To patients who are new to the practice:

We would like to thank you for choosing Internal Medicine Specialists of Atlanta as your medical provider. If you are currently scheduled for an appointment as a new patient, please note the following:

1- If you need to cancel your appointment, please notify us 3 business days in advance for a physical and 1 business day prior to an office visit.

2- We strongly encourage each patient to contact their insurance company to confirm what is or isn't covered by their policy BEFORE the appointment.

3- Always present your insurance card at the time of your visit and promptly notify us of changes in your insurance plan and/or demographics.

4- On the day of your appointment, you will receive an e-mail from: noreply@FollowMyHealth.com inviting you to register to our patient portal. We encourage all of our patients to register on Follow My Health for easy access to test results, appointment requests and general messaging.

Welcome to our practice!

Internal Medicine Specialists of Atlanta, P.C

J. David Spivey, M.D. | Robert B. Malamis, M.D. | John E. Perry, M.D. | Wesley A. Hoke, M.D.
John L. Elliott, M.D | Sarah J. Rhodes, PA-C | Hope Johnson, PA-C

1800 Howell Mill Road, Suite 175, Atlanta, GA 30318
Tel: 404-607-1777 | **Fax:** 404-607-1799

INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.

Patient's Name _____ Date of Birth _____ Sex _____

Home Address _____ Cell Phone _____

City _____ State _____ Zip _____ Home Phone _____

E-Mail _____ SS# _____ Work Phone _____

Employer _____ Employer Phone _____

Emergency
Contact _____ Phones: Home _____ Cell _____ Work _____

Race:

- ☐ African American
- ☐ White
- ☐ Hispanic
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Prefer Not to Say

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or latino
- ☐ Prefer Not to Say

Preferred Language: _____

PLEASE READ CAREFULLY THE FOLLOWING INFORMATION. SIGN AND DATE UPON COMPLETION.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. **In an attempt to control costs, we request that all copayments and account balances be paid upon arrival for your appointment.**

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

I hereby assign, transfer and set over to Internal Medicine Specialists of Atlanta, P.C. all of my rights, title and interest to my medical reimbursement and benefits under my insurance policy with Medicare, private insurance, and other health plans.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's Signature _____ Date _____

Responsible Party's Signature _____ SS# _____ Date _____
(If patient is a minor)

INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.

PAST HISTORY FORM

NAME:_____ DATE:_____ DATE OF BIRTH:_____

PAST MEDICAL HISTORY

CHILDHOOD:

Birth: Normal_____Abnormal_____

Illnesses:	No	Yes
Mumps		
Measles		
German Measles		
Chickenpox		
Whooping Cough		
Pneumonia		
Rheumatic Fever		
Asthma		

Other _____

IMMUNIZATIONS:

	No	Yes
Polio		
German Measles/ Rubella		
Mumps		
Measles		
DT (tetanus)		
Date Last Tetanus		

ADULTHOOD:

Serious illnesses

What:	Date	Hospital:	Physician:

Injuries:

Surgeries:

Other Hospitalizations:

Allergies: Medications:_____

Foods:_____

Other:_____

FAMILY HISTORY:

	Alive	Dead	Age	Medical Problems
Mother				
Father				
Sisters				
Brothers				
Spouse				
Children				

MEDICATIONS:

Prescription:

Name:	Dose:	How often?

Over the counter drugs:

Vitamins:

Has any blood relatives, including grandparents, aunts, uncles had:

	NO	YES	WHO?
High Blood Pressure			
Heart Attack			
Other heart disease			
Stroke			
Diabetes			
Thyroid problems			
Asthma			
Cancer			
(What kind?)			
Gallbladder problems			
Liver Disease			
Colitis			
Kidney problems			
Blood problems(anemia)			
Skin problems			
Arthritis			
Psychiatric problems			
Alcoholism			
Other			

SOCIAL HISTORY:

Occupation:_____

Recreation/Hobby:_____

Diet: Average Day (be honest!)

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Tobacco: Smoke Now ____ In past ____ No ____

How long____ Packs per day____

Other tobacco use:_____

Alcohol: 2 oz drink or equivalent:

_____ a week? _____ a day? _____

Caffeine(servings per day):

Coffee____ Tea ____ Cola ____

Any other drugs?_____

Do you see any eye doctor? _____ How often?_____

Do you see a dentist?_____ How often?_____

Do you wear seat belts? _____

Exercise: What kind _____ How many hours per week _____

INTERNAL MEDICINE
SPECIALISTS OF ATLANTA, P.C.

ADVANCE PATIENT NOTICE

Insurance companies will pay only for services that they determine to be "reasonable and necessary". If your insurance carrier determines that a particular service, though medically necessary, is not "reasonable" under your policy then payment for that service will be denied and you will be responsible for those charges. Listed below are examples of some of the components of your visit that may not be covered:

*Wellness Panel (CBC, CMP, TSH)
*Lipid Panel (Cholesterol)
*Urinalysis
*Vitamin D Screening
*Prostate Specific Agent
*HIV/Syphilis/STD Screening
Hepatitis Serologies
*EKG
Ambulatory B/P Monitor/Holter Monitor

Vaccines that include:
Tetanus
Hepatitis
HPV
Shingles
Pneumonia
Influenza
Travel Vaccines & Consultation
Other:_____

**These items are ordered as part of most wellness/physical exams*

PATIENT AGREEMENT

I have been notified by my physician that he/she believes that my insurance may deny payment for some of the services identified above. I agree to be personally and fully responsible for payment.

Patient Signature:_____ Date of Birth:_____

Patient's Name (Print): _____ Date:_____

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FINANCIAL POLICY

Listed below are our financial policies. If you have any questions, please discuss them with our financial representative.

PATIENT RESPONSIBILITY

1- All co-payments are due at the time of visit.
2- Co-insurance and unmet deductibles are your responsibility.
3- You are ultimately responsible for payment of charges for services you receive from our office.
4- In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. Any charges which are accrued because of failure of notification will be the responsibility of the patient. If we cannot verify insurance, you will be responsible for payment at the time of service.
5- It is your responsibility to ensure that our physicians are in your insurance network.
6- Cancellations must be received 3 business days in advance for a physical and 1 business day prior to an office visit to prevent the fees outlined below.
7- Payment is due for rendered services 15 days from receipt of your billing statement.
Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

FEES

1- The returned check fee is $ 30.00.
2- Failure to cancel or keep an appointment for an office visit will result in a $50.00 fee and $150.00 if the appointment is for a physical.
3- Medical records requests must be received in writing at least 5 days prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery.
4- There is a $15.00 fee for completion of documents such as FMLA and insurance forms, or any other paperwork which require time away from patient care for our doctors. Please allow 5 business days for completion.
5- All outstanding balances will be subject to a 12% APR finance charge.

MEDICAID

Our practice does not participate.

Patient's name (print): _____ **Date of birth:** _____

Patient's signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT
INFORMATION PRIVACY PRACTICES
INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.

I acknowledge that I have received and reviewed the information privacy practices for Internal Medicine Specialists of Atlanta, P.C. I understand that I may request a paper copy of the same at anytime and that I may access the practices at anytime on the practices website (www.thedoctorsarein.com).

I wish to exclude release of my privileged health information to the following person or entity: (if no exclusions, please write NONE)

_____
Printed Name

_____
Date of Birth

_____
Signature

_____
Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Legal Name: _____ Date of Birth: _____

Address: _____

Patient Phone Number(s) _____

I authorize and request: _____
Name of doctor or facility with old records

_____
Street address

_____
City State Zip

To release my records to: **INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.**

___Dr. J. David Spivey ___Dr. John E. Perry ___Dr. Robert B. Malamis ___Dr. Wesley A. Hoke ___Dr. John L. Elliott

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Date(s) of Service or Date Range Requested: _____

I understand that this authorization may be revoked by me at any time.
This revocation would not apply to information that has already been properly released.
This authorization will expire one year from the date it was signed.
I understand that information in my medical record may include information related to HIV/AIDS, confidential information, and may include psychological and mental health information. By signing below I also specifically authorize the release of this type of information.
I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of my records and it may no longer be protected by federal and state privacy regulations.
By signing below, I certify that I have the authority to sign this form and that all information I have provided is true, accurate and complete.

_____ _____
Signature of Patient or Legal Representative Printed (Legible) Name of Patient or Legal Representative

_____
Date Signed

If signed by Legal Representative, please provide the following information:

Relationship to Patient: _____