

**PERSONAL/CONTACT INFORMATION**

Patient Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Status: Single \_\_\_ Partnered \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip : \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ OK to leave messages? Y \_\_\_ N \_\_\_

E-mail Address: \_\_\_\_\_ OK to send e-mail? Y \_\_\_ N \_\_\_

Emergency Contact Information: \_\_\_\_\_

*Please be sure to include name, relationship, and phone #*

**EMPLOYMENT INFORMATION**

Employment Status: Employed \_\_\_ Retired \_\_\_ Disabled \_\_\_ Student \_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

OK to call at work? Y \_\_\_ N \_\_\_ OK to leave messages at work? Y \_\_\_ N \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip : \_\_\_\_\_

**PAYMENT INFORMATION**

Party Responsible for this Bill: \_\_\_\_\_

If not self, relationship to responsible party? Spouse \_\_\_ Parent \_\_\_ Partner \_\_\_ Other: \_\_\_\_\_

Form of Payment: Cash \_\_\_ Check \_\_\_ Credit Card \_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group No: \_\_\_\_\_

Insurance Member/ID #: \_\_\_\_\_ Phone # for Verification \_\_\_\_\_

Insurance Company Billing Address: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

**REFERRAL INFORMATION**

How did you hear about us? Yellow Pages \_\_\_ Gay Pages \_\_\_ Website/Search Engine \_\_\_ Print Advertisement \_\_\_

Insurance Network List \_\_\_ Referred by Patient \_\_\_ Referred by Physician \_\_\_ Other \_\_\_

Primary or Referring Physician Name & Phone#, If Applicable: \_\_\_\_\_

Other Referral Source, If Applicable: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to MIDTOWN WEST MEDICAL, PC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize MIDTOWN WEST MEDICAL, PC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

\_\_\_\_\_  
Signature of Insured or Legal Guardian

\_\_\_\_\_  
Date

## ADULT HEALTH HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates. **Thank you!**

Present Health Concern(s): \_\_\_\_\_  
 \_\_\_\_\_

Age: \_\_\_\_\_  M  F How would you rate your general health?  Excellent  Good  Fair  Poor

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse/Partner's Name: \_\_\_\_\_

Name/Age of Children: \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Years of Education/Highest Degree: \_\_\_\_\_

### PERSONAL HEALTH HISTORY

Childhood Illness:  Measles  Mumps  Rubella  Chickenpox  Rheumatic Fever  Polio

**Immunizations and Most Recent Dates:**

<input type="checkbox"/> Hepatitis A Date: _____	<input type="checkbox"/> Pneumovax (Pneumonia) Date: _____
<input type="checkbox"/> Hepatitis B Date: _____	<input type="checkbox"/> Varicella (Chickenpox) Date: _____
<input type="checkbox"/> Influenza Date: _____	<input type="checkbox"/> Measles Date: _____
<input type="checkbox"/> Tetanus (Td) Date: _____	<input type="checkbox"/> Rubella Date: _____
<input type="checkbox"/> Other: _____	

**Surgeries:**

Year	Reason	Hospital

**Other Hospitalizations:**

Year	Reason	Hospital

Have you ever had a blood transfusion?  No  Yes If yes, date(s): \_\_\_\_\_

**Allergies to Medications:**

Name of Drug	Reaction You Had

**List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers: (continue on back if needed)**

Name of Drug	Strength	Frequency Taken

**HEALTH HABITS AND PERSONAL SAFETY**

**Exercise:**       Sedentary (No exercise)  
 Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)  
 Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)  
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)  
 What kind of exercise? \_\_\_\_\_  
 If you do not exercise, why? \_\_\_\_\_

**Diet:**      How do you rate your diet? .....  Good     Fair     Poor  
 Do you take supplements? .....  Yes     No  
 Do you drink 4 large glasses of milk daily or take calcium supplements? .....  Yes     No  
 Number of meals you eat in an average day? \_\_\_\_\_

**Caffeine:**       None     Coffee: \_\_\_\_\_ cups/day     Tea: \_\_\_\_\_ cups/day     Cola: \_\_\_\_\_ /day  
 Chocolate: \_\_\_\_\_ oz./day

**All questions contained in this questionnaire are optional and will be kept strictly confidential.**

**Alcohol:**      Do you drink alcohol? .....  Yes     No  
 If yes, what kind? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_  
 Is your alcohol use a concern for you or others? .....  Yes     No

**Tobacco:**      Do you use tobacco? .....  Yes     No  
 Cigarettes - Pks/day \_\_\_\_\_  Chew - #/day \_\_\_\_\_  Pipe - #/day \_\_\_\_\_  
 Cigars - #/day \_\_\_\_\_  # of Years \_\_\_\_\_  or Year Quit \_\_\_\_\_

**Drugs:**      Do you currently use recreational or street drugs? .....  Yes     No  
 What kind? \_\_\_\_\_  
 Have you ever given yourself street drugs with a needle? .....  Yes     No

**Sex:**      Are you sexually active? .....  Yes     No  
 Current sex partner(s) is/are: .....  Male     Female  
 Birth control method: \_\_\_\_\_  None needed  
 Have you ever had any sexually transmitted diseases (STDs)? .....  Yes     No  
 Are you interested in being screened for sexually transmitted diseases? .....  Yes     No

**Personal Safety:**      Do you use a bike helmet? .....  Yes     No  
 Do you use seatbelts consistently? .....  Yes     No  
 Physical and/or mental abuse have become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? .....  Yes     No

**MEN ONLY**

Do you usually get up to urinate during the night? .....  Yes  No If yes, # of times \_\_\_\_\_

Do you feel pain or burning with urination? .....  Yes  No

Any blood in your urine? .....  Yes  No

Do you feel burning discharge from penis? .....  Yes  No

Has the force of your urination decreased? .....  Yes  No

Have you had any kidney, bladder or prostate infections within the last 12 months? .....  Yes  No

Do you have any problems emptying your bladder completely? .....  Yes  No

Any difficulty with erection or ejaculation? .....  Yes  No

Any testicle pain or swelling? .....  Yes  No

Date of last prostate and rectal exam? \_\_\_\_/\_\_\_\_/\_\_\_\_

**WOMEN ONLY**

Age at onset of menstruation: \_\_\_\_ Date of last menstruation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Period every \_\_\_\_ days. Heavy periods, irregularity, spotting, pain or discharge? .....  Yes  No

Number of pregnancies \_\_\_\_ Number of live births \_\_\_\_

Are you pregnant or breastfeeding? .....  Yes  No

Have you had a D&C, hysterectomy or cesarean? .....  Yes  No

Any urinary tract, bladder or kidney infections within the last year? .....  Yes  No

Any blood in your urine? .....  Yes  No

Any problems with control of urination? .....  Yes  No

Any hot flashes or sweating at night? .....  Yes  No

Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period? .....  Yes  No

Experienced any recent breast tenderness, lumps or nipple discharge? .....  Yes  No

Date of last pap and rectal exam? \_\_\_\_/\_\_\_\_/\_\_\_\_

**FAMILY HEALTH HISTORY**

	Age	Age at Death	Significant Health Problems and/or Cause of Death
Father			
Mother			
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Children	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother's Mother			
Mother's Father			
Father's Mother			
Father's Father			

**OTHER PROBLEMS**

**Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.**

Skin:

Head/Neck:

Ears/Nose/Throat:

Lungs:

Chest/Heart:

Circulation:

Intestinal:

Bladder:

Bowel:

Back:

Joints:

**Any recent changes in:**  Weight  Energy Level  Ability to Sleep

**Explain:**

**Other pain/discomfort:**

---

---

# MIDTOWN WEST MEDICAL

AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

## Physical Costs & Billing Policies

Midtown West Medical provides an **Executive Physical**, which is a comprehensive, diagnostic, problem-oriented physical examination with laboratory tests and other diagnostic testing as indicated. This physical examination is designed to identify any current health issues, as well as addressing disease prevention and reduction of risk factors. In order to conduct such a thorough and inclusive examination, we spend a considerable amount of time with each patient – much longer than is typical of most physician practices. We follow standards of care, insurance guidelines, and allowable fees, but such comprehensive care is expensive.

Your physical examination may cost a minimum of \$1,000-1,500, depending upon your health needs. If you have a complicated medical history and/or require additional outpatient testing, the total cost can be as much as \$3,000. Please note that our staff cannot provide a price for your physical prior to your appointment because we cannot predict the complexity of your situation until your history is reviewed and you are seen and examined.

If you have medical insurance, your policy will typically pay us allowable fees after your annual deductible is met. Your deductible is an out-of-pocket expense determined by your insurance company based on your contract. You must have paid the full deductible amount before any charges will be paid by your insurer. Please be aware of your deductible responsibility prior to your visit.

"Allowable fees" are the dollar amounts that the insurer sets and pays for each service. Allowable fees are determined by the insurer as those that are customary and reasonable for most doctors in this area. The individual allowable fees that we are paid are not the reason that your physical examination is expensive; it is because of the time, and thorough level of care provided. In addition, we offer some testing services "in house." We must pay a fee to the technicians and specialists (i.e., radiologist, cardiologist, neurologist, gynecologist) who perform and/or review these tests. The fees we pay in association with in-house services are reflected in your charges for these services. While this may make your office visit bill appear high to you, in-house services are actually less expensive to you and your insurer, require fewer outside referrals, and are a convenience to you as a patient.

We are an in-network provider for Blue Cross/Blue Shield PPO. We accept but are out of network for Aetna, Cigna, and United PPO plans, as well as numerous other plans. You will have no co-pays but may have a higher deductible amount when out of network. We do not accept any HMO, EPO, or POS insurance plans, as such plans require a much higher-volume patient load (with patients typically scheduled at 15-minute intervals), and that is not the type of care that we provide.

We ask that all patients discuss any insurance and monetary concerns with our billing personnel. This will **not** be discussed with the doctor in an exam room during an office visit. Our billing staff is very willing to work with any patient who requests a payment plan, or requires any assistance.

---

I understand my financial responsibility for my medical care and the billing policies of Midtown West Medical, PC.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MIDTOWN WEST  
**MEDICAL**  
AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

**Authorization for Release of Information**

I, \_\_\_\_\_, authorize Midtown West Medical, PC, to contact my insurance company or health plan administrator to release all my pertinent financial information concerning coverage and payments under my policy. My insurance company or health plan administrator is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # to verify coverage \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

I understand that the purpose for the disclosure and use of this information is to provide medical services to me, and bill for these same services to my insurance company or health plan administrator.

My authorization is voluntary. I agree that these provisions will remain in effect until one year from the date noted below, or cease immediately upon providing written revocation to Midtown West Medical.

Signature of Patient: \_\_\_\_\_

Print name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Date: \_\_\_\_\_

# MIDTOWN WEST MEDICAL AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

## Authorization for Release of Information

I, \_\_\_\_\_, authorize the release of all my medical information (including but not limited to information on psychiatric conditions, alcohol and drug abuse, and HIV or communicable diseases) from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to: Midtown West Medical, Inc.  
957 W. Marietta Street NW  
Atlanta, GA 30318-5215  
Phone: 404-817-0062

I agree that these provisions will remain in effect until I provide written revocation to Midtown West Medical.

Signature of Patient: \_\_\_\_\_

Print name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Date: \_\_\_\_\_

# MIDTOWN WEST MEDICAL

AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

## OUR FINANCIAL POLICY

*We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. Please feel free to ask to speak with our Practice Manager or a billing specialist if you have any questions about this policy.*

- All new patients are asked to complete a Patient Information form prior to being seen by a provider. We will also photocopy your insurance card and picture ID. Returning patients are periodically asked to review and update personal and insurance information. Please advise us upon check-in of any changes to your insurance or contact information. If your address changes, you are responsible for providing that information to the office. You are responsible for your bill whether you receive a statement or not, due to incorrect or insufficient address.
- **You are responsible for the payment of all co-pays AT THE TIME OF SERVICE. You are responsible for co-insurance, deductibles, non-covered services, and/or any other patient responsible balance. Your insurance may NOT pay for everything, even those services, labs or tests that you and your provider have good reason to think you need. Your insurance company may deem some services "non-covered" or "experimental." You are responsible for payment of all services, regardless of insurance determination of coverage or non-coverage, and you consent to whatever treatment your provider deems medically necessary based upon his/her education, experience and Standard of Care. Coverage or non-coverage will be reflected directly on your Explanation of Benefits (EOB). You and our office will receive the same EOB from your insurance company; the EOB is what we use to determine the charges that are billed to you on our statement. Statements are generated AFTER the determination of covered charges is made by your insurance company.**
- If you are not covered by any insurance plan, you are responsible for the full cost of services rendered at the time of service. For your convenience, we accept cash, check, debit cards, Discover, American Express, Visa or MasterCard.
- **In the event of Default:**  
**If your account becomes thirty (30) days past due, 1.5% per month (18% per year) interest will accrue. If you do not pay your account it will be placed with a third party law firm debt collector. You will then be liable for the principal, interest and attorney's fees of fifteen (15%) percent of the principal and interest owing, court costs and all costs of collection if collected by or through an attorney at law who is not our salaried employee.**
- Payment plans or other arrangements, if necessary, should be negotiated with our Practice Manager or billing specialist prior to services being rendered. We ask that you do not attempt to negotiate fees or payment plans with our medical staff, so that they may focus on patient care. We will verify your coverage; however, verification of coverage by our office is not a guarantee of payment by your insurance company and does not waive your financial responsibility for treatment here.

- If you are covered by an insurance plan with which we participate as a provider, we will file your insurance claim as a courtesy. Please remember that even if we participate with your plan, payment responsibility for any deductible, co-insurance, or non-covered service rests with you, the patient.
- If you have insurance coverage with a plan with which we do not have a provider agreement, we will prepare and submit the claim for you as a courtesy. Charges for your care and treatment are due when billed by our office statement unless other arrangements are made by you in advance.
- For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. This is true for divorced parents of minors as well, regardless of any other arrangements or decrees between them. The parent or guardian who signs the paperwork is financially responsible for the bill.
- You consent to our office or agents calling you at the phone numbers provided. Your consent is also provided for our office or agents to obtain and review your credit report.

#### **REGARDING INSURANCE**

- We must emphasize that as healthcare providers, our relationship is with you, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date services are rendered. Not every service is a covered benefit in all contracts. It is important that you read and understand your health insurance policy and its requirements for coverage. We currently send claims to hundreds of plans and it is impossible for us to know the coverage or requirements of your specific plan. There can be a time lag of two to three months involved between your office visit and the date on which we send you a statement. This is due to the time required to document and submit claims to your insurance company, and for your insurance company to process our claims. Once your claims have been processed and we have sent you a statement, you are responsible to make payment to our office within 30 days unless other arrangements have been made and documented in our files.
- Our office participates with many, but by no means all, managed care plans. Please call your insurance company to confirm whether we are participating with your plan. Many insurance cards do not indicate whether or not your plan includes out of network benefits. It is often impossible for our front desk staff to determine this simply by looking at your card. It is your responsibility to confirm whether your plan includes out of network benefits before your appointment.
- It is your responsibility to obtain all necessary referral/authorization numbers from your Primary Care Physician, if required by your insurance for your care obtained at this office. Please provide referral numbers to us prior to your visit.

#### **LATE ARRIVALS**

- Any patient who is late for his or her appointment will be seen only if the provider's time allows, or may be worked into the end of the morning or afternoon schedule. Atlanta, as we all know, has traffic issues, so please plan accordingly to arrive on time.

#### **MISSED APPOINTMENTS**

- Unless cancelled at least 24 hours in advance, you may be charged \$35 for a missed appointment. Please help us serve you better by keeping scheduled appointments. This fee is not covered by insurance, so it will be your personal responsibility.
-

**Acknowledgment, Authorization and Assignment:** Please sign below to indicate your understanding and acknowledgment of our Financial Policy. Your signature below also authorizes Midtown West Medical, PC to bill your insurance company directly for services rendered; you remain financially responsible for charges not covered by your insurer. You also authorize any holder of medical or other information about you to release to the Social Security Administration, other providers of treatment or procedures, or intermediaries any information needed for this or a related claim. You also permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to yourself or to the party who accepts assignment of benefits. You also consent to whatever treatment your provider deems medically necessary based upon their education, experience, and Standard of Care.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

### Policy on Communication of Medical Information

It is our goal to contact patients with lab and test results within two weeks (or sooner if medically indicated), either by phone or email. However, we sometimes run into communication barriers such as unreturned calls or out-of-date contact information. We will make every reasonable attempt to reach you with your results using the contact information you have provided to us, using HIPAA compliant methods.

Whenever possible, we would prefer that you schedule a follow-up appointment to discuss lab results. If you have a follow-up appointment scheduled, then you will not be contacted with results in advance of the appointment.

We will also be happy to mail your lab results to you if you provide a stamped, self-addressed envelope at your appointment. If you choose to have your results mailed, you will not be contacted by any other means unless your results require explanation or follow-up.

If you are expecting lab results via phone or email and have not heard from us within two weeks of the testing date, please contact the office by phone.

In order for us to communicate with you via email about lab results or any other aspect of your medical care, you must provide your consent below. You should recognize that while our electronic communication methods are HIPAA-compliant, there is always some risk that protected health information in an email may be disclosed to, or intercepted by, unauthorized third parties. There is also the risk that spam, junk or other mail filters will block your receipt of email communication from us.

---

I have read and understand the Midtown West Medical Policy on Communication of Medical Information.

SELECT ONE:

- I grant permission to Midtown West Medical and its designated agents to communicate with me about laboratory test results and other personal medical information via email at the following address:

\_\_\_\_\_@\_\_\_\_\_

I acknowledge and accept the possible risks associated with such communication. **If asked via email to contact the office, I will do so in a timely manner.** This permission will remain in effect until I cancel it in writing.

- I prefer not to be contacted via email.

---

Print Name

---

Signature

---

Date

# MIDTOWN WEST MEDICAL

AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

## FINANCIAL DISCLOSURE STATEMENT Updated July 31, 2006

We want you to be aware that Midtown West Medical has financial arrangements with certain companies and practitioners. We do NOT have ownership interest in any of the companies with which we do business. We do have contracted discount rates with certain insurance companies and purchased services agreements with some providers. These agreements meet the Fair Market Value criteria recommended by the AMA and United States government CMS (Medicare/Medicaid), as well as our own high standards of ethical and legal propriety. By contracting for discounted fees, we take on the responsibility for staffing, billing, and collection for the services rendered, and we assume full credit risk (meaning that we pay for services even if we are not reimbursed by the patient or his or her insurer). In addition, by offering services through purchased services agreements, we are often able to achieve lower patient "balance billing" – in other words, lower out-of-pocket costs for you.

We have found that compliance with the diagnostic testing that Dr. Johnson and Ms. Carusi routinely order is much higher when the testing is made available to our patients conveniently, efficiently, and in the comfortable atmosphere of our own offices. Also, by keeping as many of our usual diagnostic tests as possible in-house, our solo practice is able to operate more successfully as a business, which in turn allows us to maintain the excellent staff and extended appointment times we are committed to providing to you. We consider the result of these arrangements to be a "win-win" situation for our patients and the practice. Our primary objective is always to provide you with the highest quality of healthcare available. We only order medically necessary and appropriate testing for diagnostic purposes. **You are always free to use any insurance company or service provider you prefer.**

If you have any questions or concerns about this subject, please feel free to discuss it with our Practice Manager, Suzanne Combs, or with Dr. Johnson, at any time.

### Patient Acknowledgement

I have read and understand the Midtown West Medical Financial Disclosure Statement.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# MIDTOWN WEST MEDICAL

AT KING PLOW ARTS CENTER

Midtown West Medical, PC  
957 W. Marietta Street NW • Atlanta, GA 30318  
Tel: 404.817.0062 • Fax: 404.817.0064  
www.midtownwestmedical.com

Kimball A. Johnson, MD  
Gloria J. Carusi, RN, Nurse Practitioner  
Suzanne Combs, RN

## **MIDTOWN WEST MEDICAL, PC ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request and obtain a revised copy by mail or in person at our office.

By signing below, you acknowledge that you have read and reviewed a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_

Date: \_\_\_\_\_