CARDIOLOGY
Gwinnett Medical Group

Name: _____ ___ _____ **Date of Birth:** _____ **Acct :** _____
First **MI** **Last**

Address: _____ _____ _____ _____
Street Address **City/Town** **State** **Zip Code**

Home #: (_____)-_____- _____ **Work #:** (_____)- _____- _____ **ext:** _____ **Cell #:** (____)- ____- _____

May we leave a message? Yes No **Preferred method of contact?** Mail Phone Email Patient Portal

Email: _____ @ _____ **SSN #:** _____ - _____ - _____

Sex: Male ( ) Female ( ) **Marital Status** (circle one): **S M D W SEP**

Next of Kin/ Emergency Contact: _____

Telephone #:(_____)- _____-_____ **Relationship to the patient:** _____

Referring Physician: _____ **Phone:** (____)-_____- _____

Primary Care Physician: _____ **Phone:** (____)-_____- _____

Insurance Information: **We must have copies of any insurance cards before we can file your insurance!**

Primary: _____ **Secondary:** _____

Person responsible for payment (if not the patient): _____ **DOB:** _____

Insured's Employer: _____ **SSN #:** _____-_____-_____

Relationship of PATIENT to INSURED (circle one): Self Spouse Child Other _____

_____ _____

Patient Signature **Date**

GWINNETT MEDICAL GROUP
Cardiology

NEW PATIENT QUESTIONNAIRE
Encuesta para pacientes nuevos

Name ***(Nombre):***_____

Email Address (***correo electrónico***): _____

Date of Birth ***(Fecha de nacimiento):*** _____ Age ***(Edad):*** _____

Weight ***(Peso):*** _____ Height ***(Estatura):*** _____

01) Describe in your own words why you need to see a cardiologist.
Describa en sus propias palabras por qué necesita ver a un cardiológo.

_____

_____

_____

02) Past medical illnesses ***(Historia médica pasada)***
Have you ever had any of the following medical problems? If so, when?
¿A sufrido usted de alguno de los siguientes problemas médicos? Si es así, ¿cuando?

Heart attack ***(ataque al corazón)***	Yes ***(Si)***	No ***(No)***	_____
Stroke ***(apoplejía/derrame cerebral)***	Yes ***(Si)***	No ***(No)***	_____
High Blood Pressure ***(presión alta)***	Yes ***(Si)***	No ***(No)***	_____
Cancer ***(cáncer)***	Yes ***(Si)***	No ***(No)***	_____
Asthma ***(asma)***	Yes ***(Si)***	No ***(No)***	_____
Diabetes ***(diabetes)***	Yes ***(Si)***	No ***(No)***	_____
Ulcers ***(úlceras)***	Yes ***(Si)***	No ***(No)***	_____
Vascular Disease ***(enfermedad vascular)***	Yes ***(Si)***	No ***(No)***	_____
Rheumatic Fever ***(fiebre reumática)***	Yes ***(Si)***	No ***(No)***	_____
Mitral Valve Prolapse ***(prolapso de válvula mitral)***	Yes ***(Si)***	No ***(No)***	_____
Hepatitis ***(hepatitis)***	Yes ***(Si)***	No ***(No)***	_____
Thyroid Disease ***(desorden de tiroides)***	Yes ***(Si)***	No ***(No)***	_____
Kidney Disease ***(enfermedad de riñones)***	Yes ***(Si)***	No ***(No)***	_____
Endocarditis ***(endocarditis)***	Yes ***(Si)***	No ***(No)***	_____
Emphysema ***(enfisema)***	Yes ***(Si)***	No ***(No)***	_____
Hiatal Hernia ***(hernia hiatal)***	Yes ***(Si)***	No ***(No)***	_____
Gallbladder disease ***(enfermedad tie vesícula)***	Yes ***(Si)***	No ***(No)***	_____
Elevated Cholesterol ***(colesterol elevado)***	Yes ***(Si)***	No ***(No)***	_____
Sleep Apnea ***(apnea del sueño)***	Yes ***(Si)***	No ***(No)***	_____
Atrial Fibrillation ***(La fibrilación auricular)***	Yes ***(Si)***	No ***(No)***	_____

03) Past surgical history ***(Historial quirúrgico pasado - cirugías-):***

Please list any surgical procedures along with the date.
Favor de anotar todo procetlimiento quirúrgico (de cirugía) junto con la fecha

_____

_____

_____

04) Have you ever had a cardiac catheterization, angioplasty, stress test, or treadmill study? If so, when and where?
¿Alguna vez le an sometido un cateterismo cardíaco, angioplastía, prueba de esfuerzo o estudio en una cinta caminatlora/trotadora? Si es así, ¿Cuándo y dónde?

_____

_____

05) Please list all medications you are presently taking, along with the dosage **(strength)** and frequency **(number of times per day).**
Por favor de anotar todos los medicamentos que usted toma al presente, junto con la dosis (potencia) y la frecuencia (número de veces al dia) que las toma.

_____ _____

_____ _____

_____ _____

_____ _____

06) Please list all over-the counter medications you are presently taking. **(For example: decongestants, diet pills, pain pills, or antihistamines.)**
Favor de anotar todos los medicamentos sin receta que está tomando al presente. Por ejemplo: descongestionantes, píldoras dietéticas, pastillas para el dolor o antihistamínicos.

_____ _____

_____ _____

_____ _____

07) Have you ever used Redux or Phen-Fen?
¿A usado Redux o Phen-Fen alguna vez? ..... Yes ***(Si)*** No ***(No)***

08) Are you allergic to any medications? If so, please list the medication and the type of reaction.
¿Es usted alérgico a algún medicamento(s)? Si es asi, por favor anotar el medicamento(s) y el tipo de reacción.

_____ _____

_____ _____

_____ _____

09) Have you ever smoked? If so, How many years? How many packs per day? When did you quit?
¿A usted fumado alguna vez? Si es asi, ¿por cuantos años? ¿Cuántos paquetes diarios? ¿Cuándo dejó de fumar?

_____

_____

10) Do you consume alcoholic beverages? If so, how many drinks per day? ..... Yes ***(Si)*** No ***(No)*** _____
¿Consume usted bebidas alcohólicas? Si es así, ¿cuántos tragos al día?

11) Do you consume caffeine? If so, how much?
¿Consume usted cafeína? Si es así, ¿qué cantidad? ..... Yes ***(Si)*** No ***(No)*** _____

12) Have you ever used any recreational drugs? If so, what type?
¿A usado drogas recreativas alguna vez? Si es así, ¿Qué tipo de drogas? ..... Yes ***(Si)*** No ***(No)*** _____

13) Do you have a family history of heart disease?
If so, please list which family member, type of heart disease and age at the time of diagnosis.
¿Tiene historial de enfermedad cardíaca en su familia?
Si es así, anote qué miembro de su familia, la edad en que fue diagnosticado, y el tipo de enfermedad del corazón.

_____

_____

_____

_____

14) What is your occupation?
¿Cuál es su ocupación? _____

15) OVERALL SYSTEM REVIEW
REVISION GENERAL DE SU SISTEMA

Have you had recent fever or shaking chills?
¿A tenido fiebre o escalofrios recientemente? ..... Yes ***(Si)*** No ***(No)***

Have you had recent unexplained weight loss or weight gain?
¿A perdido o subido de peso sin explicación recientemente? ..... Yes ***(Si)*** No ***(No)***

Have you ever passed out?
¿Se a desmayado alguna vez? ..... Yes ***(Si)*** No ***(No)***

Do you suffer from migraines or frequent headaches?
¿Sufre usted de migrañas o dolores de cabeza frecuentes? ..... Yes ***(Si)*** No ***(No)***

Have you ever had temporary blindness or double vision?
¿Alguna vez a sufrido de ceguera o visión doble temporalmente? ..... Yes ***(Si)*** No ***(No)***

Do you have difficulty swallowing?
¿Tiene usted dificultad para tragar? ..... Yes ***(Si)*** No ***(No)***

Do you suffer from nosebleeds?
¿Sufre usted de sangrado nasal (sangre por la nariz)? ..... Yes ***(Si)*** No ***(No)***

Have you ever had vertigo (severe dizziness)?
¿Alguna vez a sufrido de vértigo (mareos severos)? ..... Yes ***(Si)*** No ***(No)***

Do you suffer from chronic coughing or wheezing?
¿Sufre usted de tos o silbido crónico? ..... Yes ***(Si)*** No ***(No)***

Do you suffer from shortness of breath?
¿Sufre de falta de respiración? ..... Yes ***(Si)*** No ***(No)***

Have you ever coughed up blood?
¿Alguna vez a tosido con sangre? ..... Yes ***(Si)*** No ***(No)***

Have you ever experienced chest pain or chest tightness?
¿Alguna vez a experimentado dolor de pecho u opresión? ..... Yes ***(Si)*** No ***(No)***

Do your feet and ankle swell?
¿Se le hinchan los pies y los tobillos? ..... Yes ***(Si)*** No ***(No)***

Do you have palpitations (skipping or racing heartbeat)?
¿Tiene palpitaciones (latidos acelerados o intermitentes)? ..... Yes ***(Si)*** No ***(No)***

Do you have problems with constipation?
¿Tiene problemas de estreñimiento? ..... Yes ***(Si)*** No ***(No)***

Do you have problems with diarrhea?
¿Sufre de diarrea? ..... Yes ***(Si)*** No ***(No)***

Have you ever passed black, tarry bowel movement?
¿Alguna vez a pasado excreta o heces de color negro o alquitranado? ..... Yes ***(Si)*** No ***(No)***

Do you have difficulty in urinating?
¿Tiene dificultad para orinar? ..... Yes ***(Si)*** No ***(No)***

Do you have pain or burning upon urination?
¿Experimenta dolor o sensación de ardor mientras orina? ..... Yes ***(Si)*** No ***(No)***

Have you ever had blood in your urine?
¿Alguna vez a tenido sangre en su orina? ..... Yes ***(Si)*** No ***(No)***

Do you have any form of arthritis?
¿Tiene usted alguna forma de artritis? ..... Yes ***(Si)*** No ***(No)***

Do you have leg pain when you walk?
¿Siente algún dolor en las piernas cuando camina? ..... Yes ***(Si)*** No ***(No)***

Have you ever had seizures or tremors?
¿Alguna vez a tenido convulsiones o temblores? ..... Yes ***(Si)*** No ***(No)***

Do you have any rashes related to medication?
¿Tiene alguna erupción o sarpullido relacionado al uso de un medicamento? ..... Yes ***(Si)*** No ***(No)***

Do you have any ulcers on your feet?
¿Tiene úlceras en sus pies? ..... Yes ***(Si)*** No ***(No)***

Have you recently experienced unusual anxiety or stress?
¿Recientemente a experimentado ansiedad o estrés fuera de lo usual? ..... Yes ***(Si)*** No ***(No)***

How many pillows do you use to sleep?
¿Cuántas almohadas usa usted para dormir? ..... _____

Date of last menstrual period ___/____/____
Fecha de su último periodo menstrual ___/____/____

16) Who is your family doctor?
¿Quién es su médico de familia/cabecera? _____

17) What pharmacy do you use? Please write the phone number
¿Qué farmacia utiliza? Por favor escriba el número telefónico de la farmacia _____ (___) _____ - _____

18) List any other physicians you see.
Anote cualquier otro médico que usted vea. _____ , _____

_____ , _____ , _____

19) Have you had any procedures, x-rays, or blood work done recently? If so, name of test and where performed.
¿Le an hecho algún procedimiento, como: radiografías o laboratorios de sangre recientemente? Si es así, indique el nombre del análisis y en dónde fue realizado?

_____

20) Why are you here today?
¿Cuál es la razón de su visita a esta clínica hoy?

❑ Doctor_____requested I see a cardiologist.
El doctor (nombre) _____solicitó que vea un cardiólogo.

❑ New patient visit
Visita inicial (nuevo paciente)

❑ Pre-operative evaluation
Evaluación pre-operativa

❑ Hospital follow-up
Cita de seguimiento luego de admisión al hospital

( ) Other:
Otra razón _____

_____

_____ _____

Patient's Signature ***(Firma del paciente)*** Date ***(Fecha)***

Rev: 8-20-15

Gwinnett Health System

PLACE LABEL HERE

NOTICE PRIVACY PRACTICES and PERSONAL REPRESENTATIVE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP):
My signature below acknowledges that I have received or have been offered a copy of Gwinnett Health System's (GHS) Notice of Privacy Practices, and I am aware that I have access to this document on the health system's website at www.gwinnettmedicalcenter.org.

OR

In an emergency treatment situation, obtain the NPP acknowledgement as soon as it is reasonably practicable to do so after the emergency situation has ended.

___The Patient is unable to sign because (check one) ❑ Patient is Critical or Unconscious. ❑ Patient Refuses to Sign.

___CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (NPP): I hereby certify that as an associate or agent of GHS, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the GHS NPP in accordance with its Provision of Notice of Privacy Practices (policy #100-105).

DESIGNATION OF PERSONAL REPRESENTATIVE:
As a patient, you may designate one or more personal representatives. A personal representative may receive Protected Health Information (PHI) about you. PHI includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payments. Personal representatives will not have access to PHI in the periods that are between treatments or admissions. My personal representative(s) is listed below and my signature of approval.

A personal representative may be a spouse, relative, domestic partner, or friend. You can remove or add personal representatives at any time, including during treatment or upon another admission to a GHS facility.

_____ (initial) I (Patient) **do not** wish to designate a personal representative. I understand that the hospital's healthcare team may designate an interim personal representative, if designating a personal representative will expedite or enhance my care as a patient.

I (Patient) designate the following as my personal representative(s):

_____ *(Name of Personal Representative)* _____ *(Relationship)*

_____ *(Address, if known)* _____ *(Telephone number)*

_____ *(Name of Personal Representative)* _____ *(Relationship)*

_____ *(Address, if known)* _____ *(Telephone number)*

_____ (Name of Personal Representative) _____ (Relationship)

_____ (Address, if known) _____ (Telephone number)

_____ Patient or Authorized Representative Signature

_____/_____ Patient Telephone Number (home/cell)

_____ Date

_____ GHS Representative Name

_____ Department

_____ Position

GWINNETT MEDICAL GROUP

PATIENT FINANCIAL RESPONSIBILITIES

Patient Name (print):_____ Date of Birth: _____

Thank you for choosing a Gwinnett Medical Group practice as your health care provider. We are committed to providing you with quality and affordable health care. Please review and sign this policy, asking questions as necessary. A copy of this document will be offered to each patient.

1. **Registration:** All patients shall complete the Patient Information form, which will be used to ensure accurate information for proper billing. We must obtain a copy of your photo ID and current valid insurance card in order to validate your coverage. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you will be responsible for the balance of a claim.

2. **Patient Payment:** All patient payments are due at the time of service. This includes co-payments and deductibles. This arrangement is part of your contract with your insurance company. If we are not able to verify insurance, you will be responsible for payment at the time of service.

3. **Insurance Plans:** We accept assignment and participate and file most insurance plans. Your insurance may not cover all services, and knowing your insurance benefits is your responsibility. Please contact your insurer with any questions regarding your coverage to receive the maximum benefits

4. **Claims:** We will submit your claim based upon service provided at the time of your visit. Your insurance company may request additional information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company; we are not party to your insurance contract.

5. **Self-Pay Patients:** We offer a prompt payment discount to our patients who do not have insurance or for non-covered services.
6. **Credit and Collection:** If your account is past due, you will receive a statement with your balance due. If a balance has remained unpaid, it will be sent to a collection agency.

7. **Missed Appointments:** There is a $25.00 charge for missed appointments. If you need to cancel your appointment, please notify our office at least one business day, prior to your appointment. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

8. **Forms:** There are charges for completion of certain forms.

9. **Assignment of Benefits:** I hereby agree to assign and transfer to Gwinnett Medical Group and treating Physicians all benefits and payments now due and payable or to become due and payable to me under any insurance policy or benefit plan or program for this visit and outpatient care.

I have read and understand my financial responsibilities and agree to the guidelines.

Signed: _____ _____ _____ _____

Patient/Patient Representative | Print | Relationship | Date Signed

Gwinnett Health System

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is applicable to the Gwinnett Health System covered entities and providers listed below:

- Gwinnett Medical Center – Lawrenceville
- Gwinnett Medical Center – Duluth
- Gwinnett Medical Group
- Glancy Campus
- Gwinnett Extended Care Center
- Hamilton Mill Imaging Center
- Johns Creek Orthopedic Surgery Center

These covered entities and providers will be referred to as "GHS" in this Notice of Privacy Practices.

This notice will tell you about the ways in which we may use and disclose medical information about you, referred to below as protected health information ("PHI"). We also describe your rights and our responsibilities regarding the use and disclosure of PHI. Your personal doctors and allied health practitioners may have different policies or notices regarding their use and disclosure of your medical information created in their offices or clinics.

Uses and Disclosures for Treatment, Payment and Health Care Operations. GHS may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you. In addition, GHS and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to provide treatment, receive payment and manage their health care operations.

For Treatment. GHS may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment. This includes sharing or disclosing your PHI to your other healthcare providers for treatment. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide you health care services or are otherwise involved in your care.

For Payment. GHS may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, GHS may need to give PHI to your health plan in order to be reimbursed for the services provided to you. GHS may also disclose PHI to its business associates, such as billing companies, claims processing companies, and others that assist in processing health claims. GHS may also disclose PHI to other health care providers and health plans for the payment activities of those providers or health plans.

For Health Care Operations. GHS may use and disclose PHI as part of its operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you, patient surveys, training, underwriting activities, compliance and risk management activities, planning & development, and management & administration. GHS may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants, and others for review and learning purposes, to help make sure GHS is complying with all applicable laws, and to help GHS continue to provide high quality health care to its patients. GHS may also disclose PHI to other entities' quality assessment and improvement activities, credentialing and peer review activities, and health care compliance such as fraud and abuse prevention and detection, provided that entity has a current or past relationship with the patient who is the subject of the information.

For Sharing PHI Among GHS And Its Medical and Allied Health Professional Staff. GHS and the physicians and other health care providers who are members of the GHS medical staff work together in an organized health care arrangement to provide medical services to you when you are a patient at GHS. GHS and the members of its medical staff will share with each other PHI that they collect from you at GHS as necessary to carry out their treatment, payment and health care operations relating to the provision of care to patients at GHS.

Other Uses and Disclosures For Which Authorization is Not Required. In addition to using or disclosing PHI for treatment, payment and health care operations, GHS may use and disclose PHI without your written authorization under the following circumstances:

As Required by Law and Law Enforcement. GHS may use or disclose PHI when required to do so by law. GHS may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. GHS may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects or problems, or to execute their health oversight or public health functions.

For Health Oversight Activities. GHS may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with applicable laws and regulations.

Coroners, Medical Examiners, and Funeral Directors. GHS may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent, determining a cause of death, or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. GHS may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, GHS may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. GHS may use and disclose PHI, to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. GHS may use and disclose PHI of military personnel and veterans under certain circumstances. GHS may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state or to conduct special investigations.

Workers' Compensation. GHS may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illnesses.

Fundraising Activities. Your PHI may be used to contact you in an effort to raise money for GHS. Your PHI may be disclosed to a foundation related to GHS. These disclosures would be limited to dates you received treatment or services, your demographic information, where you received services, your treating physician(s), outcome information and health insurance status.

Appointment Reminders; Health-related Benefits and Services; Marketing. GHS may use and disclose your PHI to contact you and remind you of an appointment at GHS, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you, such as disease management programs. GHS may use and disclose your PHI to encourage you to purchase or use a product or service through a face-to-face communication or by giving you a promotional gift of nominal value.

Disclosures to You. GHS may disclose your PHI to you or to your personal representative, and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI.

Disclosures for HIPAA Compliance Investigations. GHS must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate our compliance-with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures To Which You Have an Opportunity to Object. You will have the opportunity to object to these categories of uses and disclosures of PHI that GHS may make:

Patient Directories. Unless you object, GHS may use some of your PHI to maintain a directory of individuals in its facility. This information may include your name, your location in the facility, and your general condition (*e.g.* fair, stable, etc.). Your religious affiliation, if provided by you, may be disclosed to members of the clergy.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, GHS may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care. GHS may also notify those people about your location or condition.

Other Uses and Disclosures of PHI For Which Authorization is Required. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization. For example, your written authorization is required for psychotherapy notes (with limited exceptions), sale of your PHI, and certain marketing communications. You have the right to revoke your authorization in writing. Revocations will only apply to disclosures made after your request to revoke is received.

Regulatory Requirements. GHS is required by law to maintain the privacy of your PHI and to support your rights under HIPAA

You have the following rights regarding your PHI:

Notice of Privacy Practices. GHS must provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to abide by the terms described in this Notice. GHS reserves the right to change the terms of this Notice and of its privacy policies, and to make the new terms applicable to all PHI we maintain. Before GHS makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice as required by the regulation.

Restriction Requests. You may request that GHS restrict the use and disclosure of your PHI. GHS is not required to agree to any restrictions you request, but if GHS does so it will be bound by the restrictions to which it agrees, except in emergency situations. GHS will restrict PHI disclosures to a health plan if the PHI disclosure is for payment or healthcare operations and the PHI pertains to a healthcare item or service for which you have paid out of pocket in full. However, if the information is needed to receive payment from the insurer for subsequent related services, the restriction no longer applies.

Confidential Communications. You have the right to request that communications of PHI to you from GHS be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing and sent to the responsible GHS Department Director. GHS will accommodate your reasonable requests without requiring you to provide a reason for your request.

Access to PHI. Generally, you have the right to inspect and copy your PHI that GHS maintains, provided that you make your request in writing to the Medical Records Custodian. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), GHS will inform you of the extent to which your request has or has not been granted. In some cases, GHS may provide you a summary of the PHI you request if you agree in advance to such a summary and any associated fees. If you request copies of your PHI or agree to a summary of your PHI, GHS may impose a reasonable fee to cover copying, postage, and related costs. If GHS denies access to your PHI, it will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If GHS does not maintain the PHI you request and if it knows where that PHI is located, it will tell you how to redirect your request.

PHI Amendment. If you believe that your PHI maintained by GHS contains an error or needs to be updated, you have the right to request that GHS correct or supplement your PHI. Your request must be made in writing to the Medical Records Custodian, and it must explain why you are requesting an

amendment to your PHI. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GHS will inform you of the extent to which your request has or has not been granted. GHS generally can deny your request if your request relates to PHI: (i) not created by GHS; (ii) that is not part of the records GHS maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, GHS will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and GHS denial attached; and (iii) complain about the denial.

Accounting of Disclosures. You generally have the right to request and receive a list of the disclosures of your PHI GHS has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures for which you have provided a written authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations; (ii) made to you; (iii) for GHS patient directory or to persons involved in your health care; (iv) for national security or intelligence purposes; or (v) to correctional institutions or law enforcement officials. You should submit any such request to the Medical Records Custodian, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), GHS will respond to you regarding the status of your request. GHS will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of $10.00 for each additional request.

Breach Notification. In the unlikely event GHS or a vendor contracted by GHS inappropriately discloses your unsecure PHI in a manner which constitutes a breach, we will notify you. You have the right to receive notifications of any breach of your unsecured PHI.

You have the right to receive a paper copy of this notice upon request. You can receive a copy of this notice at our Web site, http://www.gwinnetthealth.org. To obtain a paper copy of this notice, please contact the Admissions Department.

If you have any questions regarding this notice or believe your privacy rights with respect to your PHI have been violated, you may contact the GHS Privacy Officer to issue a compliant by:

Writing:

GHS Privacy Officer
1000 Medical Center Blvd
MOB 100 - Suite 245
Lawrenceville, GA 30046

Calling: 678-312-3900
Email:
ghsprivacyofficer@gwinnettmedicalcenter.org

GHS will in no manner penalize you or retaliate against you for filing a complaint regarding GHS privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

Revised: September 23, 2013
Effective: April 14, 2003

GWINNETT MEDICAL GROUP

CONSENT TO GENERAL CARE/ROUTINE PROCEDURES AND TREATMENT

Important: Do not sign this form without reading and understanding its contents.

Patient Name (print)_____ **Date of Birth** _____

CONSENT AND TREATMENT AUTHORIZATION: I hereby consent to the provision of general care by my healthcare provider and routine procedures outlined below for a period of one year from the date of signature. I also authorize the release of medical record copies to other agencies or physicians I may be referred to for additional care as deemed necessary by the attending provider.

During the course of my care and treatment, I understand that various types of tests and diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professions ("Healthcare Professionals") as medically necessary. While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every Procedure and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the Procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis, or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

(5) **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

GWINNETT MEDICAL GROUP

CONSENT TO GENERAL CARE/ROUTINE PROCEDURES AND TREATMENT

COMPLIANCE WITH POLICIES: I agree to comply with all Health System policies including the "No Smoking" policy.

INDEPENDENT CONTRACTORS: Many of the physicians, dentists, oral surgeons, podiatrists and psychologists at the Gwinnett Hospital System are independent contractors of the Hospital and are not its employees or agents. As independent contractors, the physicians, dentists and oral surgeons, podiatrists and psychiatrists are responsible for their own actions. I understand that I may receive separate bills for their services.

REQUESTS FOR SPECIAL ASSISTANCE: Our staff wants to communicate effectively with you or other persons participating in your care or treatment who may be deaf/hearing impaired or have other special needs. Sign language and oral interpreters, TDD's (telecommunications device for the deaf), volume-control telephones, and other auxiliary aids and services are available free of charge to people who are in need of special assistance. Please contact the office manager for assistance with your needs.

I UNDERSTAND THAT: The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE MADE TO ME** concerning the outcome and/or result of any Procedures; that Healthcare Professionals participating in my care will rely on my documented medical history, as well as 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; and I may withdraw my consent for any test or procedure at any time.

BY SIGNING THIS FORM:

I consent to Healthcare Professional performing Procedures as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and

I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.

If I have any questions or concerns regarding these Procedures, I will ask my physician to provide me with additional information. I also understand that my physician may ask me to sign additional Informed Consent documents.

PATIENT NAME (print) _____ Date of Birth _____

SIGNED :_____ _____ _____

Patient/Patient's Representative Relationship Date

WITNESS_____

Reason if unable to sign: _____

Office Use Only:

Interpretive Service used on this encounter _____

Interpreter used – Name and number _____

Date/Time/Language _____

Gwinnett Medical Group

NAME: _____

ADVANCED DIRECTIVE ACKNOWLEDGMENT

DOB: _____

As a competent adult, you have the right to refuse any medical or surgical treatment for yourself for any reason. The best way for you to be in control of your medical treatment is to record your preferences in advance. You can make legally valid decisions about future medical treatments through what is commonly known as an Advance Directive. Listed below are examples of Advance Directives.

1. **Living Will:** A written document executed by the patient directing that should the patient have a terminal condition, life-sustaining procedures would be withheld or withdrawn.
2. **Durable Power of Attorney for Health Care (DPAHC):** An Advance Directive in which an individual names some else (the "agent" or "proxy") to make healthcare decisions in the event the individual becomes unable to make those decisions for him/herself. The DPAHC can also include instructions about specific choices to be made.
3. **Directive for Final Health Care:** A combination of the Living Will and the Durable Power of Attorney for Health Care.

Please check one of the following statements:

_____ I have provided the office with a copy of my Advance Directive.

_____ I have executed an Advance Directive and ***will*** provide a copy to the office.

_____ I have executed an Advance Directive and ***will not*** provide a copy to the office.

_____ I have not executed and Advance Directive but would like to obtain additional information about Advance Directives.

_____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

SIGNED: _____ _____

Patient/Patient's Representative Date

Lawrenceville
755 Walther Road, Lawrenceville, GA 30046
Phone:470-325-1000
Fax:770-995-0533

Snellville
1700 Tree Lane Road, Suite 190, Snellville, GA 30078
Phone:470-325-1150
Fax:770-978-0730

Duluth
3855 Pleasant Hill Road, Suite 250, Duluth, GA 30096
Phone:770-497-1413
Fax:770-497-1823

St. Joseph
5667 Peachtree Dunwoody Road, Suite 250, Atlanta, GA 30342
Phone:404-252-7618
Fax:404-252-8610

Buford
4745 Nelson Brogdon Blvd, Suite 300, Sugar Hill, GA 30518
Phone:770-932-5951
Fax:678-482-0111

Johns Creek
4365 Johns Creek Parkway, Suite 450, Suwanee, GA 30024
Phone:770-495-2442
Fax:770-495-3446

Athens
2005 Prince Ave, Athens, GA 30606

Hamilton Mill
2108 Teron Trace, Suite 100, Dacula, GA 30019
Phone: 678-312-9120 **Fax**: 770-271-8330

Gainesville
535 Jesse Jewell Parkway, Suite C, Gainesville GA 30501
Phone: 470-325-1000