Premier Family Medicine Center, LLC
"Let Our Family Take Care of Yours."

www.premierfmc.com

Patient Information Profile

(Patient ID#) (Internal Use Only)

_____

Premier Family Medicine Center, LLC
484 Irvin Court, Suite 110
Decatur, GA 30030
Phone: (404) 296-5114
Fax: (404) 296-5115

Primary Care Physician (PCP)		Phone Number	( ) -

Section A: Patient Registration Information (Required)

Name:	First	Middle	Last	Patient ID#:	(Internal Use Only)
Address:				Sex	□ Female □ Male
				Age	
City		State		Zip Code	
Home Phone	( ) -	SSN#		Date of Birth	
Work Phone	( ) -	Marital Status	□ Single □ Married □ Separated □ Divorced □ Widow(er) □ Minor □ Unmarried Domestic Partner		
Mobile/Other	( ) -	Email Address			

Patient Employment Information

Occupation: □ Employed □ Unemployed □ Self-Employed □ Retired □ Student □ Minor □ Other

Employer / School	
Employer / School Phone	( ) -
Employer / School Address	

Guarantor Information

□ Same as Patient (If and only if Guarantor is the same person as Patient, then do not fill out this section.)

Name:	First	Middle	Last	Patient ID#:	(Internal Use Only)
Address:				Sex	□ Female □ Male
				Age	
City		State		Zip Code	
Home Phone	( ) -	SSN#		Date of Birth	
Work Phone	( ) -	Marital Status	□ Single □ Married □ Separated □ Divorced □ Widow(er) □ Minor □ Unmarried Domestic Partner		
Mobile/Other	( ) -	Email Address			

Guarantor Employment Information

□ Same as Patient (If and only if Guarantor is the same person as Patient, then do not fill out this section.)

Occupation: □ Employed □ Unemployed □ Self-Employed □ Retired □ Student □ Minor □ Other

Employer / School	
Employer / School Phone	( ) -
Employer / School Address	

Insurance Information

Primary Insurance Company		Insured's ID#		Policy Group #	
Insured Party				Date of Birth	
□ Same as Patient □ Same as Guarantor □ Other □ Cash Pay □ N/A		Relationship to Patient		SSN#	
Secondary Insurance Company		Insured's ID#		Policy Group #	
Insured Party				Date of Birth	
□ Same as Patient □ Same as Guarantor □ Other □ Cash Pay □ N/A		Relationship to Patient		SSN#	

Emergency Contact Information	**Name:**		**Relationship to Patient:**	**Phone:**	( ) -
	Name:		**Relationship to Patient:**	**Phone:**	( ) -

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ (*Name of Insurance Company(ies)*) and assign directly to **Premier Family Medicine Center, LLC**, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Premier Family Medicine Center, LLC, may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This consent will end when my current treatment plan is completed or until such consent is revoked in a subsequent written and signed communication.

Please Print Name of Patient, Parent, Guardian or Personal Representative	Signature of Patient, Parent, Guardian or Personal Representative	Relationship to Patient	Date

(Please Print Clearly on All Pages)

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Section B: Patient Current Health Information (Required)

Name: _____ Age: _____ Date of Birth: _____
First Middle Last MM/DD/YYYY

Who sent you to us today? _____ Gender: □ Male □ Female

This person is:
□ Primary physician
□ Other physician
□ Non-physician healthcare provider
□ Friend/other

Primary physician: _____
(Name)

Phone Number: (_____) _____-_____

Date of your last physical examination: _____

Please name the major problem or symptom that brings you to us today:

_____

_____

Please describe the history of your present illness in detail:

_____

_____

_____

_____

Rate the severity of today's symptoms on a scale of 1-10, (10 = worst): _____

How long have your symptoms been present? _____

What makes your symptoms worse or better? _____

What other providers have you seen for this illness? _____

What diagnostic tests have been performed so far? _____

_____

_____

_____

_____

What treatments have been tried so far (include operations done for this illness)? _____

_____

_____

_____

_____

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Section C: Review of Systems (Required)

Please check yes for those current symptoms below which apply to you or no for those symptoms that do not apply.

	YES NO		YES NO		YES NO
GENERAL (GEN)		**GASTROINTESTINAL (GI)**		**EAR, NOSE, & THROAT (ENT)**	
Chills	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No	Bleeding Gums	☐ Yes ☐ No
Cold Intolerance	☐ Yes ☐ No	Appetite Poor	☐ Yes ☐ No	Can't Clear Throat	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Bloating	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No
Dizziness / Off Balance	☐ Yes ☐ No	Bloody / Black Stool	☐ Yes ☐ No	Ear Pain	☐ Yes ☐ No
Fainting	☐ Yes ☐ No	Bowel Changes	☐ Yes ☐ No	Ear Drainage / Discharge	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	Ear Fullness / Pressure	☐ Yes ☐ No
Forgetfulness	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Frequent Sneezing	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Excessive Hunger	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No
Heat Intolerance	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No
High Stress	☐ Yes ☐ No	Gas	☐ Yes ☐ No	Loss of Smell / Taste	☐ Yes ☐ No
Loss of Sleep	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No	Nasal Congestion	☐ Yes ☐ No
Loss of Weight	☐ Yes ☐ No	Hemorrhoids	☐ Yes ☐ No	Nasal Discharge	☐ Yes ☐ No
Mood Swings	☐ Yes ☐ No	Indigestion	☐ Yes ☐ No	Nasal Obstruction	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No	Nausea	☐ Yes ☐ No	Neck Mass / Swollen Glands	☐ Yes ☐ No
Prolonged Bleeding	☐ Yes ☐ No	Rectal Bleeding	☐ Yes ☐ No	Nosebleeds	☐ Yes ☐ No
Shaking Tremor	☐ Yes ☐ No	Stomach Pain	☐ Yes ☐ No	Persistent Cough	☐ Yes ☐ No
Sleepy in the Daytime	☐ Yes ☐ No	Vomiting	☐ Yes ☐ No	Post-Nasal Drip	☐ Yes ☐ No
Weakness	☐ Yes ☐ No	Vomiting Blood	☐ Yes ☐ No	Ringing in Ears	☐ Yes ☐ No
Other General Problems	☐ Yes ☐ No	Other GI Problems	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
MUSCLE / JOINT / BONE (MJB)		**GENITO-URINARY (G-U)**		Snoring	☐ Yes ☐ No
(Pain, Weakness, Numbness In:)		Blood in Urine	☐ Yes ☐ No	Stop Breathing During Sleep	☐ Yes ☐ No
Arms	☐ Yes ☐ No	Frequent Urination	☐ Yes ☐ No	Other ENT Problems	☐ Yes ☐ No
Back	☐ Yes ☐ No	Lack of Bladder Control	☐ Yes ☐ No	**EYE (OPTO)**	
Facial Pain	☐ Yes ☐ No	Painful Urination	☐ Yes ☐ No	Blurred Vision	☐ Yes ☐ No
Feet	☐ Yes ☐ No	Weak Urine Stream	☐ Yes ☐ No	Crossed Eyes	☐ Yes ☐ No
Hands	☐ Yes ☐ No	Other G-U Problems	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No
Hips	☐ Yes ☐ No	**SKIN (DERM)**		Eye Pain	☐ Yes ☐ No
Legs	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Eyes Crust	☐ Yes ☐ No
Neck	☐ Yes ☐ No	Change in Moles	☐ Yes ☐ No	Eyes Drain	☐ Yes ☐ No
Painful Swollen Joints	☐ Yes ☐ No	Flaking Peeling Skin	☐ Yes ☐ No	Failing Vision	☐ Yes ☐ No
Shoulders	☐ Yes ☐ No	Hives	☐ Yes ☐ No	Irritated Eyes	☐ Yes ☐ No
Other MJB Problems	☐ Yes ☐ No	Itchy Skin	☐ Yes ☐ No	Light Bothers Eyes	☐ Yes ☐ No
CARDIOVASCULAR (CARDIO)		Jaundice (yellowing of the skin)	☐ Yes ☐ No	Vision – Flashes	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Rash	☐ Yes ☐ No	Vision – Halos	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Scars	☐ Yes ☐ No	Other Eye Problems	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Sore That Won't Heal	☐ Yes ☐ No	*****WOMEN ONLY*****	
Irregular Heartbeat	☐ Yes ☐ No	Other Skin Problems	☐ Yes ☐ No	Abnormal Pap Smear	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No			Are You Pregnant?	☐ Yes ☐ No
Poor Circulation	☐ Yes ☐ No	*****MEN ONLY*****		Bleeding Between Periods	☐ Yes ☐ No
Rapid Heart Beat	☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No	Breast Lump	☐ Yes ☐ No
Swelling of Ankles	☐ Yes ☐ No	Erection Difficulties	☐ Yes ☐ No	Extreme Menstrual Pain	☐ Yes ☐ No
Varicose Veins	☐ Yes ☐ No	HIV Risk Factors	☐ Yes ☐ No	Have You Had A Mammogram?	☐ Yes ☐ No
Other Cardio Problems	☐ Yes ☐ No	Lump in Testicles	☐ Yes ☐ No	HIV Risk Factors	☐ Yes ☐ No
		Nipple Discharge	☐ Yes ☐ No	Hot Flashes	☐ Yes ☐ No
RESPIRATORY (RESP)		Painful Intercourse	☐ Yes ☐ No	Nipple Discharge	☐ Yes ☐ No
Coughing up Blood	☐ Yes ☐ No	Penis Discharge	☐ Yes ☐ No	Painful Intercourse	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No	Sore on Penis	☐ Yes ☐ No	Vaginal Discharge	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Other Male Problems	☐ Yes ☐ No	Other Female Problems	☐ Yes ☐ No
Other Respiratory Problems	☐ Yes ☐ No	Date of Last Prostate Exam →		Date of Last Menstrual Period→	
		Date of Last Testicle Exam →		Date of Last Pap Smear →	
				Number of Children? →	

Please list and explain fully any current symptom(s) that you are currently experiencing not covered in the chart above.

_____

_____

_____

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Section D: Prior Medical Conditions (Required)

Please check yes for those past medical conditions below which apply to you or no for those symptoms that do not apply.

	YES NO		YES NO		YES NO
AIDS	□ Yes □ No	Head Injury	□ Yes □ No	Past Heart Attack	□ Yes □ No
Adhesive Tape Allergy	□ Yes □ No	Heart Failure / Disease	□ Yes □ No	Polio	□ Yes □ No
Alcoholism	□ Yes □ No	Hepatitis A	□ Yes □ No	Pneumonia	□ Yes □ No
Anemia	□ Yes □ No	Hepatitis B	□ Yes □ No	Previous Skin Tests	□ Yes □ No
Anorexia	□ Yes □ No	Hepatitis C	□ Yes □ No	Prostate Problem	□ Yes □ No
Appendicitis	□ Yes □ No	Herpes	□ Yes □ No	Psychiatric Care	□ Yes □ No
Arthritis	□ Yes □ No	Hiatal Hernia	□ Yes □ No	Reflux	□ Yes □ No
Asthma	□ Yes □ No	High Blood Pressure	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Bleeding Disorders	□ Yes □ No	High Cholesterol	□ Yes □ No	Scarlet Fever	□ Yes □ No
Blocked Arteries	□ Yes □ No	HIV Positive	□ Yes □ No	Seizure Disorder	□ Yes □ No
Breast Lump	□ Yes □ No	Inhalant Allergy	□ Yes □ No	Somatic Injury	□ Yes □ No
Bronchitis	□ Yes □ No	Kidney Disease	□ Yes □ No	Stroke	□ Yes □ No
Bulimia	□ Yes □ No	Latex Allergy	□ Yes □ No	Suicide Attempt	□ Yes □ No
Cancer	□ Yes □ No	Liver Disease	□ Yes □ No	Thyroid – Low Levels	□ Yes □ No
Cataracts	□ Yes □ No	Low Blood Pressure	□ Yes □ No	Thyroid – Overactive	□ Yes □ No
Chemical Dependency	□ Yes □ No	Macular Degeneration	□ Yes □ No	Thyroid Cancer	□ Yes □ No
Chicken Pox	□ Yes □ No	Measles	□ Yes □ No	Thyroid Nodule	□ Yes □ No
Contact Allergy	□ Yes □ No	Meningitis	□ Yes □ No	Tonsillitis	□ Yes □ No
COPD Emphysema	□ Yes □ No	Migraine Headaches	□ Yes □ No	Tuberculosis	□ Yes □ No
Diabetes – Diet Control	□ Yes □ No	Miscarriage	□ Yes □ No	Typhoid Fever	□ Yes □ No
Diabetes – Insulin	□ Yes □ No	Mitral Valve Prolapse	□ Yes □ No	Ulcers	□ Yes □ No
Diabetes – Oral Meds	□ Yes □ No	Mononucleosis	□ Yes □ No	Use Aspirin	□ Yes □ No
Epilepsy	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Use Coumadin	□ Yes □ No
Fibromyalgia	□ Yes □ No	Mumps	□ Yes □ No	Use Non Steroidal (Such as: Aleve)	□ Yes □ No
Food Allergy	□ Yes □ No	Obstructive Sleep Apnea	□ Yes □ No	Use Other Blood Thinner	□ Yes □ No
Glaucoma	□ Yes □ No	Pacemaker	□ Yes □ No	Use Oxygen At Home	□ Yes □ No
Goiter	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Use Plavix	□ Yes □ No
Gonorrhea	□ Yes □ No	Past Angioplasty	□ Yes □ No	Vaginal Infections	□ Yes □ No
Gout	□ Yes □ No	Past Bypass Surgery	□ Yes □ No	Venereal Disease	□ Yes □ No

If you answered yes to any of the medical conditions above, please explain. Please tell us anything else that we should know about your medical history to better serve you today.

_____

_____

_____

_____

Do you have any history of cancer? □ Yes □ No (If yes, then please list types and treatment.)

_____

_____

_____

_____

Please list all food, contact, and inhalant allergies. **Do not include drug allergies.** (You will be given an opportunity to list those later on in the paperwork.)

_____

_____

_____

_____

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Section E: Medications Currently Taken and Drug Allergies (Required)

Pharmacy Name: _____ **Phone:** _____ **Fax:** _____

Medications (Include vitamins, herbals, and nutritional supplements)		**Drug Allergies**			
		Adhesive Tape Allergy	☐ Yes ☐ No	**Latex Allergy**	☐ Yes ☐ No
Name	**Dose**	**Name**			**Reaction**

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Section F: Prior Hospitalizations and Surgical History (Required)

Prior Hospitalizations

Year	**Hospital**	**Reason for Hospitalization and Outcome**

Surgical History

Please list all prior surgical procedures.

Operation	Date	Operation	Date

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give all applicable and approximate dates: _____

_____

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Section G: Occupational and Social History (Required)							
Occupational History							
What is your occupation?							
Answer whether or not your occupation exposes you to:							
Stress	☐ Yes ☐ No	Heavy Lifting	☐ Yes ☐ No	Hazardous Substances	☐ Yes ☐ No	Other	☐ Yes ☐ No
Social History							
Who lives with you at home?							
Answer whether or not you consume the following substances (also if applicable include how much/often you consume):							
Alcohol	☐ Yes ☐ No	**Caffeine**	☐ Yes ☐ No	**Tobacco**	☐ Yes ☐ No	**Water**	☐ Yes ☐ No	**Other**	☐ Yes ☐ No
_____ beverages per		_____ beverages per		_____ packs per		_____ glasses per		_____ per	
(day, week, month) *circle one*		(day, week, month) *circle one*		(day, week, month) *circle one*		(day, week, month) *circle one*		(day, week, month) *circle one*	

In regards to smoking cigarettes/tobacco products, if you do not currently smoke or use tobacco, but did in the past then answer accordingly:

You smoked _____ packs per (day, week, month) then about _____ years ago.

If you answered any of the questions with "Other" in the above table, please explain fully. _____

_____

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Section H: Pregnancies (Women ONLY)		
Year of Birth	Sex of Birth	Complications if Any

Confidential					
Section I: Family Medical History (Required)					
Please check yes for those illnesses below which are present in your immediate blood relatives (parents, children, or siblings) or no for those symptoms that do not apply.					
	YES NO		YES NO		YES NO
Allergies	☐ Yes ☐ No	Chemical Dependency	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Past stroke	☐ Yes ☐ No
Bleeding problem	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Sickle Cell Strain	☐ Yes ☐ No
Blocked arteries	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Attack / Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No

Immediate Family Life/Death Information				
Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				

If other family illness exists, please explain fully here: _____

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____ _____ _____
Please Print Name of Patient, Parent, Guardian or Personal Representative | Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient | Date

Reviewed By: _____ **Signature**: _____ **Date**: _____
(Premier Family Medicine Center Staff Member – Please Print Name Here) (Premier Family Medicine Center Staff Member – Please Sign Name Here)

(Please Print Clearly on All Pages)

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Section J: Traditional Communications Agreement (Required)

Patient Agreement For Traditional Communications

I understand that as part of my healthcare Premier Family Medicine Center, LLC will need to contact me from time to time in order to remind me of appointments, providing the results of tests, giving instructions, or to provide other information.

I authorize Premier Family Medicine Center, LLC to contact me in the following ways:
(Check those which you authorize)

□ Home Phone □ Voice Mail OK

(_____) _____-_____
Home Phone Number

□ Work Phone □ Voice Mail OK

(_____) _____-_____
Work Phone Number

□ Mobile Phone □ Voice Mail OK □ Text Message OK

(_____) _____-_____ _____
Mobile Phone Number Service Carrier (Required for Text Messaging)

□ Fax

(_____) _____-_____
Fax Number

I further authorize Premier Family Medicine Center, LLC to discuss matters related to my condition and care with the following:

_____ _____
Name (Please Print) Relationship to Patient

_____ _____
Name (Please Print) Relationship to Patient

I understand that Premier Family Medicine Center, LLC will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not retroactively apply to past communications.

_____
Patient or Responsible Party Name (Please Print)

_____ _____
Patient or Responsible Party Signature Date

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Section K: Electronic-Communications Agreement (Required)

Patient Agreement For Electronic-Communications

Premier Family Medicine Center, LLC (PFMC) may communicate with other providers via electronic mail (e-mail) for matters which are not urgent if patient authorizes.
PFMC may forward e-mails as appropriate for diagnosis, treatment, and other related reasons. Staff, other than your provider may have access to e-mails that are sent but access will only be to provide appropriate services. Emails will not be shared with independent third parties without written consent, except as authorized or required by law.
If PFMC agrees to exchange mail electronically, you must agree to the following requirements:

Purpose of Email Communication

Email may be used to request information and ask non-urgent questions as well as:
- □ Prescription/refills
- □ Referrals
- □ General medical advice once a face to face visit has been performed
- □ Lab test results
- □ Billing questions/Patient education

It should not be used in emergency situations.
E-mail communications will be documented in your medical record by inserting a copy.

Sending E-mail

Full name and birth date
(in the following format - MM/DD/YYYY) must be included in every communication. This information is required so that PFMC may reasonably establish that the sender requesting the information is who the sender claims to be.
The subject of the e-mail should include the purpose of the email, for example:
Test Results Request.
If PFMC does not respond to the e-mail in 2 business days, please contact our office.

Security and Privacy of E-mail

Only authorized personnel may be provided access to physician email mailboxes. As an added security measure, PFMC must verify that the email address of any communication received from patients corresponds with the email address provided by the patient on this agreement. If there is a discrepancy with the emails, PFMC will not respond.
Do not use email to send or request very sensitive information. PFMC cannot and does not guarantee the privacy or security of any messages sent over the Internet. There is the potential that email sent over the Internet can be intercepted, and read by others. Additionally, you should be aware of and understand that if you use email provided by your employer any email sent on your employer's system may be viewed by your employer. If this is of concern to you, you should not communicate with PFMC through email.
I have been informed of and understand the risks and procedures involved with using email.
I understand that the confidentiality of my individually identifiable health information may be compromised when my individually identifiable health information is sent through electronic transmission via email.

□ **I agree to the terms listed above, and I voluntarily request the use of email as a form of communication with PFMC.**

□ **I do not agree to the terms listed above, and I knowingly refuse the use of email as a form of communication with PFMC.**

_____
Patient Name (Please Print)

_____ ____/____/___
Patient email address Date of Birth

_____ ____/____/___
Patient Signature Date

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Section L: Financial Policy (Required)

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
- A $25.00 fee will be assessed for any co-payment not made at the time of service.
- Full payment is due at the time of service for those without insurance.
- We accept cash, checks, debit cards, Visa, MasterCard, Discover, and American Express. A $50 fee will be assessed for returned checks.
- Payment plans can be arranged for in advance with the Patient Billing Department.
- A fee equal to 30% of the outstanding amount will be accessed to any account forwarded to an outside collection agency.
- HMO & PPO patients requiring referral authorizations must contact our office prior to making arrangements for health care or testing outside our practice. Any unauthorized charges will be your responsibility.
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
- When labs, x-rays, or other tests are ordered by Premier Family Medicine Center, LLC, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong location.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit second or third insurance claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. If we perform a physical examination, we must bill a physical examination even if medical problems were dealt with at the same visit. Many insurance plans do not cover physical examinations or will only pay for one per year. The patient is responsible to know the rules of their health plan, as we cannot change our coding in an attempt to obtain payment.

I hereby authorize Premier Family Medicine Center, LLC, to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered.

I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood, and agree to the Financial Policy (above).

_____
Patient or Responsible Party Name (Please Print)

_____ _____
Patient or Responsible Party Signature Date

Section M: Medicare Authorizations (For Medicare Patients Only)

I request that payment of authorized Medicare benefits be made on my behalf to Premier Family Medicine Center, LLC for any services furnished to me by their providers.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made on my behalf to Premier Family Medicine Center, LLC, for any services furnished to me by their providers.

I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

_____
Patient or Responsible Party Name (Please Print)

_____ _____
Patient or Responsible Party Signature Date

Thank you for taking out the time to fully and completely fill out this patient information packet.
At Premier Family Medicine Center, LLC, our goal is to provide you and your family with the highest quality of care. The first and most critical step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all the pages of this patient information profile.
If you require assistance filling out this form or have further questions, please feel free to ask one of our staff members who should be happy to assist you.

Premier Family Medicine Center, LLC
484 Irvin Court, Suite 110
Decatur, GA 30030
Phone: (404) 296-5114
Fax: (404) 296-5115

Section N: Privacy Policy Acknowledgment (Required)

Premier Family Medicine Center, LLC
Privacy Policy Acknowledgment Statement

I hereby acknowledge that I have been made aware that Premier Family Medicine Center, LLC has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

As a patient of Premier Family Medicine Center that has privacy, I understand and acknowledge the following:

1. Premier Family Medicine Center has a privacy policy that effective within the office.
2. Premier Family Medicine Center has made this policy available to me for review, by placing a copy of a complete version in the office that resides in a waiting room or similar common area with patient access. It is also available on the Internet at: http://www.premierfmc.com/privacy
3. Premier Family Medicine Center has made me aware, that I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Premier Family Medicine Center, LLC and have read and understood the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.
For your convenience, you can view our Privacy Policy online and obtain a printer-friendly copy in PDF format for your records by going to: http://www.premierfmc.com/privacy

☐ No, I do not desire a copy, but acknowledge that the Privacy Policy exists.

☐ Yes, I do desire a copy of the Privacy Policy and acknowledge that it exists.

_____
Patient or Responsible Party Name (Please Print)

_____ _____
Patient or Responsible Party Signature Date

For more information contact the Premier Family Medicine Center Office at 404-296-5114 or the Office of Civil Rights at 404-562-7886.

Thank you for taking out the time to fully and completely fill out this patient information packet.
At Premier Family Medicine Center, LLC, our goal is to provide you and your family with the highest quality of care. The first and most critical step is to learn all we can about your medical history. Please assist us by taking a few minutes to complete all the pages of this patient information profile.
If you require assistance filling out this form or have further questions, please feel free to ask one of our staff members who should be happy to assist you.