Office Welcome Letter

To our new patients:

Welcome to our office. Thank you for trusting us with your healthcare needs. The patient is the center of our activity. Your satisfaction is our goal. We are different than other medical offices you may have visited. This is a private practice, it not owned by a large healthcare entity or a large group of physicians. Because of this we practice medicine the way it should be practiced. We spend time with our patients and really listen to your needs. Small practices like ours are an endangered species in this ever changing healthcare environment. We try to represent what is right with medicine. We hope you agree.

To our existing patients:

We recently switched to a new Electronic Medical Record system. This new system will help us to provide even better care and improve patient satisfaction. One new feature is a patient portal that allows for secure communication between our office and you the patient. It also allows us to deliver secure documents (such as lab results) to you at your request. Another new feature is better Health Maintenance management tracking which focuses on prevention/screening and providing a customized health plan based on your specific risk factors. During this transition we are taking time to redo our office forms and making sure all your contact information is up to date. Please help us do this by filling out a few additional forms.

To ensure the highest quality care, we need certain information from you and we need to inform you of our office policies. The following forms are included in the new patient packet:

- Patient Information Form
- Notice of Privacy Practices
- Patients’ Rights and Responsibilities
- Payment Policy
- Patient Portal form
- Request for Records Transfer (new patients only)
- Adult Patient Intake Form (new patients only)

Kathryn Neely, M.D. and Staff

Revised 3/2/2012
Harmony Family Medicine, P.C.
INFORMATION FORM

Today's date: PCP: Kathryn Neely, M.D.

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Last Name:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Race: (Optional but ensures highest quality of care)
- American Indian/Alaskan Native
- Asian
- Black/African American
- Native Hawaiian/Other Pacific Islander
- White

Ethnicity: (Optional but ensures highest quality of care)
- Hispanic or Latino
- Not Hispanic or Latino

Language Preference:
- English
- Spanish
- Other:

Marital status (circle one)
- Single
- Mar
- Div
- Sep
- Wid

Home phone: ( )
Mobile phone: ( )
Work phone: ( )

Email Address:
Preferred Contact Method (select only one):
- Home
- Mobile
- Work
- Email
- Mail

Street address:
City: State: Zip Code:

Occupation: Employer:

<table>
<thead>
<tr>
<th>IN CASE OF EMERGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of local friend or relative:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GRANT ACCESS TO YOUR MEDICAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may discuss my health information with the following people (caregivers, family members, etc )</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>INSURANCE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please give your insurance card to the receptionist.)</td>
</tr>
<tr>
<td>Person responsible for bill:</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Primary Insurance Company:
Subscriber’s name: | Birth date: | Policy ID: | Group #: | Patient’s relationship to subscriber: |
|                  | / /         |            |          | Self | Spouse | Child | Other |

Secondary Insurance Company:
Subscriber’s name: | Birth date: | Policy ID: | Group #: | Patient’s relationship to subscriber: |
|                  | / /         |            |          | Self | Spouse | Child | Other |

<table>
<thead>
<tr>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Harmony Family Medicine or insurance company to release any information required to process my claims. I have also reviewed the Notice of Privacy Practices.</td>
</tr>
</tbody>
</table>

Patient/Guardian signature Date

Revised 10/12/2011
HARMONY FAMILY MEDICINE, P.C.
NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This document is available on our website or you may request a copy for your records.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Robert Neely, 310 Paper Trail Way, Ste. 306, Canton, GA 30115
phone: 770-704-2763 email: Robert@kneelymd.com

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a
pharmacy when we order a prescription for you. Many of the people who work for our practice –
including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you
or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in
your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the
services and items you may receive from us. For example, we may contact your health insurer to certify
that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with
details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We
also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such
costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As
examples of the ways in which we may use and disclose your information for our operations, our practice
may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management
and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind
you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment
options or alternatives.

6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family
member that is involved in your care, or who assists in taking care of you. For example, a parent or
guardian may ask that a babysitter take their child to the pediatrician’s office for treatment of a cold. In
this example, the babysitter may have access to this child’s medical information.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to
do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable
health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are
authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or
  condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse
  or neglect of an adult patient (including domestic violence); however, we will only disclose
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

   • Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement
   • Concerning a death we believe has resulted from criminal conduct
   • Regarding criminal conduct at our offices
   • In response to a warrant, summons, court order, subpoena or similar legal process
   • To identify/locate a suspect, material witness, fugitive or missing person
   • In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers’ Compensation. Our practice may release your IIHI for workers’ compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to [insert name, or title, and telephone number of a person or office to contact for further information] specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Robert Neely, 310 Paper Trail Way, Ste 306, Canton, GA 30115, 770-704-2763, Robert@kneelymd.com. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice’s use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you
may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115, 770-704-2763. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please Robert Neely at 310 Paper Trail Way, Ste. 306, Canton, GA 30115, 770-704-2763.
Patients' Rights and Responsibilities

Harmony Family Medicine, P.C. is dedicated to providing you with the best in health care. Along with technical expertise, we want to provide you with a positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

Consent to Treatment

☐ I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of Harmony Family Medicine, P.C., its medical staff and their designees, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

This consent to treatment may be revoked in writing at any time by the patient or duly authorized agent.

Patients’ Rights

Harmony Family Medicine, P.C. is committed to providing you with respectful care as we meet your health care needs. For this reason, we want you to have a summary of your rights as a patient.

- You have a right to considerate and respectful care.
- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability or source of payment.
- You have the right to information about your diagnosis, condition and treatment, in terms that you can understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences of the refusal.
- You may consent or refuse to participate in experimental treatment or research.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to make or have a representative of your choice make informed decisions about your care.
- You have the right to formulate advance directives and have them followed.
- You have the right to appropriate assessment and management of pain.
- You are entitled to be free from any forms of restraint or seclusion as a means of convenience, discipline, coercion or retaliation.
- Seclusion and restraint for behavior management can only be used in emergency situations.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to know the names and professional titles of your physicians and caregivers.
- You can request a change of provider or second opinion if you choose.
- You have the right to personal privacy and to receive care in a safe environment.

Continued on back
Patients' Rights and Responsibilities

- You have the right to a prompt and reasonable response to any request for services within the capacity of the health care facility.
- You have the right to express concerns or grievances regarding your care to the office.
- The confidentiality of your clinical and personal records will be maintained.
- You have the right to see your medical record within the limits of the law.
- You have the right to an explanation of all items on your bill.

Patients' Responsibilities

This is a summary of your responsibilities as a patient at Harmony Family Medicine, P.C.

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health, including medications and past or present medical problems.
- You are responsible for following the instructions and advice of your health care team. If you refuse treatment or do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify a member of the health care team if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, including pain, to a member of the healthcare team.
- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of others.
- You are responsible for following the rules and regulations of the health care facility.
- You are expected to keep your scheduled appointments or to cancel them in advance if at all possible.
- It is your responsibility to pay your bills or make some arrangement with the facility to meet your financial obligations.

Questions or Concerns

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your doctor, nurse or other caregiver. If you have concerns that are not resolved, please contact Lainie Redding @ 770-704-2763 x152 or lainie@harmonyfm.net.

Certification

I certify that I have read and understood the authorization to treatment given above, as well as the patients’ rights and responsibilities specified in this agreement, and I accept its terms.

Date ____________________ Signature of Patient or Designee and Relationship to Patient
Payment Policy for Harmony Family Medicine, P.C.

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don’t have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Discounts. Discounts are offered to self-pay patients who pay their account in full on the same day as their office visit. If the account is not settled on the same day, then the discount is forfeited.

4. Noncovered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim 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 party to that contract.

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Forms/Letters/Medical Records. The completion of disability forms, FMLA forms, attending physician statements, and other supplemental insurance forms all require office supplies, physician and staff time to complete, therefore a $10.00 fee for each form will be charged and must be pre-paid. Note, there will be a 14 day turnaround time for completion, so make arrangements accordingly. Non-standard or multiple page forms may result in a higher rate.

10. Other Procedures. The following procedures are not filed with insurance companies and are subject to prepaid amounts. Sports, college, and school (eye, ear & dental) physcials are a $50.00 prepaid fee. Pre-employment, and adoption physcials are a $100.00 prepaid fee. Any additional labs/procedures that are not included in these services may incur further charges.

Initials

Revised 1/1/2016
11. Missed Appointment Fees. Our policy is to charge for missed appointments not canceled within 24 hours of the scheduled appointment time amount. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

   **First missed appointment:**
   No charge

   **Second missed appointment:**
   $25.00 charge

   **Third missed appointment:**
   $25.00 charge and possible dismissal from Harmony Family Medicine

Attestation Statement:
I have read, understand, and agree to the above Harmony Family Medicine Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Harmony Family Medicine to extend credit.

I authorize my insurance benefits be paid directly to Harmony Family Medicine.

I authorize Harmony Family Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.

**I have read and understand the payment policy and agree to abide by its guidelines:**

______________________________  ______________________
Signature of patient or responsible party    Date
PATIENT PORTAL CONSENT FORM

Printed name __________________________ Date of Birth ___________________

Patient e-mail address _________________________________________________

As of March 1, 2012, Harmony Family Medicine requests all electronic communication with our office be through our Patient Portal website. We no longer recommend the use of e-mail when communicating medical or billing questions to our office. General office questions such as office hours may still go through e-mail, but even then we recommend using our patient portal. The patient portal provides a secure method for communicating with our office. It complies with all HIPAA privacy laws and assures the confidentiality of your message.

In addition we will start placing documents (lab results and visit summaries) on the portal for you to access.

   Patient Portal website: http://hfm.myupdox.com
   A link can also be found on our website: http://www.harmonyfm.net

When we create your account, you will be assigned a unique username (typically your e-mail address) and an initial password. Typically this information is sent to the e-mail address you specified above. But if you request it, the information may be printed and a hard copy given to you. When you logon for the first time you will need to enter that username and password and confirm your date of birth. The portal will then require you to change the password. Please remember your new password as you will use it for future logins.

EMERGENCY PROBLEMS
The portal should never be used for emergency problems. In the event of an emergency, call 911.

URGENT PROBLEMS
The portal should never be used for urgent problems. In these cases, the patient should call the office at 770-704-2763.

BE CONCISE
Communication through the portal should be concise. If your problem is too complex to discuss via a simple message, you should make an appointment by calling: 770-704-2763

MEDICAL RECORD
Any message you send to our office through the patient portal may become part of your permanent medical record.

RIGHT TO OPT OUT
You have the right to opt out of using the portal account at any time. The option to opt of an existing portal account can be found under your portal account user preferences on the portal itself.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. Any questions I may have had were answered.

__________________________________________________             __________________________
Patient or Guardian Signature        Date
Authorization for Use/Disclosure of Protected Health Information

I, ______________________ hereby authorize release of my medical records as described below to Harmony Family Medicine, P.C.

TYPE OF INFORMATION TO BE DISCLOSED:

- [ ] Entire Medical Record
- [ ] Medical Record for Continuity of Care
- [ ] Financial Record
- [ ] Laboratory Test Reports
- [ ] Radiology Reports
- [ ] Discharge Summary
- [ ] Medication Record
- [ ] Other: _____________________________________________________________________________

In addition, I authorize that this will include health information relating to (check if applicable):

- [ ] Communicable diseases (including HIV and AIDS)
- [ ] Drug/Alcohol Abuse
- [ ] Mental Health records

COVERED DATES OF SERVICE:
This authorization includes the period of health care from:

- [ ] ________________ to ________________ OR [ ] All past, present and future periods

EXPIRATION:
This authorization will be effective, unless revoked in writing, for one (1) year from today’s date or until the date written here: __________________.

PATIENT INFORMATION (Please Print):
Name: __________________________ Date of Birth: _______________
Social Security Number: __________________

RELEASE MY MEDICAL RECORDS FROM:
Health Care Provider/Entity: ___________________________ Fax: ___________________________
Tel: __________________________

TO: Harmony Family Medicine, P.C.
310 Paper Trail Way, Ste. 306
Canton, GA 30115
Phone: 770-704-2763 Fax: 770-704-2765

I understand this Authorization is voluntary and I may refuse to sign it. I understand that I have the right to revoke this Authorization, in writing, at any time. I further understand that this Authorization is specific to the types of information and the dates of service listed above.

Patient or Guardian Signature: ___________________________ Today’s Date: ______________
Relationship to patient (if applicable):

- [ ] Parent or Guardian of minor
- [ ] Court appointed guardian
- [ ] Power of Attorney
- [ ] Executor of descendant’s estate

If there will be a charge for the release of records to us, please contact our office first.
Welcome to Harmony Family Medicine, P.C. Please help us establish you with our practice by providing your complete health history: body, mind and spirit.

### Personal Information:
- **Name:** 
- **Date of Birth:** 
- **Age:** 
- **Date:**

### Main Issues/Reasons for this Appointment (if possible, rank in terms of importance to you)
1. 
2. 
3. 
4. 
5. 

<table>
<thead>
<tr>
<th>Allergies (Medication or Substance)</th>
<th>Type of Reaction</th>
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<tr>
<th>Current Medications</th>
<th>Dose</th>
<th>Times/Day</th>
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<tr>
<th>Current Vitamins/Herbs/ Supplements</th>
<th>Dose</th>
<th>Times/Day</th>
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### I. SYMPTOMS

Check ( ) symptoms you are currently experiencing.

- **GENERAL**
  - Chills
  - Depression
  - Dizziness
  - Fainting
  - Fever
  - Forgetfulness
  - Headache
  - Loss of sleep
  - Loss of weight
  - Nervousness
  - Numbness
  - Sweats
  - Fatigue

- **IMMUNE SYSTEM**
  - Too many infections
  - Allergies to food
  - Allergies to environment
  - Other concerns

- **MUSCLE/JOINT/BONE**
  - Pain, weakness, numbness in:
    - Arms
    - Back
    - Feet
    - Hands
    - Hips
    - Legs
    - Neck
    - Shoulders

- **GENITO-URTINARY**
  - Blood in urine
  - Frequent urination: □ daytime □ nighttime
  - Lack of bladder control
  - Painful urination

- **EYE-EAR-NOSE-THROAT**
  - Appeteite poor
  - Chills
  - Breast lump
  - Bleeding gums
  - Blurred vision
  - Breathing difficulties
  - Difficulty swallowing
  - Double vision
  - Earache
  - Ear discharge
  - Mouth sores
  - Hoarseness
  - Loss of hearing
  - Nosebleeds
  - Bad breath
  - Ringing in ears
  - Sinus problems
  - Vision - flashes
  - Vision - halos
  - Skins
  - Bruise easily
  - Pimples
  - Itching
  - Rashes
  - Papules
  - Sore that won't heal
  - Dry skin / eczema
  - Hair loss

- **CARDIOVASCULAR**
  - Chest pain
  - High blood pressure
  - Irregular heart beat
  - Low blood pressure
  - Poor circulation
  - Rapid heart beat
  - Swelling of ankles
  - Varicose veins
  - Bruise easily
  - Pimples
  - Itching
  - Rashes
  - Papules
  - Sore that won't heal
  - Dry skin / eczema
  - Hair loss

- **PULMONARY**
  - Shortness of Breath
  - Wheezing / Asthma
  - Frequent colds
  - Cough - dry/irritating/persistant

- **NERVOUS SYSTEM**
  - Seizures
  - Nerve pain
  - Poor balance
  - Poor coordination
  - Tremors / shaking

### II. CONDITIONS

Check ( ) conditions you currently have or have had in the past.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer type?
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

### III. ILLNESSES, INJURIES & OPERATIONS:

<table>
<thead>
<tr>
<th>Illness, injury or operation</th>
<th>Date</th>
<th>Hospital</th>
<th>Treatment</th>
<th>Physician</th>
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</table>
### IV. FAMILY HISTORY
Fill in health information about your family.

<table>
<thead>
<tr>
<th>Relation</th>
<th>Age</th>
<th>Healthy?</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Check if your blood relatives had any of the following: Disease</th>
<th>Relationship to you</th>
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</thead>
<tbody>
<tr>
<td>Father</td>
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<td>Mother</td>
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<td>Brothers</td>
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<td>Sisters</td>
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### V. HEALTH MAINTENANCE: when did you last have a:

<table>
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<tr>
<th>Procedure</th>
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<td>Tetanus Shot</td>
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<td>Cholesterol Level</td>
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<td>Pneumovax</td>
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<td>Colon Exam</td>
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<td>Hepatitis Vaccine</td>
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<td>Bone Density</td>
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<td>Eye Exam</td>
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<td>Chest X-ray</td>
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<td>Mammogram</td>
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<td>Prostate Exam</td>
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<td>Hemoccult Test</td>
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Do you have a Living Will? [ ] If yes, where is it kept? 

### VI. SOCIAL HISTORY
Check those that apply

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<th>Marital Status</th>
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<td>Single</td>
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<td>Married</td>
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<td>Widowed</td>
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<th>Education Level Completed</th>
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<td>Professional School</td>
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<td>Other:</td>
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<th>Living Arrangement</th>
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<td>Alone</td>
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<td>Family</td>
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<td>Significant Other</td>
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<td>Roommate</td>
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<td>Children? (list sex &amp; ages)</td>
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<th>Major Recent Stresses</th>
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<td>Money</td>
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<td>Marriage</td>
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<td>Home Life</td>
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<td>Children</td>
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<td>Other</td>
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<th>Lifestyle / Self-Care Issues</th>
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<td>Do you smoke cigarettes/cigars?</td>
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<td>Did you ever smoke?</td>
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<tr>
<td>Do you drink alcohol?</td>
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<td>Do you use recreational drugs?</td>
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<td>Do you manage stress well?</td>
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<td>Do you exercise regularly?</td>
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<td>Do you enjoy your job?</td>
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<td>Do you allow yourself time to unwind and relax?</td>
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<td>Do you sleep soundly and enough?</td>
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<td>Are you satisfied with your sex life?</td>
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<tr>
<td>Are you satisfied with your social life?</td>
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<td>Are you satisfied with your spiritual life?</td>
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<td>Is your diet healthy enough?</td>
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Patient/Guardian Signature __________________ Date __________ Reviewer Signature __________________ Date __________