Ahava Healthcare
Jody Amazon, DSc APRN
2160 Fountain Drive #220, Snellville, GA 30078
(P) 678-336-9102 (F) 770-674-8563
Kristina Thompson - Practice Manager
Kthompson.ahava@gmail.com

LEGAL NAME: _____ _____ ____
Last **First** **MI**

DOB: _____ **Social Security:** _____-_____-_____

Telephone Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

Employment Status: Retired ☐ Disabled ☐ Employed ☐

required for billing purposes

Primary Insurance: _____ **ID#:** _____

Group #: _____

Secondary Insurance: _____ **ID#:** _____

Group #: _____

Name of physician/person that referred you: _____

Address: _____Phone: _____

Is patient in an assisted living facility, personal care home or nursing home? _____

If yes, what is the name of the facility? _____

Telephone Number _____

If other than patient, to whom should all correspondence be mailed?

Name: _____

Address: _____

City_____ State ____ Zip _____ Phone: _____

Relationship to patient: _____

Power of Attorney? Yes No
(Please provide a copy of the power of attorney for the chart)

****The power of attorney will be contacted first for all matters. If there is no power of attorney we will contact the person named above for all matters. In the event the patient, primary contact named above, or power of attorney cannot be reached, please provide the name of another person that we may contact in case of an emergency.***

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home phone_____ Work phone _____ Cell _____

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PHARMACY INFORMATION

FOR LOCAL PHARMACIES –

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number (_____) _____

FOR MAIL ORDER PHARMACIES –

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number (_____) _____

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PRE-VISIT FORM

Last Name	**First Name**	**MI**	**AGE**	**DOB**

Referred by:	**Name & phone number of Primary Care Physician:**
Spouse's Name:	**Years Married:**
# of Children:	**# of Grandchildren:**
Child Name:	**Phone #:**
Child Name:	**Phone #:**
Where were you born and raised?	**Where do you currently reside?**
Highest level of education completed: □ Primary School □ Secondary School □ High School □ College □ Advanced degree	
Occupation:	**Retired: Y or N** **Year retired:**
Do you have special living needs? Y or N **If yes, please explain:**	
Are you disabled? Y or N **If yes, please describe:**	

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HEALTH HISTORY

Reason for visit:	**Allergies:**
Do you have a memory problem? Y or N? **If yes, please explain:**	**Do you smoke? Y or N?** **Packs per day?** **If you quit, when did you stop?**
Do you have a Psychiatric History? Y or N? **If yes, please describe:**	**Do you drink alcohol? Y or N?** **If yes, how often?** **If you quit, when did you stop?**
Does your family have any psychiatric history? Y or N? If yes, please explain:	

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PAST MEDICAL HISTORY

□ Rheumatic Fever
□ Heart Attack
□ Congestive Heart Failure
□ Irregular Heartbeat
□ Dizziness
□ Ankle Swelling
□ Diabetes
□ High Blood Pressure
□ Cataracts
□ Glasses
□ Hearing difficulty
□ Ulcer
□ Diarrhea
□ Kidney Disease
□ Asthma/COPD
□ Seasonal Allergies
□ Thyroid Disease
□ Liver Disease
□ Shortness of Breath
□ Stroke
□ TIA's
□ Cancer
□ Anemia
□ Urinary Tract Infection
□ Prostate Problems
□ Loss of Consciousness
□ Arthritis
□ Constipation
□ Head Injury
□ Other

FAMILY HISTORY					
Pathology	Relationship	Pathology	Relationship	Pathology	Relationship
Alcoholism		Cancer		Glaucoma	
Asthma		Diabetes		Heart Dz	
Bleeding Dz		Seizures		Hypertension	
Kidney Dz		Mental Illness		Migraine	
Osteoporosis		Stroke		Thyroid Dz	

Year of most recent					
Tetanus Shot		Cholesterol √		Pneumovax	
Flu Vaccine		Rectal Exam		TB Test	
PSA		Mammogram		Colonoscopy	

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PAST MEDICAL HISTORY

Past Hospitalizations	
Year	Reason

Past Surgical History	
Year	Surgery

Current Medications

Ahava Healthcare

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Jae Pak, MD – Geriatric Psychiatrist
Collaborating Physician

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, employee review of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclosure your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors. And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required uses and disclosures; under the law, we must make disclosures to you and when required by the Secretary of the

Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,
upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and become effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____

Signature of Patient/Power of Attorney/Guardian

_____ _____

Printed Name of Patient **Date**

Ahava Healthcare
Jody Amazon, DSc, APRN
Jae Pak, MD Collaborating Physician

HIPAA Privacy Notice & Consent for Services Signature Form

I have received my Notice of Privacy Practices which informs me how my medical information may be used and released. This form also grants permission to Dr. Jae H. Pak, MD (Geriatric Psychiatrist) or Jody Amazon, DSc, APRN (Geriatric Nurse Practitioner) to see the patient for initial and/or follow up visits and medication management. I understand that we are under no obligation and may revoke services at any time.

_____

Signature of Patient/Power of Attorney/Guardian

_____ _____

Printed Name of Patient **Date**

Release for Billing

By signing below you grant us authority to release any medical information deemed necessary to the appropriate insurance company in order to bill for your medical services. You also agree to accept full responsibility for any balances or co-pays that are not covered by your primary and/or secondary insurance company.

Signature: _____

(Patient or Power of Attorney)

Printed Name of Patient: _____

DATE: _____/_____/_____

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Office Policies

No-Show Policy: A no show is an appointment that was not cancelled in advance. A no show for a scheduled appointment will result in a fee of **$75** for every appointment missed. After three no-shows in a row you will be discharged from the practice. By not properly cancelling your appointment you are prohibiting other patients from receiving timely treatment.

Late Policy: If you are more than **15 minutes** late to your scheduled appointment time you will be asked to reschedule.

Financial Policy: Our office is happy to submit insurance claims for your visits. Please remember that your health insurance is a contract between you and your insurance company; therefore, you are responsible for knowing the details of your insurance coverage. We will file your claim for you; however we ask that you are aware of your coverage and whether your plan included deductibles, co-pays, and/or co-insurance fees. Any and all account balances are ultimately your responsibility.

Please contact us immediately if you make any changes to your health plan coverage so we may keep accurate and current records of your account and expedite reimbursement for the services provided to you.

For your convenience, we accept cash, personal checks, Visa, Discover, MasterCard, and American Express. All returned person checks will be subject to a $25 fee.

Printed Patient Name: _____

Patient/POA Signature: _____

Date: _____/_____/_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Information:

Patient Name: _____Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

_____

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS