



Tel 678-679-6210  
3340 Paddocks Parkway

Fax 678-679-6220  
Suwanee, GA 30024

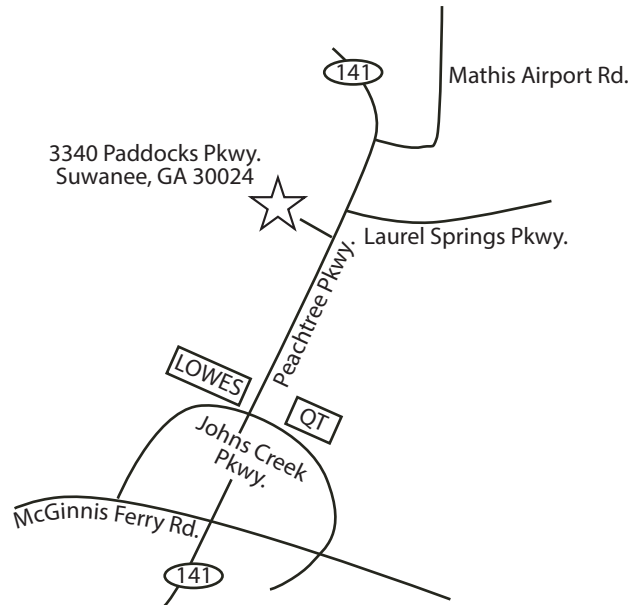
## Welcome to John's Creek Specialist Center

We at John's Creek Specialist Center are committed to excellence in healthcare. Our well-trained team is focused on providing a high standard of care in a warm, efficient office environment. We realize that you have a choice regarding your medical care. We appreciate and value your business, and we will strive to do everything we can to provide you with the personalized service you deserve.

### Directions

John's Creek Specialist Center is located at 3340 Paddocks Parkway in Suwanee. If this map does not help you with your route to our office, and if you have Internet access, just go to <http://maps.google.com>, and you can create custom turn-by-turn directions from your location.

If you do not have access to the Internet, or if the resulting directions are not helpful to you, just call our office at 678-679-6210, and we'll be glad to help you with directions.



### New patient forms

Please print the forms, fill them out by hand, and bring them with you at the time of your visit.

Thank you for your help!

# 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** \_\_\_\_\_

# NORTHSIDE HOSPITAL

## PHYSICIAN PRACTICE

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

English - Spanish

### FINANCIAL ACKNOWLEDGEMENT

**ASSIGNMENT OF BENEFITS:** Unless I have specified otherwise, verbally or in writing, 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. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

**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, you may receive a bill 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. Medicare and Medicare Advantage patients will receive a coinsurance liability estimate. 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 annually. 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 (“Notice”) from Northside Hospital, Inc. and the Northside Hospital medical staff. The Notice 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 is subject to change. If Northside Hospital changes the 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 #

# NORTHSIDE HOSPITAL

PATIENT'S 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 one or more Northside Hospital affiliated medical practices ("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 mid-level 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 each 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.** Each 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 a 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.

**Privacy, Individuals Involved In My Care.** I understand that, unless I request confidentiality, the privacy laws allow the hospital to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with you.

**Telemedicine** I consent to telemedicine consultations as recommended by my physician. My medical information may be discussed with Georgia licensed health professionals through telecommunication technology and, in some cases, a physical examination will be performed. A non-medical technician may be present to assist with the technology and, unless I object, audio or video recordings may be taken during the consultation. I can withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any Medicaid benefits to which you would otherwise be entitled. If I do not consent to a telemedicine consultation, some services may not be available at all Northside locations. All state and federal laws, including privacy and confidentiality, apply to records of the telemedicine consultation.

**PHOTOGRAPHY AND RECORDING.** Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

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.**

Witness	Date	Time	Signature of Patient or Legal representative	Date	Time
Interpreter (Note: if phone interpretation used, record interpreter ID#)			Relationship to patient		reason patient can't sign

**NOTICE OF NON-DISCRIMINATION**

Northside Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **ATTENTION:** If you speak a language other than English, language assistance services, free of charge, are available to you. Call 404-845- 5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)

Northside Hospital cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee).

Northside Hospital tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 404-845-5898 (Atlanta/Forsyth); 678-493-1507 (Cherokee)





Please mark any of the following symptoms that you are experiencing.

**General**

- unexplained rapid weight gain       fever       unexplained rapid weight loss
- extreme tiredness

**Endocrine**

- excessive sweating/night sweats       low blood sugar       calcium problems
- potassium problems       heat/cold intolerance       adrenal problems
- thyroid problems       pituitary problems

**Eyes**

- eye laser treatments       glaucoma       poor vision/blindness
- macular degeneration       tunnel vision (poor peripheral vision)       double vision
- color blindness       retinal detachment

**ENT**

- loss of hearing/deafness       dentures/bridges       mouth dryness
- difficulty swallowing       changes in voice, hoarseness       pain in front of the neck
- enlarged thyroid or neck lumps       impaired smell or taste

**Heart/lungs**

- use oxygen       sleep apnea, use CPCP/BiPAP       shortness of breath on exertion
- pacemaker or internal defibrillator       blood in sputum       short of breath at night/rest
- chest/arm/jaw discomfort on exertion       asthma or COPD       slow, fast or irregular heart beat
- long term cough       ankle/leg swelling with water       calf pain while walking

**Breast**

- nipple discharge       breast lump/mass       breast pain/tenderness or swelling

**Gastrointestinal**

- nausea       vomiting       early satiety
- eating disorder       diarrhea       constipation
- irritable bowel       crohn's disease or colitis       frequent heartburn, indigestion
- abdominal pain       bloody or black, tarry stools       food intolerances

**Blood**

- history of blood clots       bleeding problems       easy bruising
- anemia       radiation treatments to head, neck or whole body

**Urological**

- frequent bladder or vaginal infections       kidney problems       kidney stones
- frequent urination

**Men only**

- pain or lump in testicles       STD/discharge       difficulty achieving/maintaining erections
- change in desire to have sexual intimacy (libido)

Patient's name

Date

Physician's initials



**Women only**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> date of last period                                      | <input type="checkbox"/> irregular periods | <input type="checkbox"/> spotting between periods |
| <input type="checkbox"/> pregnant now   | Number of pregnancies                      | Number of live births                             |
| <input type="checkbox"/> contraception use (birth pill, iuds, condoms, vasectomy) |  |   |

**Muscle/bones**

- |                                       |  |                                      |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> muscle aches | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> gout        |
| <input type="checkbox"/> arthritis    | <input type="checkbox"/> fractures       | <input type="checkbox"/> amputations |

**Skin**

- |  |                                    |  |
|--|------------------------------------|--|
| <input type="checkbox"/> foot/leg ulcers | <input type="checkbox"/> skin rash | <input type="checkbox"/> darkening or lightening of the skin |
| <input type="checkbox"/> dry skin        | <input type="checkbox"/> hair loss | <input type="checkbox"/> brittle nails                       |

**Neuro/psych**

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> frequent severe headaches | <input type="checkbox"/> dizziness   | <input type="checkbox"/> previous head injury                 |
| <input type="checkbox"/> unsteady gait             | <input type="checkbox"/> seizures    | <input type="checkbox"/> loss of consciousness                |
| <input type="checkbox"/> paralysis                 | <input type="checkbox"/> tremor      | <input type="checkbox"/> burning, shooting pain in hands/feet |
| <input type="checkbox"/> decreased sensation/feet  | <input type="checkbox"/> memory loss | <input type="checkbox"/> depression/anxiety/fears             |

Anything else you would like us to know about you?

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Patient's name \_\_\_\_\_ Date \_\_\_\_\_ Physician's initials \_\_\_\_\_