EVANS MEDICAL GROUP

Patient Information:

LAST Name:_____ FIRST Name:_____

Middle Name:_____ Preferred Name: _____

Sex: Male____Female____ Birthdate: _____/_____/_____ SSN#_____-_____-_____

Address:_____

Zip:_____City:_____State:_____

Home Phone: ( )_____-_____ Mobile: ( )_____-_____

Work#:( )_____-_____ Consent to Text: (please circle) YES NO

Patient Email Address to Register for Patient Portal:

_____ Decline Portal: (please circle) YES

Primary Care Doctor?: (please circle) Apostol Jordan Ikeler

Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___

Partner___

Preferred Language: (circle one) English Spanish Other

Race: (circle one) Caucasian African-American Asian Chinese Other

Ethnicity: (circle one) Non-Hispanic Hispanic

Are you hearing impaired?: YES or NO

GUARANTOR Information: *(A guarantor is the person responsible for paying the bills.)*

Guarantor LAST Name: _____FIRST Name: _____MI_____

Guarantor Birthdate: _____/_____/_____

Mailing Address:_____Zip:_____City:_____State:_____

SSN#_____-_____-_____ Guarantor Phone for contact:: ( )_____-_____

Patient's Relationship to Guarantor: _____

EVANS MEDICAL GROUP

C*onsent for Treatment:* I, the undersigned, a patient of Evans Medical Group, requests and authorize my attending physician any whomever he may designate as his/her associates or assistants, to administer such treatment as is medically necessary. I give my physician permission to give and receive prescription history information with pharmacies, other providers, and medication prescribing networks. I voluntarily consent to said medical care, evaluation and treatment, as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of services involving pathology, radiology and immunizations. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

I nearby acknowledge that Evans Medical Group will share my medical information, as permitted under federal law (HIPAA) and Georgia state law, with my healthcare providers through a health information exchange. Evans Medical Group may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants.

***Financial Obligation to Evans Medical Group*: I authorize payment of medical benefits to Evans Medical Group for services rendered. I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for services provided, regardless of insurance coverage or other third party coverage unless waived by contractual agreements between Evans Medical Group and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account, including billing fees, collection agency cost, and/or reasonable attorney fees if applicable, if the account is placed for collection. All returned checks incur a $35.00 service charge or the maximum allowed by law, to be paid by cash or credit card along with balance of patients account within 10 days of notification by Evans Medical Group, or its assigned agent. Failure to comply and meet financial responsibility may also result in a patient discharge from practice.**

***Patient Portal Access*: The Evans Medical Group Patient Portal is a communication service offered as a convenience to our patients. We reserve the right to change the terms, conditions, and notices under which Patient Portal is offered. Upon Registration and use of the Patient Portal, you acknowledge and agree that this message service is intended to facilitate dialogue regarding personal health matters. We reserve the right, in our sole discretion, to limit or discontinue your use of Patient Portal at any time and for any reason, including, but not limited to, your use of Patient Portal on behalf of another person. Family Access: The patient portal has a family access function allowing one email address as a log in for multiple users. Evans Medical Group will only enable "Family Access" if all adult (18+ years) USERS agree to be on one portal account.**

***Medication History Authority:* I authorize Evans Medical Group to automatically import my medication history from a third party source (i.e. pharmacies). In order to transfer your current and past medications to our new Electronic Health Records system we must have your authority.**

***Privacy Notice (HIPAA):* By my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Evans Medical Group and a copy provided, upon request, for me at my discretion. I hereby authorize Evans Medical Group to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment, and healthcare operations. The language should indicate that the exchange of health information through the Common Well network is a permitted use under HIPA's Privacy Rule because the date is exchanged for permissible treatment purposes.**

I acknowledge, that it is my responsibility as a patient or parent/guardian of Evans Medical Group to notify the office regarding any changes to the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information. Signature required by patient, parent if minor child, guardian, or representative/caregiver if Medicare, for acknowledgement of the above: Billing Fees, Consent for Treatment, Contact Me, Financial Obligations to Evans Medical Group, Patient Portal Access, Medication History Authorization, Privacy Notice (HIPAA), Reminder Calls, and Results Call Features.

I authorize Evans Medical Group to communicate with the individuals named on this form (HIPAA) about my condition or treatment, all other individuals will be excluded. As a parent/guardian I will list myself and any other parent/guardian with whom Evans Medical group may communicate health related information to. I understand that the contacts listed on the front of this form may potentially be aware of the patients (my) medical chart information at this office.

HIPAA CONTACT NAME	Relationship	Phone Number
1._____	_____	( )_____-_____
2._____	_____	( )_____-_____
3._____	_____	( )_____-_____
4._____	_____	( )_____-_____

5. **NO ONE** _____

X_____**Date:**_____

Signature of Patient/Parent of Guarantor (required)