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| **KATIE CLINIC INC.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Today’s date:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **PCP:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s last name:** | | | | | | | | | | | | | | | | | **First:** | | | | | | | | | | | | | **Middle:** | | | | | | | | | | **❑ Mr.**  **❑ Mrs.** | | | | | | | | | **❑ Miss**  **❑ Ms.** | | | | | | | | **Marital status (circle one)** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Single / Mar / Div / Sep / Wid** | | | | | | | | | | | | | | | | | | | | |
| **Is this your legal name?** | | | | | | | | | | | **If not, what is your legal name?** | | | | | | | | | | | | | | | | | | | | | | | | **(Former name):** | | | | | | | | | | | | | | | | | | | **Birth date:** | | | | | | | | **Age:** | | | | | | | | **Sex:** | | | | | | | |
| **❑ YES** | | | **❑ NO** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | **/ /** | | | | | | | |  | | | | | | | | **❑ M** | | | **❑ F** | | | | |
| **Mailing address: OR P.O. box:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Social Security no.:** | | | | | | | | | | | | | | | | | | | | | **Home or Cell phone no.:** | | | | | | | | | | | | | | | | | | | | |
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| **City:** | | | | | | | | | | | | | | | | | | | | | | | | | | **State:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **ZIP Code:** | | | | | |  | | | | | | | | | | | | | | | |
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| **Employer:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Employer phone no.:** | | | | | | | | | | | | | | | | | | | | |
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| **Referred to clinic by (please check one box):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **❑ Dr.** | | | | | |  | | | | | **❑ Insurance Plan** | | | | | | | | | | | | | | | | | | | **❑ Hospital** | | | | | | | | | | |
| **❑ Family** | | | | | | | **❑ Friend** | | | | | | | | | | | | **❑ Close to home/work** | | | | | | | | | | | | | | | | | | | | | | | | | | **❑ Yellow Pages** | | | | | | | | | | | | | | | | | | | | **❑ Other** | | | | | | | | | |  | | |
| **Names of other family members seen here:** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **(Please give your insurance card to the receptionist.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Person responsible for bill:** | | | | | | | | | | | | | **Birth date:** | | | | | | | | | | **Address (if different):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Home phone no.:** | | | | | | | | | | | | | | | |
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| **Is this person a patient here?** | | | | | | | | | | | | | | | **❑ Yes** | | | | | | | | **❑ No** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **Occupation:** | | | | | | | | **Employer:** | | | | | | | | | | | | | **Employer address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Employer phone no.:** | | | | | | | | | | | | | | | | |
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| **Is this patient covered by insurance?** | | | | | | | | | | | | | | | | | | | | | | **❑ Yes** | | | | | | | | | | | **❑ No** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please indicate primary ins.** | | | | | | | | | | | | | | **❑** | | | | | | | | | | | | | | | | | | | | | **❑** | | | | | | | | | | | **❑** | | | | | | | | | | | | | | | | | | **❑** | | | | | | | | | | | |  | |
| **❑** | | | | | | **❑** | | | | | | | | | | **❑** | | | | | | | | | | | | | | | **❑ Welfare (Please provide coupon)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **❑ Other** | | | | | |  | | | |
| **Subscriber’s name:** | | | | | | | | | | **Subscriber’s S.S. no.:** | | | | | | | | | | | | | | | | | **Birth date:** | | | | | | | | | | | | **Group no.:** | | | | | | | | | | | | | | | | | **Policy no.:** | | | | | | | | | | **Co-payment:** | | | | | | | | | | | |
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| **Patient’s relationship to subscriber:** | | | | | | | | | | | | | | | | | | | | | | | **❑ Self** | | | | | | | | | | | **❑ Spouse** | | | | | | | | | | | | | | | | | **❑ Child** | | | | | | | | | **❑ Other** | | | | | | | | |  | | | | | | | | |
| **Name of secondary insurance (applicable):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Subscriber’s name:** | | | | | | | | | | | | | | | | | | | | | | | | | | | **Group no.:** | | | | | | | | **Policy no.:** | | | | | | | | | | | | | | |
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| **Patient’s relationship to subscriber:** | | | | | | | | | | | | | | | | | | | | | | | | **❑ Self** | | | | | | | | | | | | | | **❑ Spouse** | | | | | | | | | | | | **❑ Child** | | | | | | | | | **❑ Other** | | | | | | | | | | | |  | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of friend or relative (not living at same address):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Relationship to patient:** | | | | | | | | | | | | | | | | | | **Home phone no.:** | | | | | | | | | | | | | | | **Work phone no.:** | | | | | | | | | | | | | | | |
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| **I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required processing my claims.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Patient/Guardian signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | **Date** | | | | | | | | | | | | | | | | | | | | | | | | |  |

**KATIE CLINIC, INC**

**4585 AUSTELL RD.**

**AUSTELL, GA 30106**

**PH: (770) 948-9338, FAX: (770) 948-5556**

**Notice of Privacy Practices**

**(HIPPA and Georgia Laws)**

**And**

**Client Privacy Statement**

This notice describes how your medical information may be used and disclosed and how you may get access to this information. Please review it carefully. Federal, state privacy and medical record laws protect your rights as a client of Katie Clinic, Inc. This notice applies to your current contract with Katie Clinic, Inc. and all future contracts, whether the contact is in person, by telephone, or by mail.

**Notice Information**

This notice of Privacy Practice describes how we may use and disclose your PHI to carry out treatment, payment, health care operations, and for the purpose that are specified by law. We reserve the right to change this notice. The change will apply for PHI we already have about you and PHI we receive about you in the future. We will provide an update notice to you when you request one. We will also post the most current notice in our waiting room area. If you have questions about this notice, our privacy practices, or Katie Clinic, Inc. services this notice applies to, please contact us at: Katie Clinic, Inc.

**HIPPA PRIVACY OFFICER**

**4585 Austell RD. Austell, GA 30106**

**PH: (770)948-9338 FAX: (770)948-5556**

**Protected Health Information**

Protected Health Information (PHI) is: (1) Information about your physical or mental health, related health services, or payment for health care services. (2) Information that is provided by you, created by us, or shared with us by related organizations. (3) Information that identifies you or could be used you identify you, such as /demographic information, address and phone number, social security number, age, date of birth, dependents, and health history.

How Katie Clinic, Inc. protects your PHI

Except as described in this notice or specified by law, we will not use or disclose your PHI. We will use reasonable efforts to request, use and disclose the minimum amount of your PHI necessary. Whenever possible, we will de-identify or encrypt your personal information so that you cannot be personally identified. We have put physical and procedural safeguards in place to protect your PHI and comply with federal laws.

**Patient’s Rights:**

You have the following rights with respect to your PHI**. *Obtain a copy of this notice.***You may obtain a copy of this notice at any time. Even if you have agreed to receive the notice electronically, you are still entitled to your paper copy**. *Request restrictions.*** You may ask us not to use or disclose any part of your PHI. Your request must be in writing and include what restriction(s) to apply. We will review and grant responsible requests, but we are not to agree to any restrictions.

You May Withdraw Your Permission

If you do provide your written authorization and then later want to withdraw it, you may do so in writing at any time. As soon as we receive your written revocation, we will stop using or disclosing the PHI specified in your original authorization, except to the extent that we have already used it based on your written permission.

***You May File A Complaint***. If you believe your privacy rights have been violated, you can file a health complaint with the Katie Clinic, Inc. privacy officer, or with the United States Department of Health and Human Services at: **Medical Privacy Complaint Division Office of Civil Rights U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. room 509F, HHH Building, Washington, D.C. 20201 (PH): (800)368-1019.** Filing a complaint will in no way affect the care or services you receive from Katie Clinic, Inc.

**Data Privacy**

***Why do we ask for information?*** We ask for information from you to determine what service or help you need, develop a service plan with you, and give you the service you want. The information may also be used to determine your charges for services or for collection of payment from insurance companies or other payment sources. ***Do you have information to give us?*** There is no law that says you must give us some information; however, if you choose to not give us some information, it can limit our ability you serve you well. ***What will happen if you do not answer the questions we ask?*** If you are here because of a court order, and you refuse to provide information, we may not be able to tell who should pay for your services. ***What privacy rights do minors have?*** If you are under 18 you may request that information about you be kept from your parents. You must give us your request in writing, describe the information, and tell us why you don't want your parents to see it. If after reviewing the request Katie Clinic, Inc. staff believes that giving information to your parents is not in your best interest, we will not share the information. If Katie Clinic, Inc. staff believes this information could be safely shared with your parents, we will inform you of this decision. If you are 16, you may ask for mental health services without the consent of your parents, but you have to pay for the services if you do not want your parents to know.

**Please sign this form. Your signature shows that we have informed you of your privacy rights and that you are aware of the possible uses and disclosures of your protected health information.**

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**Client's/ Guardian’s Signature Date**

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**Witness Signature Date**

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| **KATIE CLINIC, INC** |

**TODAY’S DATE**: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHIEF COMPLAINT**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CURRENT ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PAST HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**FAMILY HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**SURGICAL HISTORY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOSPITALIZATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_