

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 consent to whatever treatment my provider deems medically necessary based upon education, experience and Standard of Care. 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 <i>Date:</i> _____	<input type="checkbox"/> Pneumovax (Pneumonia) <i>Date:</i> _____
<input type="checkbox"/> Hepatitis B <i>Date:</i> _____	<input type="checkbox"/> Varicella (Chickenpox) <i>Date:</i> _____
<input type="checkbox"/> Influenza <i>Date:</i> _____	<input type="checkbox"/> Measles <i>Date:</i> _____
<input type="checkbox"/> Tetanus (Td) <i>Date:</i> _____	<input type="checkbox"/> Rubella <i>Date:</i> _____
<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 consent to whatever treatment my provider deems medically necessary based upon their education, experience, and Standard of Care. 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

INSURANCE VERIFICATION & RELEASE FORM

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 indefinitely from the date noted below, or cease immediately upon providing written revocation to Midtown West Medical, PC. I will be asked to sign a new Insurance Authorization and release Form any time my insurance coverage changes.

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: _____

Policy on Communication of Medical Information

It is our goal to go over lab and test results within two weeks (or sooner if medically indicated), during the follow-up visit scheduled at the time labs are performed. However, we understand that occasionally we may need to e-mail results, using HIPAA compliant methods.

Our Office Policy is that you schedule a follow-up appointment to discuss lab results. If you have a follow-up appointment scheduled, then you will be provided a copy of your lab or test results to take home with you.

In the event you do not receive a copy of your lab or test results at the follow-up visit, you may request that these results be e-mailed to you.

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 HIPPA compliant, there is always some risk that protected health information in an e-mail 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 e-mail 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 e-mail 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

Updated April 2009

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.**
- **Unpaid account balances are charged a monthly interest rate of 1.5%.**
- 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.
- It is your responsibility to make sure we have current, correct insurance information on file, so that we may file your claim within your policy's time limits (usually six months to one year after you are seen). If we have incorrect or outdated insurance information on file, and you have not presented us with the correct information within the Timely Filing Limit specified by your policy, you will be responsible for all charges for services rendered if charges are declined by your insurance.

- 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.
- Should it ever become necessary to use the services of an outside collection agency to collect on your account, you are responsible for any costs incurred for collection.

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

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: _____