ☐ Ruptured Disc
- ☐ Schizophrenia
- ☐ Sciatica
- ☐ Seizure Disorder
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Stroke
- ☐ TIA
- ☐ Tremors
- ☐ Vertigo

Skin
- ☐ Acne
- ☐ Athlete's Foot
- ☐ Contact Dermatitis
- ☐ Dermatitis
- ☐ Eczema
- ☐ Fungal Nail Infection
- ☐ Fungal Skin Infection
- ☐ Hyperkeratosis Plantaris
- ☐ Ingrown Toenail
- ☐ Keloid / Scarring
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Rash
- ☐ Scleromderma
- ☐ Skin Cancer
- ☐ Skin Disorders
- ☐ Warts
- ☐ Vitiligo

PREVIOUS SURGERIES OR HOSPITALIZATIONS: Date

☐ **No previous surgery**

PATIENT NAME:_____ DOB: _____ PATIENT ACCT#:_____

Height _____ Weight _____ Shoe Size _____

FAMILY MEDICAL HISTORY:

☐ Heart disease ☐ Arthritis ☐ Asthma ☐ Cancer/type:_____

☐ Diabetes/type:_____ ☐ Hypertension (high blood pressure)

☐ *Other (please provide details):_____

_____

SOCIAL HISTORY:

Tobacco Use: (please choose one)

☐ Never ☐ Former (Quite date) _____ Current (How many years?)_____ Packs / day:_____

Alcohol Use: (please choose one)

☐ Never ☐ Rare ☐ Occasional ☐ Moderate ☐ Daily Drinks / week: _____

Illicit Drug Use: ☐ Yes ☐ No Drugs used: _____

Prescription Drug Abuse: ☐ Yes ☐ No Drugs used: _____

Occupation: _____ Employer: _____

Time on your feet during the day: ☐ Minimal ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Do you exercise? ☐ Sedentary ☐ Minimal ☐ Active but no formal exercise ☐ Heavy

Type of exercise: _____ How many times a week:_____

_____

CURRENT MEDICATIONS:

Medication / Dosage

*If more medications, please attach with paperwork

_____

DRUG ALLERGIES:

☐ No allergies

☐ Penicillin ☐ Sulfa ☐ Bactrim ☐ Amoxicillin ☐ Keflex ☐ Erythromycin ☐ Neosporin

☐ Cipro

☐ Other Antibiotic(s): please list:

☐ Iodine ☐ Betadine ☐ Shellfish ☐ Contrast Dye ☐ Codeine ☐ Demerol

☐ Aspirin ☐ Hydrocodone ☐ Latex ☐ Tape ☐ Skin Adhesives ☐ Metal ☐ Anti-inflammatories

_____

OTHER KNOW ALLERGIES:

☐ Food: _____

☐ Environmental: _____

☐ Other:_____

PAST MEDICAL HISTORY

REVIEW OF SYSTEMS

PATIENT NAME: DOB: PATIENT ACCT#:

Constitutional
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight Loss
- ☐ Fever
- ☐ Body Aches
- ☐ Chills
- ☐ Night Sweats
- ☐ Loss of Appetite

Eyes
- ☐ Discharge from Eye
- ☐ Double Vision
- ☐ Floaters
- ☐ Eye Discomfort/Pain
- ☐ Impaired Vision
- ☐ Foreign Body Sensation
- ☐ Blurred Vision
- ☐ Changes in Vision

HENT
- ☐ Headaches
- ☐ Nasal Discharge
- ☐ Recent Head Injury
- ☐ Sore Throat
- ☐ Nose Bleeding
- ☐ Dental or Gum Disease
- ☐ Lightheadedness
- ☐ Neck Stiffness
- ☐ Nasal Congestion
- ☐ Thyroid Mass
- ☐ Dentures
- ☐ Dizziness
- ☐ Neck Pain
- ☐ Sinus Pain
- ☐ Hoarseness

Cariovascular
- ☐ Chest Pain
- ☐ Syncope / Fainting
- ☐ Varicose Veins
- ☐ Pacemaker / Defibrillator
- ☐ Irregular Heartbeat
- ☐ Shortness of breath-Exertion
- ☐ Lower Extremity Edema
- ☐ Cardiac Arrest
- ☐ Slow or Rapid Heartbeat

Repiratory
- ☐ Shortness of Breath
- ☐ Pain with Breathing
- ☐ Painful Cough
- ☐ Productive Cough
- ☐ Difficulty Breathing
- ☐ Coughing up Blood
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Gallstones
- ☐ Heartburn
- ☐ Black Stools
- ☐ Diarrhea
- ☐ Loss of Appetite
- ☐ Jaundice
- ☐ Eating Disorder

Gentourinary
- ☐ Urinary Frequency
- ☐ Possible Pregnancy
- ☐ Painful/Difficulty Urinating
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Pelvic Pain

Integument
- ☐ Rash
- ☐ Dry Skin
- ☐ Acne
- ☐ Itching
- ☐ Change/Loss Hair Growth
- ☐ Skin/Mole Changes in Pigmentation
- ☐ Discolored, Thickened, of Damaged Nails
- ☐ Blisters
- ☐ Ingrown Nail

Neuologic
- ☐ Muscle Weakness
- ☐ Loss of Muscle Control
- ☐ Loss of Coordination
- ☐ Loss of Balance
- ☐ Numbness
- ☐ Tingling
- ☐ Tremors
- ☐ Seizures
- ☐ Dizziness
- ☐ Paralysis
- ☐ Difficulty with Speech
- ☐ Loss of Consciousness
- ☐ Loss of Sensation
- ☐ Memory Loss/Confusion

Musculoskeletal
- ☐ Muscle Weakness
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Limitation of Motion
- ☐ Leg Swelling
- ☐ Instability
- ☐ Ankle Weakness and/or Leg Pain
- ☐ Foot Pain
- ☐ Ankle Pain
- ☐ KneePain
- ☐ Leg Pain
- ☐ Hip Pain
- ☐ Join Pain/Other

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Loss of Hair
- ☐ Weight Gain / Loss

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Bi-polar
- ☐ Difficulty Sleeping
- ☐ Hallucinations

Heme-Lymph
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes

How did you hear about Alpharetta Foot and Ankle Specialists?

☐ Physician ☐ Friend ☐ Print Ad ☐ Radio Ad ☐ Website ☐ Other

If other, please name source:

Signature

Date

Alpharetta Foot and Ankle Specialists

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

Name of Patient: _____ Phone #: _____

Address: _____ Patient's Date of Birth: _____

_____

The Northside Hospital Physician Office Practice identified above is hereby authorized to **(Please mark appropriate box)**:

☐ **Release to** OR ☐ **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) **(Please identify by name or general description and provide address, if known)**: _____

_____

_____

The following protected health information regarding the patient **(Please mark appropriate box(es))**:

☐ Complete Medical Record ☐ Abstract of Medical Record (physician dictated reports & diagnostic reports)

☐ Labs only ☐ Radiology only ☐EKG only

☐ Other **(Please specify clearly)** _____
For the following dates of service: _____

Unless you state otherwise, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol,** except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

Unless you state otherwise by marking one or both boxes below, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/ AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

☐ I **object** to the release of **HIV/AIDS** confidential information.

☐ I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is **(Please describe each purpose of the requested use or disclosure)**:

_____

Original – Medical Records
Copy - Patient

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:(a) _____**(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit)**; (b) the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.

_____	_____
Witness	Signature of Patient or Legally Authorized Representative, including Legal Guardian, Health Care Agent, or Parent of Minor Child
_____ AM/PM _____	Print name: _____
Date Time	
	Relationship to patient:_____
_____	
Interpreter (if applicable)	Reason patient unable to sign: _____

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

This authorization can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified on the front of this form. I understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. I also understand that treatment of the patient (either myself or the patient named above) at the Northside Hospital Physician Office Practice and/or Northside Hospital will not be affected if I refuse to sign this authorization.

Note: To authorize the disclosure of psychotherapy notes, the additional form entitled ***Authorization for Release of Psychotherapy Notes*** will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled ***Authorization for Release of Alcohol and Drug Abuse Patient Records*** will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.

> **This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

ADDRESSOGRAPH

NH2520

NORTHSIDE HOSPITAL

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Ebola Virus Disease (EVD) Screening
Outpatient Settings

In order to keep our patients and staff safe, we would like to ask you some questions about recent travel to areas where Ebola has been found.

1. Have you traveled to West Africa (Guinea, Liberia, Mali or Sierra Leone) within the 21 days (3 weeks) of symptom onset or had any exposure to anyone with suspected or confirmed Ebola? Yes ____ No ____

AND

2. Do you have any of the following symptoms: fever, headache, joint and muscle aches, weakness, fatigue, diarrhea, vomiting, stomach pain and lack of appetite, and in some cases bleeding? Yes ____ No ____

If "Yes" to BOTH questions:
IMMEDIATELY

(1) PROVIDE* patient with a surgical or isolation mask and a gown (or blanket) with instruction for them to apply
(2) CALL clinic Manager/Supervisor
(3) NOTIFY patient's physician
(4) CALL Georgia Department of Public Health (DPH) at 1-866-PUB-HLTH (1-866-782-4584)

NOTE: After the call is placed to DPH, the Medical Epidemiologist will call back to triage and advise on next steps, and arrange for EMS transport to an appropriate treatment facility if necessary. DO NOT CALL 911 unless there is a medical emergency.

ASPR
ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE

Name _____ Signature _____ Date/Time_____

***Healthcare workers should not touch patient without application of their own Personal Protective Equipment (gowns, gloves, mask, goggles, etc.)**

Reorder #NH2520 **U**
Piedmont Graphics 12/08/14
PP034