FRONTLINE Internal Medicine
6 Lester Road, Statesboro, GA 30458
Ph: 912-681-8999; Fax: 912-681-8989

Thank you for choosing Frontline Internal Medicine for your medical needs.
We look forward to providing you with great care.

Dear New Patient;

Welcome to Frontline Internal Medicine. You are scheduled for an appointment with **Ogechi "Helen" Mbakwe, MD.**

(Please arrive 20 minutes early so that we may complete your registration in time for your appointment)

Enclosed you will find the forms we will need in order to set up your medical record account. We ask that you bring the completed forms to your first appointment.

In addition to these forms you will need to bring the following:

- **Photo Identification** and all **insurance cards or proof of coverage** for payment of charges. Without proper coverage you will be asked to pay at the time services are provided.
- We ask that you bring all of your **medications that you are taking in the bottles** to the appointment. If you are unable to keep this appointment, please call 48 hours in advance.

Referrals: If your insurance or basic health coverage requires an authorization from your primary care doctor, it is your responsibility to make sure that is in place for your appointment. Without the proper authorization number available you may be asked to reschedule the appointment or pay in advance for the services.

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Payment: if your insurance plan includes a co-payment amount, we are required to collect this at the time of your appointment. You are responsible for payment of the services rendered by your Physician. As a courtesy to you, we will bill your Primary and Secondary insurance's.

We look forward to providing services to you and hope having this information will help speed up the process of getting you registered and seen by the provider.

If you have any questions or need to reschedule your appointment, please call us at:

(912)681-8999.

Thank you for choosing Frontline Internal medicine for your medical needs. We look forward providing you with a comprehensive care.

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PATIENT REGISTRATION INFORMATION

PATIENT NAME: ----------

Date of Birth: ---------- Sex: M ( ) F ( )

SOCIAL SECURITY #:----------

Marital Status: M ( ) S ( ) W ( )

Address:

City: ---------- State: ---------- Zip: ---------

Student: Yes ( ) No ( )

Home Phone: ---------- Work Phone: ----------

Employer: ---------- Email: ----------

Address: ----------

Cell Phone: ---------- Emergency Phone: ----------

Emergency Contact: ---------- Relationship: ----------

Referring physician: ---------- Primary physician: ----------

INSURANCE INFORMATION:

Do you have medical insurance No ( ) Yes*( )

IF YES, YOU WILL NEED TO PRESENT YOUR CARD TO THE RECEPTIONIST AT EACH VISIT, AND FILL OUT THE INFORMATION BELOW.

Primary plan name---------- Workman's Comp? Yes ( ) No ( )

Group #:---------- ID#:----------

Is the patient the policy holder? Yes ( ) No*( ) *If no, fill in below:

Policyholder name: ----------

Relationship to Patient: ----------

Policyholder SSN: ---------- Date of birth: ----------

Employer Name: ---------- Phone: ----------

Group #:---------- ID#:----------

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If person responsible for payment of balance is different from patient or policyholder, please fill out below:

Responsible party name:---------- Relationship:----------
Address:---------- Phone:----------
City:---------- State:---------- Zip:--------

I authorize the release of information to insurance necessary for payment of claims and benefits assigned to provider.
We are committed to fiscal responsibility and want to inform you of our billing practices and expectations:

- Co-pays, co-insurances and deductibles must be paid at time of service.
- Insurances are filed as courtesy, however, patient holds ultimate responsibility for Co-pays, and any services not covered by their plan.
- Deposits are required prior to services for all private pay accounts.
- All payment plan requests must go through an approval process. The minimum monthly payments are based on your outstanding balance.
- A fee of $30.00 will be charged on all returned checks. Delinquent accounts will be placed in collections.

I HAVE READ THE FINANCIAL POLICY AND HAVE ACCEPTED IT'S TERMS.

Signature: ---------- Date: ----------

If patient is unable to sign, please indicate reason: ----------

Signature of person authorized to consent for patient: ----------

Witness: ----------

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Patients Personal History

This information will remain confidential unless you authorize it's release.

Date: ---------- Name: ---------- Date of Birth: ----------

Age: ---------- Marital Status: S ( ) M ( ) W ( )

Referred By: ----------

When was your last complete health exam? ----------

Current Occupation: ----------

Prior Occupation: ----------

Personal Health History

Height; ---------- Weight: ----------

Have you ever been vaccinated for any of the following, if yes, when?

Y	N	Year		Y	N	
			Measles			Any diet restrictions
			Mumps			Exercise
			Polio			Do you get enough
			Hepatitis			
			Tetanus			
			Influenza			
			Rubella			
			Zoster			
			Pneumonia			
			DTap			

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REVIEW OF SYSTEMS

DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?
IF NONE APPLIES, CHECK NORMAL.

Normal	Applies	General	Normal	Applies	GI (Contd)
		Recent weight loss? Pounds? -------			Frequent stomach pain
		Recent weight gain? Pound? --------			Nausea and vomiting
		Night Sweats			Vomiting blood
		Fever			Gallstones
		Fainting spells/blackouts			Frequent Diarrhea
		Loss of appetite			Ulcer disease
		Swollen ankles			Black or Tarry stools
		Severe skin itching			Red blood in stool
		Increased thirst			**Cardiovascular**
		New lumps in skin or armpits			Heart murmur
		Fatigue, lack of energy			Chest pain at rest
		Other----------			Chest pain with walking or exercise
		Head, Eyes, Ears, Nose, Throat			Frequent irregular heart beat
		Double vision			Need to sit up to breath at night
		Persistent hoarseness			Pain in thighs or calves that goes away when you rest
		Frequent bleeding gums			**CNS**
		Frequent nosebleeds			Severe, frequent headaches
		Diminished hearing			Weakness in arms or leg
		Hay fever			Excessive worry
		Lungs			Memory concerns
		Chronic cough			Depression
		Coughing up blood			Crying spells
		Pain with breathing			Feeling of worthlessness
		Wheezing			**GU**
		Shortness of breath			Frequent urinary tract infections
		GI			Burning with urination
		Difficulty swallowing			Frequent urination
		Frequent heartburn			Blood in urine

Normal	Applies	Musculoskeletal	Normal	Applies	GU (contd.)
		Joint pains? Site----------			Lose urine when you

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					cough or laugh
		Back pain? Site----------			Trouble starting urination
					Urge to urinate, but pass small amounts.

Preventive Care

Normal	Applies	Females	Normal	Applies	Males
		Regular Periods			Discharge from penis
		Irregular periods			Sexual problems
		Breast lumps			Breast lumps
		Vaginal discharge			
		Do you do monthly self-breast exams			
		Unusual vaginal bleeding			
		Sexual problems			

Females	**Males**
Date of Last menstrual cycle:	Date of last rectal exam:
Age of onset:	Date of last PSA:
Date of last pap smear/pelvic exam:	
Date of last mammogram:	
Both Males and Females	
Date of last Colonoscopy(If applicable):	
Date of last Bone Density(If applicable):	

Family History

Disease	**Relationship**	**Age of onset**	**Living or deceased**

HIPAA FORM 3

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH

FRONTLINE Internal Medicine
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Patient Name: ---------- Date of Birth: ----------

Address: ----------

Phone Number: ---------- Fax Number: ----------

( ) Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

Name of Facility	**Address**	**Phone Number**	**Fax Number**

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: ----------

FRONTLINE Internal Medicine
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( ) Complete Medical Record

( ) Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)
( ) History & Physical (H&P)
( ) Discharge Summary
( ) Operative Report
( ) Consultation Reports
( ) X-ray and imaging reports
( ) Progress Notes
( ) Laboratory Test Results
( ) Immunization Record

( ) Other- list specific items: ----------

Behavioral Health Reports:

( ) Social History
( ) Client Data Form
( ) Referral/Treatment Form
( ) Admission Evaluation
( ) Notification of Admission
( ) Treatment Plan
( ) Academic History
( ) Aftercare Instructions
( ) Psychological Evaluation

( ) Other — list specific items; ----------

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law,
5. This information may be disclosed to and used by the following individual/organization:

   Name of Facility: Frontline Internal Medicine

   Address: 6 Lester Road, Statesboro, GA, 30458

   Phone #: 912-681-8999, Fax #: 912-681-8989

For the purpose of:

FRONTLINE Internal Medicine
6 Lester Road, Statesboro, GA 30458
Ph: 912-681-8999; Fax: 912-681-8989

( ) Further Medical Care
( ) Inspection/Copying of my records
( ) Personal
( ) Other (please specify):
( ) Insurance Eligibility/Benefits
( ) Legal Investigation or Action
( ) Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.

7. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. 1 understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless <u>otherwise</u> specified.**

Signature of Patient: ---------- Date: ----------

(If signed by someone other than the patient, indicate relationship and authority to do so.)

Name of Patient (Please Print):----------

Patient is:
( ) Minor ( ) Incompetent
( ) Disabled ( ) Deceased

Legal Authority:
( ) Custodial Patent ( ) Legal Guardian
( ) Executor of Estate of Deceased ( ) Power of Attorney for Health Care ( ) Authorized Legal Personal Representative

Signature of Witness: ---------- Date: ----------

HIPAA Form 3
Version 1
06/01/2013
Frontline Internal Medicine HIPAA Form 3 Authorization

MEDICARE ASSIGNMENT AND AGREEMENT TO PAY MEDICARE NON-COVERED CHARGES

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I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my Physician to release to the Social Security administration and /or its intermediaries and /or carriers any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing these services, or authorize the above to submit a claim to Medicare to payment to me. I understand Medicare participating Physicians have been advised by the Health Care Financing Administration (HCFA) that services provided to Medicare Beneficiaries, which are determined by HCFA to be unnecessary, and will not be paid for my Medicare. The Physician may not collect for these services from the patient, unless prior notification has been given. I request that this authorization apply to the period from ---------- to----------

---------- ----------

Beneficiary Representative Payee Signature Date

AUTHORIZATION FOR MEDICAL TREATMENT

I authorize Dr. Mbakwe and her staff to conduct and direct my medical care while I am a patient at Frontline Internal Medicine, LLC. I also authorize Frontline Internal Medicine, LLC staff, directed by my Physician, to give medications, perform diagnostic procedures and provide other care which, in the judgment of my doctor, is required for my best care and treatment.

---------- ----------

Patient Signature Date

Patient authorization to discuss medical issues/leave messages:

I, ----------, give my authorization

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to my physician/physician's staff to discuss any medical issues concerning me to:

My spouse: ----------

My son / daughter / children: ----------

My caregiver: ----------

Other: ----------

I, ----------, also give my physician/physician's staff permission to leave a message on my home answering machine or to any person answering my home phone.

I, ----------, also give permission to my physician/physician's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my physician/physician's staff to leave a message for me to return their call.

If there is any medical information I do not want to be discussed or a message to be left at my home or at my place of employment, I will notify my physician/physician's staff of this in writing. If there is any change in information pertaining to this consent, I will also notify my physician/physician's staff of this in writing.

I,---------- , also give permission to my physician/physician's staff to fax any information regarding me to another physician's office that may be covering for my physician/physician's staff, or a physician I may be referred to by my physician/ physician's staff.

I, ----------, also give permission to my physician/physician's staff to view my prescription history from external sources and/or from pharmacy data.

Patient signature: ---------- Date: ----------

FRONTLINE Internal Medicine
6 Lester Road, Statesboro, GA 30458
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Effective Date: 06/01/13

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

If you have any questions about this notice please contact our practice Manager at:

(912) 681-8999

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **06/01/2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Who Will Follow This Notice

This notice describes our privacy practices. As such, we may share your medical information and the medical information of others we service with each other as needed for treatment, payment or health care operations relating to our health care arrangement.

The following participate in the privacy policies and procedures regarding your rights under the HIPAA Privacy Rule:

Our physician and members of our medical staff.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your medical information to a physician or other health care provider in order to provide treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you. We may disclose your medical information to another health care provider or entity subject to the federal and state Privacy Rules so they can obtain payment.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. These uses are necessary to make sure that all our patients receive quality care.

Some examples are:

- Review of our treatment or services to evaluate the performance of our staff providing your care;
- sending you a satisfaction survey;
- Review of information about many of our patients to determine if additional services should be added or perhaps are no longer needed;
- Information may be given to our doctors, nurses, medical and health care students, and other personnel to be used for education and learning purposes;
- we may remove information that identifies you from the medical information so others may use it for studies in health care delivery without learning who the patients are; and
- we may disclose your medical information to another provider who has a relationship with you and is subject to the same Privacy rules, for their health care operation purposes.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

To Your Family and Friends: Unless you object, **w**e may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of medical information.

By Law or Special Circumstances: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;

- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- to law enforcement officials after receiving subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Health Related Benefits and Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.

We may use or disclose your medical information to encourage you to purchase or use a product or service specific to your health care needs by face-to-face communication or to provide you with promotional gifts.

Use and Disclosure of Certain Types of Medical Information: For certain types of medical information we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your medical information or purposes of use or disclosure of your medical information:

Disclosure of Medical Information for Treatment, Payment and Health Care Operations. In order to disclose your medical information in the ways discussed above for treatment, payment and health care operations without specific authorization, we must obtain your general written permission.

HIV Information. We may not disclose HIV information unless required by law, pursuant to an authorization or the disclosure is to you or your personal representative; to the health care provider who

ordered an HIV test; to your spouse or sexual partner or any of your children whom a physician believes is

at risk of HIV infection, but the physician must first attempt to inform the subject that the disclosure will be made; to the Georgia Department of Human Resources; or, to any health care provider (or employee or agent of health care provider) who is or will be providing care to you and is at risk of HIV infection.

Genetic Information. We may not disclose your genetic information to any other person or entity unless we have obtained specific authorization from you or the disclosure is required by law.

Alcohol and Drug Abuse Information. We may not disclose your medical information that contains alcohol and drug abuse information except to you, your personal representative or pursuant to an authorization or as may otherwise be allowed by law.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy: You have the right to look at or get copies of your medical information, with limited exceptions. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice.

You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a fee for copying and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

We may deny your request to inspect and copy in very limited circumstances as allowed by law. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities. You must make a request in writing to request a listing of disclosures. You may obtain a form to request the accounting by using the contact information at the end of this notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place certain restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing. You may obtain a form to request additional restrictions on the use or disclosure of your medical information by using the contact information listed at the end of this notice.

We will not be bound to the restrictions unless our agreement is signed by you and the appropriate hospital representative.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. For example, you might request that we contact you at work or by mail. You must make your request in writing. You may obtain a form to request alternative communications by using the contact information listed at the end of this notice. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information**.** Your request must be in writing, and it must explain why the information should be amended. You may obtain a form to request an amendment by using the contact information listed at the end of this notice. We may deny your request if we did not create the information you want amended and the individual who provided the information remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

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If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Marc Mbakwe, Clinic Manager.

Telephone: 912-681-8999

Fax: 912-681-8989

Address: 6 Lester Road, Statesboro, GA 30458

THIS NOTICE IS YOUR COPY TO RETAIN FOR ANY FUTURE QUESTIONS OR CONCERNS REGARDING THE USE OF YOUR PROTECTED HEALTH INFORMATION.

Please sign the Acknowledgement to signify your receipt and understanding of this document for our records.
Thank you.

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

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Patient Name: ----------

Medical Record Number: ---------- Social Security Number: ----------

Date of Service: ---------- Notice Version (Date):----------

Acknowledgement of receipt of Privacy Practices Notice

I, ----------, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: ---------- Date: ----------

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ----------

Relationship to Individual: ----------

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: ----------

Describe the reason why the individual would not sign this form: ----------

SIGNATURE: (Practice Representative)

I attest that the above information is correct.

Signature: ---------- Date: ----------

Print name: ---------- Title: ----------

Include this acknowledgement form in the individual's records.