Orthopedics Sports Medicine & Surgery, LLC
Upson Cardiology Services
Upson Clinic
Upson ENT, Ear, Nose & Throat
Upson Family Medical Center

Upson Family Physicians, LLC
Upson OB/GYN
Upson Surgical Associates, LLC
Upson Urology Associates

DATE: __________________

Name: ____ DOB: ____________________
FIRST MIDDLE LAST

Mailing Address: ____
CITY STATE ZIP

Home Phone Number: ____________________ Cell Phone Number: ____________________

Employer: ____________________________ Work Phone Number: ____________________

SS#____________________________ Email Address: ____________________________

Pharmacy: ____________________________ Primary Care Physician: ____________________

Insurance Name: ____________________________ Secondary Insurance? ____________________

Policy Holder Name/DOB/SSN: ____

Are you covered by Medicare? ___YES ___NO Eligibility based on ___Age ___Disability ___Renal Failure

If yes, Date of Retirement__________________ Date of Spouse Retirement__________________

*** *******

Spouse/Next of Kin Name: ____________________________ Relationship:____________________

Mailing Address: ____
CITY STATE ZIP

Cellular Number: __________________ Alternate Number: ______________________________

Emergency Contact Name: ____________________________Relationship:____________________

Mailing Address: ____
CITY STATE ZIP

Cellular Number: __________________ Alternate Number: ______________________________

Please present co-pays along with insurance cards and picture ID to the receptionist

Authorization, Release & Acknowledgement of Payment: I authorize the physician and other physicians or healthcare professionals of **Upson Family Physicians, LLC; Upson OB/GYN; Upson Surgical Associates, LLC; Upson Urology Associates; Upson ENT, Ear Nose & Throat, Upson Cardiology Services, Orthopedics Sports Medicine and Surgery LLC.; Upson Clinic and Upson Family Medical Center, LLC.** to perform treatment and procedure necessary for proper care. I authorize **Upson Family Physicians, LLC; Upson OB/GYN; Upson Surgical Associates, LLC; Upson Urology Associates; Upson ENT, Ear Nose & Throat, Upson Cardiology Services, Orthopedics Sports Medicine and Surgery LLC.; Upson Clinic and Upson Family Medical Center, LLC** to release my information (via email, mail, or fax) including the diagnosis and records of any treatments or examinations rendered to me/ my child during the period of such medical care to third party payers, and other entities and/ or health practitioners. I authorize and hereby request my insurance to pay direct to **Upson Family Physicians, LLC; Upson OB/GYN; Upson Surgical Associates, LLC; Upson Urology Associates; Upson ENT, Ear Nose & Throat, Upson Cardiology Services, Orthopedics Sports Medicine and Surgery LLC.; Upson Clinic; and Upson Family Medical Center,** and benefits otherwise payable to me. I understand that my insurance carrier(s) may pay less than the actual bill for services. I understand that I am responsible for payment within 60 days of service rendered on my behalf or on the behalf of my dependants regardless of insurance status. Finally, the HIPAA notice of Privacy Practices has been made available to me and/or my dependent & I give consent for this office to discuss my medical and financial responsibilities with the following people: ____

Signature of Patient/Guardian: ______________________________ Date: ______________

MEDICAL RECORDS TRANSFER AUTHORIZATION

RE: MEDICAL RECORDS OF PATIENTS OF

DANIEL BRIDGES, M.D.

I, the undersigned, being now or formerly a patient of **Daniel A. Bridges, M.D**. do hereby authorize said physician to transfer my medical records to Upson Surgical Associates, LLC, d/b/a Upson Urology Associates in connection with Dr. Bridges' employment by Upson Surgical Associates, LLC, d/b/a Upson Urology Associates and consent to allow Dr. Bridges and any and all other physicians and staff employed by or associated with Upson Surgical Associates, LLC, d/b/a Upson Urology Associates unlimited access to any and all of my medical records, in whatever form they exist, including protected health information, and hereby agree to allow all of my signed said records to be physically delivered to , and become the property of, Upson Surgical Associates, LLC, d/b/a Upson Urology Associates for use in my care and treatment.

____
Signature of Patient, or Parent of a Minor patient

____
Print Name of Patient

____
Date

____
Witness

If you oppose such transfer please sign here: ____________________________________
Signature of Patient, or Parent of a Minor Patient

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT

Patient Name: ______________________

I acknowledge that a copy of the Joint Notice of Privacy Practices for *Hospital Authority of Upson County, Georgia; Upson County Hospital, Inc. d/b/a Upson Regional Medical Center; Upson County Health Resources, Inc.; Upson Health Care, Inc.; Upson Medical Associates, LLC; Upson Regional Wellness Center, LLC; Upson Family Physicians, LLC; Upson Family Physicians, LLC d/b/a Barnesville Internal Medicine; Upson Women's Services, LLC; URMC Health Foundation, Inc.; Upson Surgical Associates, LLC; Upson Surgical Associates, LLC d/b/a Upson Urology Associates; Upson Surgical Associates, LLC d/b/a Upson ENT, Ear, Nose & Throat and Orthopedics Sports Medicine and Surgery LLC.* has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I have read and understand the Notice. I understand the most current version of the Notice will be posted within the Health System and on www.urmc.org.

Signature of Patient: ______________________ Date: __________

Signature of Patient's Authorized Representative, Signing on Behalf of Patient:

____

Basis of Authority to Sign for Patient: ______________________

For Use by Health System Personnel Only: *[Complete if patient Acknowledgment is not obtained]*

A copy of the Notice of Privacy Practices was made available to the patient and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because

____.

Signature of Health System Representative: ______________________ Date: __________

UPSON
Regional Medical Center

SUMMARY OF JOINT NOTICE OF PRIVACY PRACTICES
Effective Date: ***9/23/2013***

Our Legal Duty: We have a duty to protect the privacy of medical information about you. This is a brief summary of our Notice of Privacy Practices. We are required to provide you with Notice explaining ways we may use and disclose your medical information and describing your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties Following The Notice: The Notice will be followed by the us and our affiliates, our health care professionals, staff and volunteers; members of the Medical Staff (doctors) and those participating in managed care networks; and other companies that provide services to us.

How We May Use and Disclose Medical Information About You: We may use or disclose medical information about you for many important reasons, including but not limited to the following:

- To treat you as a patient, to bill for services, and to run our business,
- Activities of managed care networks in which we participate,
- To send appointment and refill reminders,
- For health oversight activities,
- For fundraising activities (unless you opt out),
- For public health and safety purposes,
- For blood, organ and tissue donation,
- To audit our business,
- To avert a serious threat to health or safety,
- For national security and protective services,
- To work with coroners, medical examiners and funeral directors,
- To research,
- For workers' compensation,
- To military command authorities,
- To handle lawsuits, government requests, administrative hearings/reviews, & disputes.
- For law enforcement purposes,
- To comply with the law and as further explained in our Full Notice of Privacy Practices.

We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for facility patient directories, to individuals involved in your care or payment and for disaster relief purposes.

HIE: We participate in a health information exchange that will share your medical information with other treating providers across the country. These providers will use the same common electronic medical record to document and review services they provide to you. If you do not want your information in the HIE, please contact Health Information Services.

Patient Portal: We may use and disclose information through a patient portal which allows you to view certain parts of your medical (e.g. lab results) and billing information securely.

Authorizations: **In general, other uses and disclosures of your medical information not described in our full Joint Notice of Privacy Practices will require your written authorization.** For example, most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes (particularly if we were to get paid money for your information) and disclosures that involve the sale of PHI will require your written authorization.

Your Privacy Rights: You have rights with respect to your health information, such as -

- The right to ask for confidential communications and to ask us to use different ways of communicating with you.

- The right to ask for limits on certain uses or disclosures of your medical information (including limiting the information we send to your insurance company when you have paid in full, if we are allowed to limit by law)
- The right to look at and get a copy of your paper and electronic medical record.. (We may charge a cost-based fee.)
- The right to ask us to fix mistakes in your medical record and have a written statement of disagreement placed in your record.
- The right to a list of certain types of disclosures of your medical information that were not for treatment, payment or business purposes.
- The right to get notice of a breach of your unsecured health information.

Changes to the Notice: We reserve the right to change the Notice. Changes will apply to all information we have about you. We will post any revised Notice in our facilities and on our website at www.urmc.org.

Complaints: If you believe your rights have been violated, you may file a written complaint with Privacy Officer at 706-647-8111 x1160 or 801 W. Gordon St., Thomaston, GA, 30286 or with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Right to a Copy of Our Complete Notice: Copies of our full Notice of Privacy Practices are available within our facilities at primary registration sites and on our website at www.urmc.org. We will be happy to give you a copy upon your request. If you have any questions about this Summary Notice, please contact Privacy Officer.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Upson Urology Associates

Are you allergic to Latex YES or NO

Are you allergic to IV contrast YES or NO

What Pharmacy do you use? ______________________________

Allergies to medications, foods,etc:

____

Are you currently taking a blood thinner (EX: PLAVIX, WARFARIN, XARELTO, ELIQUIS):____

Past Medical History

PLEASE ONLY CHECK ITEMS THAT YOU HAVE BEEN DIAGNOSED WITH CURRENTLY OF IN THE PAST:

ENDOCRINE

___ DIABETES

MUSCULOSKETEAL

___ GOUT

RESPIRATORY

___ COPD

___ CPAP

___ Asthma

Cardiovascular

___ DVT (blood clots)

___ Atrial fibrillation

___ Cardiac arrhythmias

___ Coronary artery disease

___ Heart failure

___ Heart valve disease

___ Hyperlipidemia (high cholesterol)

___ Hypertension (high blood pressure)

___ MI (heart attack)

Genitourinary

___ Dialysis

___ Kidney diease

___ Past UTI (urine infection)

___ Past kidney stones

Infectious Disease

___ AIDS

___ Hepatitis

___Tuberculosis

Disabilities

___ Hearing deficit

___ Vision deficit

Psychiatric

___ Depression/Anxiety

Hematology/Oncology

___Brain Cancer
___Breast Cancer
___Cervical cancer
___Colorectal cancer
___ GI cancer (stomach)
___ GU cancer (bladder
___ Kidney cancer
___ Leukemia
___ Liver cancer
___ Lung cancer
___ Lymphoma
___ Myeloma
___ Ovarian Cancer
___ Skin Cancer
___ Thyroid cancer
____Uterine cancer
Other________________________

Neurological

___Dementia (Alzheimer's)
___ Headaches
___ MS (Multiple Sclerosis)
___ Parkinson's Disase
___ Seizures

PAST SURGICAL HISTORY

PLEASE LIST ANY PAST SURGERIES:

____
____
____
____
____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY HAVE CURRENTLY OR HISTORY OF CANCER, DEMENTIA (ALZHEIMER'S), DIABETES, STROKE? IF SO, PLEASE LIST RELATION:

____
____
____
____
____