Marietta Family Medicine
3535 Roswell Road, Suite 20, Marietta, GA 30062
http://mariettafamilymed.com

Irshad Syed, MD

Welcome! **DATE: _____**

Thank you for choosing Marietta Family Medicine for your primary care. Below you will find our informational packet for new patients. Please take time to review and complete the following information. Should you have any questions or concerns, feel free to ask the front desk.

Last Name:	First Name:	Middle Initial:
Date of Birth:	Sex: Male Female	Race/Ethnicity:
Address:		
City:	State:	Zip Code:
Cell:	Home:	Work:
Email (Needed for Portal):	Social Security:	Preferred Contact Number:
Employed: YES NO	Marital Status:	
Preferred Pharmacy: Name: Location:		Emergency Contact- Name: Phone:

Insurance Information:

- **PRIMARY** Insurance Company Name: _____

Policy #: _____ Group Number (If Applicable): _____

- **SECONDARY** Insurance Company Name: _____

Policy #: _____ Group Number (If Applicable) _____

Responsible Party/Guarantor Information:

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

Last Name: _____First Name: _____D.O.B.: ___/___/_____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone #: _____Work Phone #: _____

To maintain quality of care, I give permission to MFM to release and receive my medical records regarding any specialists, hospitals or medical facilities associated with my care plan. I understand that MFM abides by HIPAA regulations and that only the records pertaining to the visit will be released.

Signature: _____ **DATE:** _____

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Please fill out the following information so that we understand your current medical status:

Current Medications: Name, Dosage and Directions

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

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

Allergy	Symptoms

Medical Problems: Have you have now or have you had in the past, any of the following medical problems:

__ High Blood Pressure	**__Cancer**	**__ Asthma**	**__Glaucoma/ cataract**
__Diabetes	**__Depression/Anxiety**	**__Headache**	**__Dementia/ Memory loss**
__Heart Disease	**__Anemia**	**__COPD**	**__ Seizure/Disorder**
__High Cholesterol	**__ Stroke/ TIA**	**__Fibromyalgia**	**__Positive HIV/AIDS**
__Acid Reflux	**__Hepatitis-B/C**	**__Gout**	**__Sexually Transmitted Diseases**
__Thyroid Disease	**__DVT/PE**	**__Arthritis**	**__Other (Please Specify)**

Past Surgeries: (Surgery and Year):

1._____ **2.**_____
3._____ **4.**_____

Other Providers or Specialists who assist in your care:

Name:	Specialty:	Contact:

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Social History:

Do you smoke now __Yes __No **Did you quit & when? _____**

Do you use alcohol or drugs __Yes __ No **If yes, how many drinks/weeks? _____**

Family History: Do you have a family history of:

-High blood pressure __Yes __No If yes, what relation? _____
-Heart Disease: __Yes __No If yes, what relation? _____
-Diabetes: __Yes __No If yes, what relation? _____
-Cancer: __Yes __No If yes, what relation? _____
-Mental Disease: __Yes __No If yes, what relation? _____

Preventative Care:

	Most Recent Date	Doctor who treated you (Optional)
Eye Exam		
Colonoscopy		
Mammogram		
Pap Smear		

Vaccinations: (enter "X")	**Approximate Date(s):**
___ **Seasonal Influenza (Flu)**	
___ **COVID-19**	
___ **Pneumonia**	
___ **Shingles**	
___ **Tetanus**	
___ **Hepatitis A/B**	

Office Policies

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, or in office.

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

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 is in your best interest.

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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 office hours.

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Patient Financial Policy Agreement

Insurance: We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance: All patients must complete our demographic form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to prove insurance. If you fail to provide us with the correct insurance card at the time of your appointment, you may have to pay the self-pay fees for the visit.

Coverage Changes: If your insurance changes, please notify us when you check-in for your appointment to help you receive your maximum benefit.

Co-payment, Deductible, and Co-Insurance: Your responsibility is to pay any deductible, co-pay, co-insurance, or any portion of the charge as contracted with your insurance company that is considered to fall under patient responsibility.

Non – Covered Services: Please be aware that some -and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay any portion of the charges your insurance policy does not cover. This includes Prior Authorizations and legal forms including but not limited to Disability and FMLA paperwork. Patients WILL be billed for remaining balances not covered by their insurance. Accepted forms of payment are Visa, Master Card, Discover, check or Cash. Payments may be made online through our Healow Portal. Personal information may also be updated via the Patient Portal. 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.

Claim Submission: As a courtesy to you, we will submit your claims and assist in any way we can reasonably help get your claims paid. We will only file claims to your primary and secondary insurance policies; we do not file claims to tertiary plans. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that your claim's balance is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Payments: Unless we approve other arrangements in writing, you are responsible for paying your balances within 30 days of rendered services. Once we send you a statement, the balance on your account is due and payable upon receipt.

Returned Checks: There is a $30 fee for returned checks. It is our policy not to accept personal checks for future appointments in this situation.

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 $55.00 cancellation fee. This fee will not be submitted to insurance and it will be the patient's sole responsibility for payment. Please call 24 hours in advance to reschedule or cancel your appointment. We understand that circumstances beyond your control may arise and, in these cases, we ask that you inform us as soon as possible.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein regarding our company's financial policies and the agreement will be in full force and effect.

- Please be aware we only verify that you have active insurance, and we can file a claim on your behalf. Our office does not verify what your specific plan covers.

PATIENT NAME (Print): _____ SIGNATURE:_____DATE: _____

RESPONSIBLE PARTY: _____ SIGNATURE: _____DATE: _____

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Privacy Practices Acknowledgement and HIPAA Authorization Form

On April 14, 2001, the Health Insurance Portability and Accountability Act became law, with an effective date of April 14, 2003. This law impacts on many aspects of the healthcare industry and expands your rights as a patient to the protection of your Individually Identifiable Health Information (IIHI).

Our responsibility:

Our practice is dedicated to maintaining the privacy of your IIHI (Individually Identifiable Health Information). In conducting our business, we will create electronic medical records regarding you and the treatment and services we provide to you. We are required by law to provide you with this important information concerning our procedures relative to the use of your IIHI and your rights as a patient to know as to how we will use or disclose your IIHI, your privacy rights in your IIHI, and our obligations concerning the use and disclosure of your IIHI.

We may use and disclose your Personal Healthcare Information (PHI) in the day-to-day operations of our offices as pertains to Treatment, Payment and Operations (TPO). This relates to the continuum of care between primary care givers and consulting physicians, as well as healthcare workers on our staff. We may be required to share your PHI with your insurance carrier as related to healthcare issues or payment events. Or we may use your PHI within our practice to evaluate our quality of care.

Further, we may use your IIHI to contact you for medical purposes, or for appointment reminders; to inform you of certain treatment options or alternatives; or as may be requested or directed by you to release said information to family or care giving personnel.

We may, from time to time, be required to release your PHI because of federal or state mandate, or by competent legal directive.

Your rights:

You have a right to request that we communicate with you in a certain manner or location, for example, appointment reminders at work or at home.

You have the right to request a restriction to use or disclose of your IIHI to certain individuals or entities.

You have the right to inspect or obtain a copy of the IIHI, less psychotherapy notes. This request must be made in writing.

You may ask to amend health information, if you believe that it is incorrect or incomplete, and you may ask for amendment of your PHI, subject to restrictions as established by the HIPAA law.

You have the right to request an accounting of the disclosures of your PHI, again, the request must be in writing.

This represents a summary of our legal mandate, with the details to be found in the published Policy Statement. You can be assured that we will make every attempt to honor your privacy, and to maintain our record of confidentiality. You may contact our office relative to any questions you may have regarding this new law.

May we discuss billing/medical information with a person other than yourself? If so, please list:

1: _(NAME)_____(Relation)_____ phone: _____

2: _(NAME)_____(Relation)_____ phone: _____

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 (NAME):_____ and give Marietta Family Medicine authorization to provide treatment.

Parent/Guardian Signature: _____ ***Date:*** _____

Consent for Treatment:

Permission is hereby given for any medical/surgical procedures, x-rays, drug or laboratory tests, medications or exams as deemed necessary by the physician, physician assistant, and/or nurse practitioner.

Patient or Parent/Guardian Signature: _____ ***Date:*** _____

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Patient Health Questionnaire

Name:_____ **Date:**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "x" to indicate your answer)

Scoring Guide: 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, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure, or have let yourself or 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 could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better off dead or of hurting yourself in some way				
Tallying Result Count:				

Total score: _____

If you checked off <u>any</u> 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?

Not difficult at all	Somewhat difficult	Exceedingly difficult	Extremely difficult