

Northeast Cardiology
 700 Sunset Dr., Building 300, Suite 302
 Athens, GA 30606
 Phone: (706) 548-9111
 Fax: (706) 548-9224

Please Fill Out Completely:

Patient's Last Name					First Name					MI
Social Security Number	Date of Birth	Age	Gender	Race	Marital Status	Ethnicity (Circle one): Latino Non-Latino Other			Language	
Address (Street, Route, Apt. No., etc.)					City			State	Zip Code	
Home Phone		Cell Number			Cell phone carrier (ex. Verizon)					
Email Address					Best way to contact (Circle one): Home Phone Cell Phone Email Letter					
Employed by										
Business Phone		Employer's Address			City			State	Zip Code	

SPOUSE/GUARDIAN (If patient is married, give spouse information. If patient is a child, give parent information.)

Name		Address			City		State	Zip Code		
Home Phone	Social Security			Date of Birth		Relationship to Patient				
Employed by				Business Phone						
Employer's Address				City			State	Zip Code		
Emergency Contact (Friend or relative not at Patient's address who can get a message to you.)							Daytime Phone			

PHYSICIAN INFORMATION

Primary Care Physician _____

Address _____ Phone _____

Referring Physician (If different from Primary Care Physician) _____

Address _____ Phone _____

St. Mary's Medical Group will use the email provided above to enroll you into our patient portal. You will receive an email to complete the enrollment process.

Is the email given above used by another member of your household or family? If yes, by whom: _____

Are you a currently patient at any other St. Mary's Medical Group Location? If so, which locations: _____

INSURANCE INFORMATION

(Please provide your insurance card(s) at the time of visit)

 Patient or Guardian Signature

 Date

NORTHEAST CARDIOLOGY
OWNED AND OPERATED BY ST. MARY'S MEDICAL GROUP, INC.
A SUBSIDIARY OF ST. MARY'S HEALTH CARE SYSTEM, INC.
("SMMG")

CONSENT TO TREATMENT

I hereby authorize and consent to such care, examinations and treatments including, but not limited to, any medical care or treatment, examinations, diagnostic procedures, and the furnishing of such supplies in connection with or relating to treatment as are necessary or desirable in the judgment of the treating physician.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by SMMG physicians. I agree that in return for the services provided to me, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the above mentioned medical practice for payment. If any account is sent to collections, I agree to pay collection expenses.

ASSIGNMENT OF PAYMENT OF BENEFITS

In consideration of SMMG advancing or extending credit to me for my care, I hereby assign and transfer to SMMG all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, or under any other benefit plan. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request payment of authorized Medicare benefits for me, or on my behalf, for any services furnished to me by or in SMMG, including physician services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize SMMG or their representatives to release any of my medical information, protected health information or related information pertaining to this period of treatment, including AIDS Confidential Information and psychiatric information, that may be requested by any physician, provider, hospital, healthcare facility, any insurer or third party payor with whom I have coverage, my employer, or any public agency which may be assisting in payment of my care. I authorize SMMG to release to the Social Security Administration, Department of Medical Assistance, their intermediaries or carriers, or to review organizations, any information about me as needed for this or a related Medicare, Medicaid, or Tricare claim, including medical information relating to my treatment. I understand that health care services may be subject to review by review organizations as well

I HAVE READ THE FOREGOING CONSENT TO TREATMENT, FINANCIAL AGREEMENT, ASSIGNMENT OF PAYMENT OF BENEFITS, AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION. I AM AWARE OF THE CONTENTS OF EACH AND FULLY UNDERSTAND EACH.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ST. MARY'S HEALTH CARE SYSTEM, INC.

IN WITNESS WHEREOF, I HAVE PLACED MY HAND AND AFFIXED MY SEAL AS OF THE DATE INDICATED BELOW.

Patient Name (Print)

Patient Date of Birth

Patient or Guardian Signature

Date

I have agreed to let certain individuals participate in discussions and decisions related to my health care. I thereby give permission for Northeast Cardiology owned and operated by St. Mary's Medical Group, Inc. a subsidiary of ST. MARY'S HEALTH CARE SYSTEM and Doctor _____ to discuss my personal health care information with the following individual(s).

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Name/Relationship _____ Phone Number _____

Conditions for Disclosure (check all that apply):

- The Clinic may disclose my personal health information to the individual(s) above **only** in my presence.
- Unless indicated otherwise, the Clinic may disclose my personal health information to the individual(s) above in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.
- Other conditions of disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to our office.

Patient signature: _____ Date: _____

Legal Representative: _____ Date: _____

Reason for Representative: _____

FCA: 06/03

Some or all of the health care professionals performing services in this Health Care System are independent contractors and are not Health Care System agents or employees. Independent contractors are responsible for their own actions and the Health Care System shall not be liable for the acts or omissions of any such independent contractors. O.C.G.A. 51-1-29.5(d)

**Consent For Disclosure to Family Member
and/or Personal Representative for
Northeast Cardiology and
St. Mary's Health Care System, Inc.**

Patient Name _____
Address: _____

Date of Birth: _____
SSN# _____
Telephone # _____

Authorization for Release of Medical Information

Patient: _____ **Date of Birth:** _____
(First) (Last)

I authorize the use or disclosure of the above-named patient's protected health information as described below.

I hereby authorize _____ to release the information.

For the purpose of: _____

Check Type of Record to be Released

- | | | |
|---|---|--|
| <input type="checkbox"/> Complete Health Record (or check for certain sections) | | |
| <input type="checkbox"/> ER Record | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Echocardiogram Results |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Most Recent Lab Work
(BMP, CMP, Lipids, LFTs) | <input type="checkbox"/> Nuclear Stress Test Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG | <input type="checkbox"/> CT Scan Results |
| <input type="checkbox"/> Consultation Report | | <input type="checkbox"/> Carotid-Vascular Study
Results |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Chest X-Ray Report | <input type="checkbox"/> Other as
Specified _____ |
| <input type="checkbox"/> Nursing Documentation | <input type="checkbox"/> Exercise Stress Test Results _____ | |

I understand that information in my health record may include information relating to Confidential Information and may include mental health, HIV/AIDS diagnosis, alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Office Manager. This would not apply to information that has already been release prior to my written revocation.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign the authorization.

Patient Signature **Date:** ____/____/____

Printed Name of Legal Representative **Date:** ____/____/____

If signed by Legal Representative please provide the following:

Relationship to patient: _____

Authority to sign on Behalf of the Patient: Custodial Parent Durable Power of Attorney for Healthcare
 Other, Please describe: _____

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St. Mary's Medical Group**

Name: _____ Date: _____

Referring MD: _____ Date of birth (age): _____

Chief Complaint: _____

History of Present Illness: _____

Please provide complete answers to the questions in sections 1 through 5:

1.) Do you now have or have you previously had any of the following conditions? (Please circle):

Diabetes High blood pressure High cholesterol Family member age less than 55 with heart disease

Previous heart attack Heart failure Heart catheterization or angioplasty (year) _____

Cancer Kidney Problem Peptic Ulcer Thyroid Problem Stroke Bleeding Problem

Other health problems: _____

Date of last: Mammogram _____ Colonoscopy _____ Pneumovax _____

2.) Please list any previous surgeries: _____

3.) Social History: Past or present use of tobacco? No Yes If yes, # of packs/day _____ x _____ yrs.

Exposure to second hand smoke? No Past Present

Number of alcoholic beverages consumed per day, week, or month: _____

Do you or have you used cocaine or other street drugs? Yes No

How much caffeine do you drink per day? _____

Do you exercise regularly? No Yes Type of Exercise: _____

Are you employed? _____ If yes, type of position _____

Are you married: _____ Single: _____ Widowed: _____ Divorced: _____

**Northeast Cardiology
St. Mary's Medical Group**

4.) Family History: Please check all known health conditions in your family members.

	Heart Attack	High Blood Pressure	Stroke	Diabetes	Cancer	Other
Mother						
Father						
Brothers						
Sisters						
Grandparent						

5.) Review of Systems:

Please check all symptoms listed below that you may have experienced in the last 30 days.

- Fatigue**
- Chest Pain at Rest**
- Chest Pain with exertion/activity**
- Palpitations (heart racing or "skipping beats")**
- Peripheral edema (swelling of legs and/or arms)**
- Paroxysmal nocturnal dyspnea (waking at night feeling short of breath)**
- Orthopnea (difficulty breathing when lying down)**
- Dyspnea on exertion (difficulty breathing with activity)**
- Syncope (fainting/"passing out")**
- Claudication (pain or cramping in legs with activity)**
- Shortness of Breath**
- Excessive snoring**
- Stroke like symptoms**
- Unusual change in weight**
- GI bleed (bloody stools)**
- Muscle cramps**
- Rash**
- Anxiety**
- Depression**

Please bring all of your medications with you to your appointment

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eRx Consent

ePrescribing is a federally mandated initiative that requires all physicians to prescribe medications electronically beginning in 2011.

ePrescribing software sends your prescriptions over the internet to your pharmacy in a safe, secure way through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your physician see important information like drug interactions and your prescription history.

The benefit to you is:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

Patient Consent:

I agree that Northeast Cardiology may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature (or legal guardian)

Print Patients Name

Primary Pharmacy Name

Pharmacy Street and City

Secondary Pharmacy if applicable

Pharmacy Street and City

Date