INTERNAL MEDICINE
SPECIALISTS OF ATLANTA, P.C.

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

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If you are currently scheduled for a complete physical with your doctor, please note the following:

INSTRUCTIONS:

Nothing to eat or drink EXCEPT water starting 12 hours prior to your appointment and until AFTER your blood is drawn

Drink plenty of water the morning of your appointment

Take your regular medications with water at their regular scheduled time

FOR DIABETIC PATIENTS ON MEDICATION:

Bring your insulin or pills and a snack with you to the office

After your lab work has been drawn, take your medications and eat your snack

ADDITIONAL INFORMATION:

If you need to cancel your physical, please notify us 3 business days in advance; if you do not appear for your physical, a missed appointment fee of $150.00 may be charged to your account. This fee is not covered by insurance carriers

We will make every effort to confirm your appointment, however, if two days prior to your appointment we have not been able to reach you to confirm, we may cancel your physical exam appointment

Please check your benefits prior to your visit and find out what is or isn't covered by your policy. Insurance companies will not reimburse for some lab tests, vaccines or any treatment they don't consider preventive medicine. If that's the case, these charges will be your responsibility

PLEASE PRESENT YOUR INSURANCE CARD WHEN CHECKING IN

Thank you,

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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				

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 _____

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			

INTERNAL MEDICINE SPECIALISTS OF ATLANTA, P.C.

DATE OF APPT:_____ NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

PHONE: (CELL)_____ (WORK)_____ (HOME)_____

EMAIL ADDRESS:_____

EMPLOYER: (NAME)_____ (PHONE)_____

YES	NO		YES	NO	
_____	_____	Tired	_____	_____	Fainting, lightheadedness
_____	_____	Recent weight gain or loss	_____	_____	High cholesterol
_____	_____	Fever or chills	_____	_____	Breast lump
_____	_____	Excessive sweating	_____	_____	Nipple discharge
_____	_____	Lumps or swollen glands	_____	_____	History of breast biopsy or surgery
_____	_____	Hot flashes or night sweats	_____	_____	Mammogram in past
_____	_____	Intolerance to heat or cold	_____	_____	Do you examine?
_____	_____	Excessive thirst	_____	_____	Increase or decrease in appetite
_____	_____	Increased or decreased body hair	_____	_____	Food intolerance
_____	_____	Thyroid problems	_____	_____	Trouble swallowing
_____	_____	Diabetes	_____	_____	Nausea and/or vomiting
_____	_____	Eye pain	_____	_____	Vomiting up blood
_____	_____	Dry eyes	_____	_____	Indigestion
_____	_____	Glaucoma	_____	_____	Change in bowel habits
_____	_____	Cataracts	_____	_____	Painful bowel movements
_____	_____	Other eye problems	_____	_____	Constipation
_____	_____	Hearing loss	_____	_____	Diarrhea
_____	_____	Earache	_____	_____	Change in stool size
_____	_____	Ringing in ears	_____	_____	Bright blood in stools
_____	_____	Dizziness (vertigo)	_____	_____	Black stools
_____	_____	Frequent colds	_____	_____	Abdominal pain
_____	_____	Stuffy nose or postnasal drip	_____	_____	Hemorrhoids
_____	_____	Nose bleeds	_____	_____	Rectal itching
_____	_____	Loss of smell	_____	_____	Jaundice or hepatitis
_____	_____	Sinus infection	_____	_____	Ulcers
_____	_____	Hay fever	_____	_____	High alcohol intake
_____	_____	Hoarseness	_____	_____	Pancreatitis
_____	_____	Fever blisters	_____	_____	Pain with urination
_____	_____	Gum disease	_____	_____	Frequent urination
_____	_____	Toothache	_____	_____	Difficulty holding urine
_____	_____	Coughing	_____	_____	Difficulty starting urine
_____	_____	Shortness of breath with mild exertion	_____	_____	Frequent night urination
_____	_____	Awakening at night short of breath	_____	_____	Unusual color of urine
_____	_____	Coughing up blood	_____	_____	Blood or pus in urine
_____	_____	Wheezing or asthma	_____	_____	Wetting the bed
_____	_____	History of pneumonia	_____	_____	Kidney stones
_____	_____	Frequent bronchitis	_____	_____	Kidney or bladder infection
_____	_____	TB or positive TB skin test	_____	_____	Varicose veins
_____	_____	History of heart murmur or click	_____	_____	Pain in legs with walking
_____	_____	Palpitations, irregular or fast heartbeat	_____	_____	Blood clots in leg veins
_____	_____	Chest discomfort or pain	_____	_____	Cold/painful fingers in cold weather
_____	_____	High blood pressure	_____	_____	Painful, swollen or aching joints
_____	_____	Swelling of feet or legs			

NAME:_____ DATE OF BIRTH:_____

YES	NO	
_____	_____	History of injury to joints
_____	_____	History of fractures
_____	_____	Back pain
_____	_____	Skin rashes
_____	_____	Hives
_____	_____	Acne
_____	_____	Itching
_____	_____	New or changing moles
_____	_____	Increased or decreased skin pigmentation
_____	_____	Headaches
_____	_____	Face pain
_____	_____	Trouble with balance
_____	_____	Shaking
_____	_____	Convulsions/seizures
_____	_____	Problems with concentration/memory
_____	_____	Numbness
_____	_____	Weakness
_____	_____	Problems sleeping
_____	_____	(a) Early awakening
_____	_____	(b) Trouble getting to sleep
_____	_____	Crying spells
_____	_____	Poor appetite
_____	_____	Compulsive eating
_____	_____	Past suicide attempt or thoughts of suicide
_____	_____	History of physical, sexual or emotional abuse
_____	_____	Medicine for nerves or sleep (now or ever)
_____	_____	Past or present therapy or counseling
_____	_____	Feel anxious
_____	_____	Feel depressed
_____	_____	Recent stresses?_____
_____	_____	_____
		History of anemia
_____	_____	Prolong bleeding with injury or surgery
_____	_____	Easy bruising
_____	_____	Blood transfusion
_____	_____	If so, what year:_____

Anything else your doctor should know?_____
_____
_____
_____

Any questions? _____
_____
_____
_____

FOR WOMEN ONLY

Date last period: _____
Age first period: _____
Cycle (day 1 of period to day 1 of next) _____ days
Problems with period: _____
Birth control method, if used:
Now: _____
Previous: _____
Problems with birth control method: _____

Obstetrics History:
List all pregnancies and outcome:
_____
_____
_____
_____

Date of last Pap smear:____Are you sexually active?___

Have you ever had:

YES	NO	
_____	_____	Vaginitis
_____	_____	Genital Herpes
_____	_____	Abnormal Pap smear
_____	_____	Endometriosis
_____	_____	Tumor or cysts
_____	_____	Fibroids
_____	_____	Pelvic infection
_____	_____	Rape or threat of rape
_____	_____	Pain with intercourse
_____	_____	Menopause/menopausal symptoms
_____	_____	Any other problems?_____
		_____

FOR MEN ONLY

Have you ever had:

YES	NO	
_____	_____	Sores on penis
_____	_____	Problems with erections
_____	_____	Prostate problems
_____	_____	Painful sex or ejaculation
_____	_____	Tenderness or lumps in testicles
_____	_____	Penile discharge
_____	_____	Blood in ejaculate
_____	_____	Any sexually transmitted diseases
_____	_____	Are you sexually active

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Dear Patients,

A number of you have inquired about getting charges for a *physical exam* and an *office visit* during the same appointment. Insurance companies now dictate how physicians bill for these services and we would like to offer an explanation of this bureaucratic creation.

Physical examinations are defined, particularly by insurers, as *preventive visits*. Prevention includes reviewing your personal and family medical history, determination of your risk for future health problems, recommendations for screening tests and lifestyle changes, immunizations, and physical examination. Prevention does not include addressing specific, individual health problems, whether brought up by the patient or discovered by the physician during the exam, These health problems, injuries, and disease take extra physician time and fall outside the realm of a *preventive visit*.

As such, please understand that when we address your individual medical problems during a *preventive visit*, an additional *office visit* charge will be added to the charge for the preventive visit. While most insurers cover treatment for these medical problems at a significantly reduced rate, they may shift an additional co-payment/co-insurance /deductible back to you. We are informing you about this so you are not surprised if you receive a charge for these additional services. The alternative is scheduling a separate appointment for a *preventive visit* and a problem visit.

We believe in taking the necessary time with our patients. We believe screenings and preventive interventions are an important part of providing quality care. We also want our patients to have the option of bringing up a reasonable number of concerns or problems during their visit, including *physical exams*. Although we don't always have time to address everything, we will do our best to address what we can without sacrificing quality, within the time scheduled. However, you will be charged appropriately for the nature and duration of the visit.

We appreciate your trust and strive to provide the quality of care you deserve.

Internal Medicine Specialists of Atlanta, P.C.

Patient's name: _____ **Patient's signature:** _____

Date: _____

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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

INTERNAL MEDICINE
SPECIALISTS OF ATLANTA, P.C.

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

___Sarah Rhodes, PA-C ___Hope Johnson, PA-C

1800 Howell Mill Road, NW
Suite 175
Atlanta, GA 30318
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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: _____