NORTHSIDE CHEROKEE SURGICAL ASSOCIATES
900 Towne Lake Parkway, Suite 412 • Woodstock, GA 30189
770-924-9656 • Fax 770-852-7574

1. Patient Information (Please include all information as shown on insurance card.)

Patient's Last Name		Patient's First Name	
Date of Birth:	Gender		SSN
Street Address		Street Address 2	
City	State		Zip Code
Race	Ethnicity	Primary Language	Marital Status
Home Telephone		Alternate Telephone	
Emergency Contact Name		Emergency Contact Telephone	
E-Mail Address			
Primary Care Physician		Referred By	

2. Medical Insurance Policy Holder ☐ (Check if self and complete only **Insurance Information**)

Primary Insurance Company	Policy Number		Group Number
Insurance Telephone	Policy Holder Last Name		Policy Holder First Name
Relationship to Patient	Policy Holder SSN		Policy Holder Date of Birth
Street Address			Employer Name
Street Address 2			Work Telephone
City	State	Zip Code	Home Telephone
Secondary Insurance Company	Policy Number		Group Number
Last Name	First Name		Date of Birth
Insurance Telephone	SSN		Relationship to Patient

3. Responsible Party/Guarantor ☐ (Check if self and complete only **Employment Information**)

Last Name	First Name		Date of Birth
Street Address			SSN
Street Address 2			Relationship to Patient
City	State	Zip Code	Home Telephone
Employee Name	Work Telephone		

Complete only if patient is a minor and information differs from above.

Parent's Last Name	Parent's First Name		
Street Address	City	State	Zip Code

4. Assignment of Benefits/Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians.

Signature of Patient/Legal Guardian:	Date

#NCSA004
Piedmont Graphics 08/09/13

PATIENT REGISTRATION

NORTHSIDE CHEROKEE SURGICAL ASSOCIATES
900 Towne Lake Parkway, Suite 412 • Woodstock, GA 30189
770-924-9656 • Fax 770-852-7574

PATIENT INFORMATION

Patient Name: _____

Self Medical History:

Please indicate whether YOU have had any of the medical illnesses listed below

Sensory Defects
- Loss of Hearing or Deaf ☐ Yes ☐ No
- Loss of Vision or Blind ☐ Yes ☐ No

Respiratory (Lung or Breathing Problems)
- Asthma / Wheezing ☐ Yes ☐ No
- Emphysema / COPD ☐ Yes ☐ No
- Sleep Apnea ☐ Yes ☐ No

Cardiac (Heart Problems)
- Fast Heart Rate Requiring Therapy ☐ Yes ☐ No
- Heart Attack / Angioplasty / CABG ☐ Yes ☐ No
- Heart Failure ☐ Yes ☐ No
- Heart Murmur ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- High Cholesterol ☐ Yes ☐ No

Vascular (Circulation Problems)
- Aneurysm ☐ Yes ☐ No
- Peripheral Artery Disease ☐ Yes ☐ No
- Varicose veins ☐ Yes ☐ No
- Wounds or Sores ☐ Yes ☐ No

Gastrointestinal (GI or Abdominal Problems)
- Gall Bladder Problems ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No
- Hemorrhoids ☐ Yes ☐ No
- Anal Rectal ☐ Yes ☐ No
- GI Bleeds ☐ Yes ☐ No
- Hernia ☐ Yes ☐ No

Renal (Kidney Problems)
- Kidney Failure ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Kidney Stones ☐ Yes ☐ No

Immunologic / Infectious Disease
- AIDS ☐ Yes ☐ No
- HIV ☐ Yes ☐ No
- Auto-Immune (e.g. Lupus) ☐ Yes ☐ No

Endocrine
- Diabetes ☐ Yes ☐ No
- Low Blood Sugar ☐ Yes ☐ No
- Thyroid Problems ☐ Yes ☐ No

Musculoskeletal (Bone, Joint, or Muscle Problems)
- Arthritis ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No

Neurological (Brain or Nerve Problems)
- Headaches / Migraines ☐ Yes ☐ No
- Parkinson's / Tremor ☐ Yes ☐ No
- Seizures ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- TIA ☐ Yes ☐ No

Mental Health
- Alzheimer's / Dementia ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- Mental Illness ☐ Yes ☐ No

Hematologic (Blood Problems)
- Anemia ☐ Yes ☐ No
- Bleeding Disorder ☐ Yes ☐ No
- Clotting Problems ☐ Yes ☐ No

Oncologic (Cancer)
- If yes, what type? _____
- Chemotherapy ☐ Yes ☐ No
- Radiation Therapy ☐ Yes ☐ No

Breast
- Breast Cancer/Mass ☐ Yes ☐ No

Skin
- Skin Cancer ☐ Yes ☐ No

Other Medical Illnesses (please list)

_____
_____
_____
_____
_____

PATIENT INFORMATION

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Family Medical History:

Please indicate whether any of your **BLOOD RELATIVES** have any of the medical illnesses listed below.

- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Problems _____
- ☐ DVT _____
- ☐ Bleeding Disorders _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Throat Cancer _____
- ☐ Other Cancer _____

Previous surgeries or hospitalizations:

Reason for Hospitalization	Date	Hospital Name	Any Complications

Social History

Do you Smoke? ..... ☐ Yes ☐ No
How long? _____
How many cigarettes per day? _____
Do you drink Alcohol? ..... ☐ Yes ☐ No
What type? _____
How often? _____

Do you use drugs? ..... ☐ Yes ☐ No
Do you Work? ..... ☐ Yes ☐ No
What is your job? _____
Retired? _____
Disability? _____

Primary Care Physician _____
Heart Doctor (Cardiologist) _____
Pharmacy _____

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SURGERY REVIEW OF SYSTEMS

Please check/circle if you are experiencing or have experienced the following symptoms.

Review of Symptoms

General
___ Weakness
___ Lack of appetite
___ Weight Loss

Eyes
___ Decreased ability to see
___ Loss of vision

Skin
___ Change in skin color or temperature
___ Nail changes
___ Skin ulcers

Respiratory (Lung or breathing problems)
___ Asthma
___ Shortness of breath at rest
___ Shortness of breath with exertion

Cardiovascular (Heart problems)
___ Chest pain/tightness/squeezing
___ Need to sit up to breathe
___ Irregular heart beat (palpitations)
___ Swelling of the legs
___ Varicose Veins
___ Leg pain at rest
___ Leg pain with exertion
___ Blue/purple discoloration of hands/feet

Gastrointestinal (GI or abdominal problems)
___ Nausea
___ Vomiting
___ Diarrhea
___ Abdominal pain
___ Abdominal pain after eating
___ Blood in stools

Genito-urinary System (Urination problems)
___ Pain or burning on urination
___ Frequent urinationt
___ Unusually large volumes of urine
___ Extreme urge to urinate

Endocrine
___ Heat intolerance
___ Cold intolerance
___ Increased thirst

Musculoskeletal
(Bone, joint or muscle problems)
___ Neck Pain
___ Right Shoulder or arm pain
___ Left Shoulder or arm pain
___ Back pain

Pain down your legs
___ Right leg pain
___ Left leg pain
___ Painful joints
___ Deformities of the joints or extremities

Neurologic (Brain or nerve problems)
___ Headaches
___ Blackouts
___ Dizziness
___ Double vision
___ Numbness or tingling?
Where?_____

Paralysis or weakness of limbs
___ Loss of sensation
___ Loss of balance or coordination
___ Problems speaking

Psychiatric (Mental health)
___ Depression
___ Anxiety

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MEDICATION RECORD

Name: _____ **Medical Record #:** _____

Allergies: _____

Pharmacy _____ **Pharmacy Phone:** _____

DATE	MEDICATION	DOSAGE	FREQUENCY	ACTIVE	STOPPED

MEDICATION RECORD

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Please contact the Director of Health Information Services in writing, at the Northside Hospital – Atlanta Campus (as listed at the end of this Notice) to obtain and complete the required form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Northside Hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. Please contact the Director of Health Information Services in writing, at the Northside Hospital – Atlanta Campus location (as listed at the end of this Notice) to obtain and complete the required form. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. To request this list or accounting of disclosures, you should contact the Director of Health Information Services in writing, at the Northside Hospital – Atlanta Campus location (as listed at the end of this Notice) to obtain and complete the required form. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. In addition, because of the many health care providers participating in the organized health care arrangement, we generally cannot agree to special requests. If we do agree, we will comply with such request unless the information is needed to provide you emergency treatment. You have the right to request that we restrict information from being disclosed to a health plan if the information is related to services for which you have paid for the service in full out of pocket.

To request restrictions, you should contact the Director of Health Information Services in writing, at the Northside Hospital – Atlanta Campus location (as listed at the end of this Notice) to obtain and complete the required form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. **To be binding, any agreement to comply with special restrictions must be in writing signed by the Director of Health Information Services.**

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Northside Hospital, Attn: Patient Access Department Manager, 1000 Johnson Ferry Road, Atlanta, GA 30342. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use of disclosure of your health information that compromises the privacy or security of your health information.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, www.northside.com.

To obtain a paper copy of this notice, you may contact Northside Hospital, Attn: Patient Access Department Manager, 1000 Johnson Ferry Road, Atlanta, GA 30342.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for medical information we already have about you as well as any information we receive in the future. The current notice will be posted in the Practice and will include the effective date. In addition, each time you visit the Practice for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated by the Practice, you may file a complaint with Northside Hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with Northside Hospital, contact the Privacy Officer at your location of service (as listed below). All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer and Director of Health Information Services Contact Information:

Northside Hospital – Atlanta Campus:
1000 Johnson Ferry Road, Atlanta, GA 30342
Privacy Officer Contact Phone: 404-845-5534

NORTHSIDE HOSPITAL
1000 Johnson Ferry Road, N.E., Atlanta, GA 30342-1611

REORDER #NH2344
PIEDMONT GRAPHICS 08/27/13

NORTHSIDE HOSPITAL
1000 JOHNSON FERRY ROAD, N.E., ATLANTA, GA 30342-1611

HIPAA NOTICE OF PRIVACY PRACTICES

Northside Hospital, Inc. and Affiliates

Effective Date: April 14, 2003

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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices of Northside Hospital's Physician Practices (each a "Practice" and collectively, the "Practices") and those of:

- Any health care professional authorized to enter information into your chart.
- All employees, staff and other Practice personnel.

Northside Hospital and its Practices operate as an "organized health care arrangement" and are presenting this document as a joint notice of privacy practices.

All Practice entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Practice personnel who are involved in your care and treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We may also disclose medical information to family members, clergy or other individuals involved in your care.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect from you, your insurance company or a third party payer. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: We may use and disclose medical information about you for Practice operations. These uses and disclosures are necessary to run the Practice and make sure that all of our patients receive quality care. We may also combine medical information about many Practice patients to decide what additional services the Practice should offer and what services are not needed. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Practices to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Practice.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities: We may use medical information about you to contact you in an effort to raise money for Northside Hospital and its operations. We may disclose medical information to a foundation related to Northside Hospital so that the foundation may contact you in raising money for Northside Hospital. We only would release contact information, such as your name, address and telephone number and the dates you received treatment or services. You may opt out of being contacted for fund-raising purposes. If you do not want to be contacted for fundraising efforts, please notify us via email at optout@northside.com.

Individuals Involved in Your Care or Payment for Your Care: WWe may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. We generally will obtain your written authorization to use your medical information for research purposes. There may be limited circumstances when access to your information for research purposes may be allowed without your specific consent. These will be limited to cases when use or disclosure was approved by an Institutional Review Board or Privacy Board.

Business Associates: There are some services provided for the Practice through contracts with business associates. One example is the copy service we use when making copies of your health record. When these services are contracted, we may disclose your healthcare information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.

Psychotherapy Notes: Most uses and disclosures of psychotherapy notes will only be made with your written authorization.

Other Uses and Disclosures: Other uses and disclosures of your health information not covered by this Notice will be made only to you or with your written authorization.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Your written authorization to this release is required, however, if you do not consent to release of information, your workers' compensation benefits may be denied and you will be responsible for the costs of your medical care.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using; or
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

NORTHSIDE CHEROKEE SURGICAL ASSOCIATES
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770-924-9656 • Fax 770-852-7574

Acknowledgement of Receipt of "Notice of Privacy Practices" for Protected Health Information

I acknowledge that I have received a copy of Northside Cherokee Surgical Associates "Notice of Privacy Practices" for protected health information on the date set forth below.

_____
Date of Receipt

Patient Information *(please print clearly):*

_____ _____
Last Name *First Name* *Middle Initial* *Date of Birth (Month/Day/Year)*

_____ _____
Print Name of Parent/Legal Guardian/Personal Representative *Relationship to Patient*

_____
Signature of Patient/Parent/Legal Guardian/Personal Representative

Release and Assignment: The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform Northside Cherokee Surgical Associates of any changes in my address, phone number or insurance. I understand that I am financially responsible for any amounts not covered by my insurance. _____
Initials

For use by Northside Cherokee Surgical Associates Personnel Only
*(complete this section if patient acknowledgment is **not** received):*

An Acknowledgement of Receipt of Notice of Privacy Practices was not received because:

- ☐ Patient refused to sign Acknowledgment
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier
- ☐ Patient was unable to sign Acknowledgement due to emergency treatment situation
- ☐ Other: *Please indicate reason* _____

Signature of Northside Cherokee Surgical Associates Representative _____

Date _____