Marietta Family Medicine **Dr. Irshad Syed, M.D.**
3535 Roswell Road, Suite 20, Marietta, GA 30062
http://mariettafamilymed.com

Welcome!
Thank you for choosing Marietta Family Medicine as your primary care provider. Attached you will find our informational packet for new patients. Please take the time to review and complete the following information. We would appreciate it if you could bring this packet with you to the office on your scheduled appointment date. Should you have any questions or concerns, feel free to contact us via phone call at (678) 741-7185 or via text message at (844) 252-3330. Text messages should be answered by the end of the following working day.

Personal Information

You may complete this form online - PRINT & BRING TO YOUR APPOINTMENT

Last Name: _________________________ First Name: _________________________ Middle Initial: ____

D.O.B.: ___/___/_____ SS#: ______________ Gender/Sex : _______ Email: _______________________

Address: ___________________________________ City: __________ State: _____ Zip Code: _________

Phone #(s): Cell: ____________________ Work: ____________________ Home: _____________________

Marital Status (enter “X”): ___Single ___Married ___Divorced ___Widowed ___Partner ___Legally Seperated

Employment Status (enter “X”): ___Yes ___No ___Student

Additional Demographics

Race (enter “X”):

___American Indian or Alaska Native

___Asian

___Black or African American

___Hispanic or Latino

___Native Hawaiian or Other Pacific Islander

___White

___Other (please specify): ____________

Ethnicity (enter “X”):

___Hispanic

___Non-Hispanic

___Other (please specify): ____________

If English is not your preferred language, please indicate what language is: _________________

Emergency Contact(s):

Please list at least ONE person we may contact in an emergency situation. This person will be notified of medical information in the event of an emergency ONLY.

Name: _______________________________ Relationship to you? _______________________________

D.O.B: ___/___/_____ Phone #(s): Cell: ____________________ Work: ____________________

Name: _______________________________ Relationship to you? _______________________________

D.O.B: ___/___/_____ Phone #(s): Cell: ____________________ Work: ____________________

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Last Name: ________________________ First Name: ________________________ Middle Initial: ____

D.O.B.: ___/___/_____

Preferred Pharmacy Information:

Local Pharmacy Name: __________________________________ Phone #: ______________________

Address: _________________________________ City: __________ State: _____ Zip Code: _________

Insurance Information:

PRIMARY Insurance Company Name: ____

Policy #: _______________________ Group Number/Name: ___________________________________

Policy Holder Last Name: __________________________ First Name: ___________________________

D.O.B.: ___/___/_____ SS#: ______________ Relationship to you: ______________________________

Insured's Employer: ____

Address: ______________________________ City: _______ State: _____ Zip Code: _________

Work Phone #: ______________________

SECONDARY Insurance Company Name (if applicable): _______________________________________

Policy #: _______________________ Group Number/Name: ___________________________________

Policy Holder Last Name: __________________________ First Name: ___________________________

D.O.B.: ___/___/_____ SS#: ______________ Relationship to you: ______________________________

Responsible Party/Guarantor Information

Relationship to you: ______________________________ *If "SELF," you may skip the rest of this section*

Last Name: _____________________________ First Name: _____________________________

D.O.B.: ___/___/_____ SS#: ______________

Responsibly Party's Employer: ____

Address: ______________________________ City: _______ State: _____ Zip Code: _________

Work Phone #: ______________________

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New Patient Medication Form

You may complete this form online - PRINT & BRING TO YOUR APPOINTMENT

Last Name: _________________________ First Name: _________________________ Middle Initial: ____

D.O.B.: ___/___/_____

I consent to Marietta Family Medicine obtaining my medication history from other providers/pharmacies:

Patient or Parent/Guardian Signature: _______________________________ Date: ___/___/_____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

Name of Prescription Medications	Mg/Dose	How often is it taken?

Do you have any Allergies? (enter "X") **___Yes ___No If yes, please list all allergies below:**

Allergy	Symptoms

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New Patient History Form

You may complete this form online - PRINT & BRING TO YOUR APPOINTMENT

Last Name: ________________________ First Name: ________________________ Middle Initial: ____

D.O.B.: ___/___/_____

Have you had (or do you currently have) any of the following medical problems? (enter "X")

___ **High Blood Pressure**	___ **Cancer**	___ **Asthma**	___ **Glaucoma/Cataract**
___ **Diabetes**	___ **Depression or Anxiety**	___ **Headache**	___ **Dementia/Memory Loss**
___ **Heart Disease**	___ **Anemia**	___ **COPD**	___ **Seizures**
___ **High Cholesterol**	___ **Stroke/TIA**	___ **Fibromyalgia**	___ **Positive HIV/AIDS**
___ **Acid Reflux**	___ **Hepatitis-B/C**	___ **Gout**	___ **STDs/STIs**
___ **Thyroid Disease**	___ **DVT/PE**	___ **Arthritis**	___ **Other (please specify)**

PLEASE LIST PAST SURGERIES:

Year	Procedure(s)

PLEASE LIST ANY HOSPITALIZATIONS (OTHER THAN FOR PROCEDURES NOTED ABOVE):

Year	Reason(s) for Hospitalization

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Last Name: ________________________ First Name: ________________________ Middle Initial: ____
D.O.B.: ___/___/_____

Social History:

Do you currently smoke? (enter "X"): ___Yes ___No Did you quit? If so, when? _______________

Do you use alcohol or drugs? (enter "X"): ___Yes ___No If yes, how often? ______________________

Family History:

Do you have family history of any of the following? (enter "X")

High blood pressure : ___Yes ___No If "Yes", who? ________

Heart Disease: ___Yes ___No If "Yes", who? ________

Diabetes: ___Yes ___No If "Yes", who? ________

Cancer: ___Yes ___No If "Yes", who? ________

Mental Illness: ___Yes ___No If "Yes", who? ________

Preventative Care:

	Most Recent Date	Doctor Who Treated You
Eye Exam		
Colonoscopy		
Mammogram		
Pap Smear		

Vaccinations: (enter "X")

	Approximate Date
___ **Seasonal Influenza (Flu)**	
___ **COVID-19**	
___ **Pneumonia**	
___ **Shingles**	
___ **Tetanus**	
___ **Hepatitis A/B**	

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Consent and Authorization for Treatment

Last Name: ________________________ First Name: ________________________ Middle Initial: ____
D.O.B.: ___/___/_____

Consent for Treatment:

Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory test, medication or exam as may be deemed necessary by the physician, physician assistant, and/or nurse practitioner.

Patient or Parent/Guardian Signature: ______________________________ Date: ___/___/_____

Financial Responsibility:

I understand that it is the responsibility of each patient to arrange for payment for medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Marietta Family Medicine, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

Patient or Parent/Guardian Signature: ______________________________ Date: ___/___/_____

Consent to Obtain Medical Records:

I hereby authorize Marietta Family Medicine to obtain medical records from any other physician or medical facility necessary in the course of any treatment

Patient or Parent/Guardian Signature: ______________________________ Date: ___/___/_____

Release for Treatment of a Minor (if applicable):

Except under certain legal exemptions, a parent or guardian signature is required for the treatment of a minor. I am the parent/guardian for __________________________, and give Marietta Family Medicine authorization to provide treatment.

Parent/Guardian Signature: ______________________________ Date: ___/___/_____
Office or Other Witness Signature: ______________________________ Date: ___/___/_____

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Policies and Procedures

Scheduling:
Patients can request appointments through the patient portal available via the HEALOW App or online at http://mariettafamilymed.com. Alternatively, appointments can be scheduled by phone at (678) 741-7185, by text at (844) 252-3330, or by office.

It is the responsibility of the patient/guardian to give office staff any updated information changes including, but not limited to, insurance, pharmacy information, address, phone number, etc. Personal information may also be updated via the Patient Portal. Insurance card(s) should be brought to every visit. Insurance updates for primary care providers may need to be filed with insurance prior to appointments. Marietta Family Medicine CANNOT be held responsible for any fees incurred by a patient failing to give updated information.

We ask that all patients arrive 15 minutes before their scheduled time.

Payment:
Payment will be requested at the time of visit for all services which are non-covered or determined to be the patient's responsibility, including copayments and deductibles. Patients WILL be billed for remaining balances not covered by their insurance. Accepted forms of payment are Visa, Master Card, Discover, or Cash.

Medication Refills:
Medications will NOT be refilled without required follow up visits. Depending on medical necessity, you may be required to follow up every 1-6 months as determined by your physician. It is the patient's responsibility to make follow up appointments prior to need of refills, and it is recommended that you make your follow-up appointment upon completing your current visit. If for any reason a refill is needed between follow-up visits, you should allow 48 hours for your pharmacy to receive your request. There are no exceptions to this policy. Please understand that this policy is for your safety and in your best interest.

Cancellation Policy:
We realize that patients may need to change their appointments; however, we require a notice 24 hours prior to your original appointment time so that we may offer that time to another patient. Failure to cancel without due notice, may result in a $25.00 cancellation fee. This fee will not be submitted to insurance and it will be the patient's sole responsibility to cover this fee.

After Hours:
Visit the patient portal via the HEALOW App or online at http://mariettafamilymed.com for appointment scheduling and lab/test results. Other issues will be handled during routine office hours.
If you have a life-threatening emergency, please call 911 or immediately go to the nearest emergency room.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:
* **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
* **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
* **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this alternatively i.e. electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated.

You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Marietta Family Medicine
3535 Roswell Road, Suite 20
Marietta, GA 30062
Phone: (678) 741-7185
Text: (844) 252-3330

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Phone: (202) 619-0257
Toll free: 1-800-1019

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Acknowledgement of Receipt of "Notice of Privacy Practices"

You may complete this form online - PRINT & BRING TO YOUR APPOINTMENT to SIGN AT OUR OFFICE

I, _________________________, D.O.B: ___/___/_____ acknowledge that I have received a copy of Marietta Family Medicine's "Notice of Privacy Practices" on the date set forth below. I grant permission to leave medical information in the specified manner and to the specified person(s) set forth below.

APPROVED PHONE NUMBERS FOR PERSONAL HEALTH COMMUNICATIONS (or opt out below)

You may leave PERSONAL MESSAGES INCLUDING LAB RESULTS on phone numbers below:

Mobile: _______________________ Home: _______________________ Work: _______________________

or opt out (enter "X"): ___ *No personal health messages except appointment confirmations/changes*

DESIGNATED PEOPLE WE MAY SHARE YOUR MEDICAL & ACCOUNT INFO WITH (or opt out below)

You may share medical and account information with this/these designated individual(s) as follows:

Name: _______________________________ Relationship to you? _______________________________
D.O.B: ___/___/_____ Phone #: _______________________
Name: _______________________________ Relationship to you? _______________________________
D.O.B: ___/___/_____ Phone #: _______________________

or opt out (enter "X"): ___ *Do not share information with anyone other than me.*

If you provide your email address to Marietta Family Medicine, your lab results will be available for you to review via the SECURE patient portal accessible online or with the HEALOW app. You should receive an email notification when results are available online.

Email Address: ____

STOP. PLEASE BRING WITH YOU TO SIGN IN PERSON AT OUR OFFICE.

Policies and Procedures:

I have been provided the opportunity to read, or it has been read to me, the "Policies and Procedures" at Marietta Family Medicine. I have been provided with a copy of the "Policies and Procedures" at Marietta Family Medicine. I understand the "Policies and Procedures" at Marietta Family Medicine.

Patient or Parent/Guardian Signature: _______________________________ Date: ___/___/_____
Office or Other Witness Signature: _______________________________ Date: ___/___/_____

After any lab testing, if you do not hear from the office within two weeks, please contact our office.

Patient or Parent/Guardian Signature: _______________________________ Date: ___/___/_____
Office or Other Witness Signature: _______________________________ Date: ___/___/_____

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Patient Health Questionnaire

You may complete this form online - PRINT & BRING TO YOUR APPOINTMENT

Last Name: ________________________ First Name: ________________________ Middle Initial: ____

D.O.B.: ___/___/_____

In the last 2 weeks, how often have you been bothered by any of the following problems? (enter "X")

Score	0	1	2	3
	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself, or that you are a failure, or that you have let your family down				
7) Trouble concentrating on things such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts about hurting yourself or that you would be better off dead				
Total				

Total Score: _____

If you checked off ANY problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (enter "X")

___ Not difficult at all

___ Somewhat difficult

___ Exceedingly difficult

___ Extremely difficult