Dunwoody Village Clinic

Patient Information Form

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE PICTURE ID AND INSURANCE CARD BEFORE SEEING A DOCTOR

Date___________ **Acct#_________________**

Please Print

NAME: ____
First M. Last

Social Security #:______________________________DOB____/_____/_______

Marital Status (Please circle): S M W D **Spouse Name**: _____________

Minor: Y/N Sex: M/F **Race (Please circle)**: Asian African Am. Hispanic White Refuse

Other _____________ **Ethnicity (Please Circle)**: Hispanic Not Hispanic Refuse

ADDRESS: ____**Apt.**______

CITY: ________________________**STATE**:_____________**ZIP**:____________

Home Phone: ________________ **Cell Phone**: _______________**Work**:__________

Email: ____________________________________

Employer: ___________________________**Occupation**:___________________

Emergency Contact: ____________________________**Phone**:_______________

Parents Name (minor) or POA:____
Address if Different form above____
Phone #:______________________________________

INSURANCE INFORMATION
Primary Insurance Name____
Name of Insured_____________________________________Relation__________________
Insured DOB___________________ SSN#___________________________________
Secondary Insurance____

ALL CO-PAYMENTS DUE AT TIME OF SERVICE

TREATMENT, PAYMENT AND OPERATIONS CONSENT:
I authorize you to give me reasonable and proper medical care by today's standards. I authorize payment of medical benefits to Dunwoody Village Clinic. I understand that what my insurance does not pay I will be responsible to pay. I authorize release of medical information necessary to process all claims.____ ___________________
Signed date

MEDICARE ONLY: I understand that Medicare pays only a small amount for Physicals. If I request a physical, I will agree to pay the Doctor treating me, knowing that Medicare may not reimburse the cost of my visit. If I have any test not covered by Medicare, I will be responsible for balance /cost of that test.____ ___________________
Signed date

I have read and acknowledge HIPPA policy____________________ Initial

DUNWOODY VILLAGE CLINIC, P.C.

JAMES J. KINAHAN, M.D., PhD.

DUNWOODY VILLAGE CLINIC HISTORY AND INFORMATION FORM

NAME_______________________________SSN#____________________DATE_________
ADDRESS______________________________________OCCUPATION________________
PHONE (HOME) ________________WORK________________DATE OF BIRTH__________

CHIEF COMPLAINTS____
ALLERGIES____
CURRENT MEDICATIONS____
IMMUNIZATIONS____
LONG TERM MEDICATION HISTORY__________________________________

HOSPITALIZATIONS OR SURGERIES:
REASON____ DATE ___________________
REASON____ DATE ___________________
REASON____ DATE ___________________

MEDICAL HISTORY (CHECK ALL THAT APPLY):

HEADACHES ____________
SHORTNESS OF BREATH _________
HEART PALPITATIONS ___________
HEART MURMUR ______________
CHEST PAIN ________________
DIZZINESS/FAINTING ___________
VENEREAL DISEASE ____________
ALLERGIES _________________
ASTHMA ___________________
BRONCHITIS ________________
PNEUMONIA ________________
ULCER _____________________
GI DISORDER _______________

LACTOSE INTOLERENCE ______________
GALLBALLER DISEASE _______________
PROSTATE EXAM ___________________
BOWEL IRREGULARITY ______________
INCONTINENCE ____________________
SEXUAL DISORDER _________________
MENSTRUAL DISORDER ______________
PERIPH. VAS. DISEASE ______________
FREQUENT INFECTIONS _____________
HEPATITIS _______________________
ANEMIA _________________________
ARTHRITIS _______________________
OSTEOPOROSIS ____________________

NERVOUSNESS ___________
DEPRESSION _____________
SCARLETT FEVER ________
GOUT __________________
CHRONIC RASHES ________
RHEUMATIC FEVER _______
MUMPS _________________
MEASLES _______________
RUBELLA _______________
POLIO _________________
DIPTHERIA ______________
TETANUS _______________
OTHER _________________

FAMILY HISTORY:

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
EPILIPSY/CONVULSIONS						
HIGH BLOOD PRESSURE						
HEART DISEASE						
STROKE						
CANCER						
GLAUCOMA						
DIABETES						
SLEEPING DISORDERS						
BLEEDING DISORDERS						
KIDNEY DISEASE						
THYROID DISEASE						
MENTAL ILLNESS						
OSTEOPOROSIS						

HABITS:

SMOKING – PACKS PER WEEK ____
HOW LONG __________

COFFEE – CUPS DAILY _____
OTHER CAFFEINE __________

ALCOHOL – TYPE _____
AMOUNT ______

DIFFICULTY FALLING ASLEEP? _________
STAYING ASLEEP? _________
SNORING? ______________
CONTACT WITH BODILY FLUIDS AT WORK? _____________

DIET – SALT INTAKE ___________
FAT INTAKE ___________
EARLY AWAKENING? _______

24 Hour Cancellation & “No Show” Fee Policy

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Dunwoody Village Clinic reserves the right to charge a fee of $25.00 for each missed (No Show) appointment that is, absent of a compelling reason and/or is not cancelled at least 24 hours prior. “No Show” fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period will result in a warning regarding continuing care with our practice.

Thank you for your cooperation, in helping us take care of all our patients.

By signing below you acknowledge that you have received this notice and understand this policy

____________ _______________

Initial ***Date***

PAYMENT IS EXPECTED AT THE TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made in advance. Dunwoody Village Clinic accepts cash, check, VISA, MasterCard, Discover, and American Express. There is a service charge of $25.00 for returned checks. Patients with an outstanding balance of 90 days or more must make arrangements for payment prior to scheduling appointments.

INSURANCE:

It is the patient’s responsibility to provide their current insurance card at the time of service. If you fail to provide your current insurance, it may be necessary to reschedule your appointment. We bill participating insurance companies as a courtesy to you. If we have not received payments from your insurance company or if the payments are denied within 90 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Please note your insurance plan determines your co-pay/co-insurance/deductible; they also determine what codes they cover and do not cover. Your EOB (Explanation of Benefits) should outline this information. We do not bill third party insurance companies.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., RPPG, HMO, etc.), you must receive a referral from your primary care physician before seeing a specialist. Retroactive referrals are not always guaranteed. Humana HMO does not offer back dated referrals so call ahead of time, otherwise it will be your responsibility to deal with payment.

DISABILITY /FMLA/INSURANCE FORMS:

A $25.00 flat fee, pre-payment will be charged for 3 or more pages. Please allow 2-7 business days for them to be completed. I have read and understand the Financial Policy of Dunwoody Village Clinic. I agree to assign insurance benefits to Dunwoody Village Clinic whenever necessary.

______________________________________ ______________________

Signature *Date*

Refills:

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I will not come to Primary Care for my refill until I am called by the nurse. I must keep track of my medications. No early or emergency refills may be made.

PATIENT'S INSURANCE OBLIGATION

In order to accommodate the needs and requests of our patients, we have contracted with numerous managed care companies. By doing so, we agree to file your insurance claim in a timely manner and to accept a discounted fee for service, in addition to fulfilling other contractual obligations.

It is your responsibility to contact your insurance company to verify that we are on your particular plan.

We rely on you to give us the correct insurance information needed to file your claim properly. For this reason, we will ask you to present your insurance card at every visit. We can assure you that we file the claim with days of your office visit.

In addition, it is impossible for us to know all the individual requirements unique to the specific contract your employer has made with your insurance company. Some contracts exclude particular lab tests, require you to use a specific lab for blood work, deny screening test or wellness visits, or require pre-certification for particular x-rays. You can only help yourself by becoming familiar as possible with your benefits. You need to know your particular insurance plan. By becoming an informed consumer and assuming an active role in your healthcare, you can prevent unexpected personal expenses.

In the event that a non-covered service is performed, we will expect you personally to assume responsibility for payment of your medical care.

I have read this insurance statement and agree to accept responsibility as described above.

____ __________

PATIENT (OR PARENT/GUARDIAN, IF PATIENT IS A MINOR) **DATE**

Dunwoody Village Clinic

James Kinahan, M.D PH D
Kristen Tinker PA-C
Jamie Morrison PA-C
Noel Anderson PA-C

PATIENT NAME: ____
ADDRESS: ____
PHONE NUMBER: _______________________ **DATE OF BIRTH**: _____________

The HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is provided the right to request confidential communication or that a communication of "Protected Health Information" be made by alternative means, such as sending information to a patient's office, instead of their home.

Please identify your preferred method(s) of contact for communication below:
I have no objection to the physician discussing my medical or surgical care and treatment with the following persons.

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

Name: _________________________ Relationship: _______________ Phone: _____________
(Please Print)

HOME PHONE: (Check Box)
Leave message with details: _____
Leave message with call back number only: _____

OFFICE PHONE: (Check Box)
Leave message with details: _____
Leave message with call back number only: _____

WRITTEN COMMUNICATION:
Mail to my home: ______
Mail to my work: ______
Fax to designated phone #_____________________

I give the Provider's at Dunwoody Village Clinic permission to use and disclose "Protected Health Information" necessary to carry out treatment, payment or operations. This substantiates a good faith effort made on behalf of the doctors. I understand the privacy practices of this office that have been disclosed to me: This information will stay on record for 5 years.

SIGNATURE: ____**DATE**:___________