Advanced Healthcare Center
391 South 1St Street, Jesup GA. 31545

Thank you for allowing Advanced Healthcare Center (AHC) to participate in your healthcare needs. We are here to serve you.

Advanced Healthcare Center (AHC) is a multidisciplinary healthcare facility with multiple Medical, Chiropractic, Physical Therapy, and Massage Therapy Providers working as a team to formulate a comprehensive Evaluation and Treatment Plan that will restore you to maximum medical improvement as soon as possible.

It is important to understand that Teresa Cezar, MD, is the medical director at AHC and ultimately reviews all patient charts to make sure All medically necessary products and services performed both onsite at AHC and off site are documented and ordered in your chart . All ordered products and services will then be reviewed with you ASAP, a detailed Report of Findings (ROF) by an AHC clinical staff member will be performed. We also provide a Financial Consult (FC) immediately following to resolve any and all financial questions or concerns you may have involving your plan of care at AHC.

AHC takes pride in providing high quality, effective, complete healthcare for every patient. Our slogan is "*HEALTH FOR LIFE*" and that is our goal for you. Without you as a valued patient, we would not be in business..

Never hesitate to contact AHC staff or myself with questions or concerns.

Sincerely,
Edwin Davis, Jr., DC

Edwin Davis Jr., DC
PRESIDENT/CEO
Office: (912) 427-8433
Email: drdavis@gachiro.org

YourHealthFile Registration Online

To become a registered member with our office and have access to your health record, simply fill out the form below. Once your request has been approved, you will be notified via email. Please make sure the email address you provide is accurate.

Please note that we respect your privacy, and will not loan, sell, or otherwise distribute your personal information to any third party.

Fields marked with an * are required for registration.

General Information:

First Name: ________________________________ Last Name: _______________________________

Address: ____

City: ________________________________ State: _________ Zip: __________ Country: ________

Phone: ______________________________________ Fax: ____________________________________

Birthday: __________ / __________ / __________

Member Log-In:

Specify desired email address for website access

*E-Mail Address: ___________________________________

*Password: Will be sent to the email above

☐ **Yes, I would like to receive special announcements from the office and a free subscription to the Newsletter.**

Check off topics of interest:

☐ Backaches & Sciatica ☐ Headaches & Neck Pain ☐ Wellness Topics

☐ Diet & Nutrition ☐ Exercise & Fitness ☐ Women's Health Issues

☐ Children's Health Issues ☐ Stress Management ☐ Doctor's Announcements

391 S. 1st Street
Jesup, GA. 31545
(912) 427-8433
AHCforHealth.com

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records and used to better assess your health. THANK YOU.

Name________________________ D.O.B. ___________________ Age ______________ Sex [ ] M [ ] F

Address __________________________________ City/State ________________ Zip ______________

Soc. Sec. #_____ - _____ - _____ Home Ph. ____________________ Cell ____________________

Email ______________________________ Marital Status [ ] M [ ] D [ ] S [ ] W

Children? [ ] Yes [ ] No Spouses Name __________________________

Occupation ___________________________ Employer __________________________________

Who referred you to us/ how did you hear about us? ____

What is your major complaint? ____

____

How long have you had this condition? ____

Have you had this or similar conditions in the past? ____

Do any positions make it feel better? ____

Do any positions make it feel worse? ____

Is this condition [ ] Improved [ ] Unchanged [ ] Getting Worse

Is this condition interfering with your [ ] Work [ ] Sleep [ ] Daily Routine [ ] Other: ______________________

Other therapist who have treated this condition ____

What do you think caused this condition ____

____

Please list any surgical operations and the approximate dates:

____

____

Do you have a family physician? [ ] No [ ] Yes: Name __________________________________

Medications, dosage and frequency: ____

Have you been in an auto accident or had any other personal injuries? [ ] Yes [ ] No

Please explain: ____

____

Signature ____ Date ____________________

Parent/Guardian ___________________________________ Date ____________________

Is this visit due to an accident? YES or NO

1. Accident Date: ____________________ 2. Type of Accident: auto or work
3. Has the accident been reported: YES or NO
4. If yes, to whom: Employer ____ Auto Carrier _____ Attorney: _____
5. Attorney/Employer/Auto Carrier Name ______________________________
6. Address _______________________________ Phone: ___________________

Case Number: _________________________
Do you have Med Pay on your automobile insurance plan? Yes or No
Insurance contact information for MedPay:
____

Health Insurance Information

(Please bring this completed form, a picture ID and insurance card to your appointment)

Primary Insurance Carrier:	2nd Insurance Carrier: ___________________
Primary Insured Person:	Primary Insured Person:___________________
Insured Person Birth Date:	Insured Person Birth Date:_________________
ID/Member # from Card:	ID/Member # from Card:__________________
Group number:	Group number:_________________________
Relationship to insured:	Relationship to insured:___________________

**** Self Pay _________ No health insurance to file- I will be responsible for all fees associated with my visits.**

Any additional billing information you would like to share regarding these payers?

____
____
____

I authorize payment of medical benefits to physician or supplier for services and all future claims. I authorize release of any medical information necessary to process any claims for payment of services.

Sign ____

(Signature Insured or authorized person)

Radiology Fees

This contract is a legal binding agreement between the patient and Advanced Healthcare Center. The patient agrees and consents that when necessary your complete X-Ray series may need to be over read by a board certified Radiologist on staff at South Georgia Radiology Associates. The patient further agrees to pay a separate, non-insurance reimbursable fee of $15.00 per study area for the Radiologists over read with a written report.
This agreement has been reviewed, signed and agreed by both parties.

Patient Signature: ______________________________________ **Date:** _____________

Witness: ____ Date _______________

****

For woman only:

Should x-rays be necessary, we would like to confirm you are NOT pregnant at this time. By signing below you are providing that confirmation to proceed with the x-ray if necessary.

Name: _______________________________ Date: ______________________

- **There is a possibility I may be pregnant**
- **Yes, I am definitely pregnant**
- **No, I am definitely NOT pregnant**
- **I request the x-ray films NOT be taken because:** __________________________

Date of last menstrual cycle: _________________________

Patient signature: ____ Date: ___________________

REVIEW OF SYSTEMS (CHECK ONES YOU HAVE OR HAD)

GENERAL	NOW	PAST
Weakness	[ ]	[ ]
Fatigue	[ ]	[ ]
Fever	[ ]	[ ]
Chills	[ ]	[ ]
Night Sweats	[ ]	[ ]
Fainting	[ ]	[ ]
SKIN		
Color Changes	[ ]	[ ]
Nail Changes	[ ]	[ ]
Hair Changes	[ ]	[ ]
Moles	[ ]	[ ]
Rashes	[ ]	[ ]
Sores	[ ]	[ ]
Weakness	[ ]	[ ]
HEAD		
Headaches	[ ]	[ ]
Injuries	[ ]	[ ]
Bumps	[ ]	[ ]
Last eye exam	________	
Glasses	[ ]	[ ]
Contacts	[ ]	[ ]
Cataracts	[ ]	[ ]
EARS		
Hard of Hearing	[ ]	[ ]
Deafness	[ ]	[ ]
Ringing	[ ]	[ ]
Discharge	[ ]	[ ]
Earache	[ ]	[ ]
Itching	[ ]	[ ]
Dizziness	[ ]	[ ]
Room Spins	[ ]	[ ]
NOSE		
Decreased Smell	[ ]	[ ]
Bleeding	[ ]	[ ]
Pain	[ ]	[ ]
Discharge	[ ]	[ ]
Obstruction	[ ]	[ ]
Post Naval Drip	[ ]	[ ]
Deviated Septum	[ ]	[ ]
Runny Nose	[ ]	[ ]
Sinus Congestion	[ ]	[ ]
MOUTH		
Bleeding Gums	[ ]	[ ]
Sores	[ ]	[ ]
Dental Problems	[ ]	[ ]
Bad Breath	[ ]	[ ]
Loss of Taste	[ ]	[ ]
Dry Mouth	[ ]	[ ]
Ulcers	[ ]	[ ]
Blisters	[ ]	[ ]

THROAT	NOW	PAST
Soreness	[ ]	[ ]
Bad Tonsils	[ ]	[ ]
Hoarseness	[ ]	[ ]
Pain	[ ]	[ ]
Swallowing	[ ]	[ ]
Infections	[ ]	[ ]
Neck		
Enlarged	[ ]	[ ]
Stiff Neck	[ ]	[ ]
Soreness	[ ]	[ ]
Lumps	[ ]	[ ]
Masses	[ ]	[ ]
Breasts		
Discharge	[ ]	[ ]
Lumps	[ ]	[ ]
Pain	[ ]	[ ]
Bleeding	[ ]	[ ]
Skin change	[ ]	[ ]
Bloated	[ ]	[ ]
LUNGS		
Cough	[ ]	[ ]
Phlegm	[ ]	[ ]
Blood	[ ]	[ ]
Shortness	[ ]	[ ]
Wheezing	[ ]	[ ]
Pain	[ ]	[ ]
Congestion	[ ]	[ ]
Inhalants	[ ]	[ ]
HEART		
Murmur	[ ]	[ ]
Palpitations	[ ]	[ ]
Tachycardia	[ ]	[ ]
Swollen	[ ]	[ ]
Cold Limbs	[ ]	[ ]
Pain	[ ]	[ ]
Pressure	[ ]	[ ]
Varicose	[ ]	[ ]
Blood Clots	[ ]	[ ]
Blue Limbs	[ ]	[ ]
BLOOD		
Anemia	[ ]	[ ]
Low Iron	[ ]	[ ]
Easy Bruising	[ ]	[ ]
Easy Bleeding	[ ]	[ ]
Swollen Nodes	[ ]	[ ]
Painful Nodes	[ ]	[ ]
Red Spots	[ ]	[ ]

DIGESTIVE	NOW	PAST
Abdominal Pain	[ ]	[ ]
Nausea	[ ]	[ ]
Bloated	[ ]	[ ]
Belching	[ ]	[ ]
Heartburn	[ ]	[ ]
Indigestion	[ ]	[ ]
Irregular Bowels	[ ]	[ ]
Constipation	[ ]	[ ]
Diarrhea	[ ]	[ ]
Gas	[ ]	[ ]
Hemorrhoids	[ ]	[ ]
Poor Appetite	[ ]	[ ]
Food Intolerance	[ ]	[ ]
Bloody Stools	[ ]	[ ]
GENITOURINARY		
Urgency	[ ]	[ ]
Incontinence	[ ]	[ ]
Straining	[ ]	[ ]
Back Pain	[ ]	[ ]
Frequent Voiding	[ ]	[ ]
Stones	[ ]	[ ]
Burning	[ ]	[ ]
Bed Wetting	[ ]	[ ]
Small Stream	[ ]	[ ]
Discharge	[ ]	[ ]
Impotence	[ ]	[ ]
Dribbling	[ ]	[ ]
Cloudy Urine	[ ]	[ ]
Urine Color	________	
Cramps	[ ]	[ ]
Discharge	[ ]	[ ]
Itching	[ ]	[ ]
Painful Intercourse	[ ]	[ ]
Irregular Periods	[ ]	[ ]
Hot Flashes	[ ]	[ ]

Contraception Type ____________

Age at first period ______________

Duration of Cycle ______________

No. of Pregnancies ______________

No. of Births ____________________

No. of Miscarriages ______________

No. of Abortions ________________

Menstrual Flow [ ] Heavy [ ] Med. [ ]Light

Last Period ____________________

Spotting Btwn. Periods

[ ] Now [ ] Past

REVIEW OF SYSTEMS (Continued.)

Neurologic	NOW	PAST
Seizures	[ ]	[ ]
Vertigo	[ ]	[ ]
Hand Trembling	[ ]	[ ]
Loss of Sensation	[ ]	[ ]
Incoordination	[ ]	[ ]
Loss of Facial	[ ]	[ ]
Weak Grip	[ ]	[ ]
Paralysis	[ ]	[ ]
Difficulty Speech	[ ]	[ ]
Tingling	[ ]	[ ]
Loss of Memory	[ ]	[ ]
Numbness	[ ]	[ ]

ENDOCRINE

Weight Loss	[ ]	[ ]
Weight Gain	[ ]	[ ]
Extremely Thin	[ ]	[ ]
Heat Intolerance	[ ]	[ ]
Cold Intolerance	[ ]	[ ]
Hair Changes	[ ]	[ ]
Breast Changes	[ ]	[ ]

PSYCHIATRIC

Hyperventilation	[ ]	[ ]
Insecurity	[ ]	[ ]
Depression	[ ]	[ ]
Troubled Sleep	[ ]	[ ]
Irritable	[ ]	[ ]
Undecidedness	[ ]	[ ]
Timid	[ ]	[ ]
Hallucinations	[ ]	[ ]
Loss of Memory	[ ]	[ ]
Alcoholism	[ ]	[ ]
Drug Addiction	[ ]	[ ]
Drug Dependent	[ ]	[ ]
Suicidal Thoughts	[ ]	[ ]
Extreme Worry	[ ]	[ ]
Sexual Problems	[ ]	[ ]

MUSCULOSKELETAL

Muscle Pain	[ ]	[ ]
Muscle Weakness	[ ]	[ ]
Muscle Cramps	[ ]	[ ]
Muscle Twitching	[ ]	[ ]
Joint Stiffness	[ ]	[ ]
Joint Pain	[ ]	[ ]

PAST MEDICAL HISTORY. CHECK ONLY THE ONES YOU HAVE HAD.

Hay Fever	[ ]	Parasites	[ ]
Mumps	[ ]	Epilepsy	[ ]
Rheumatic Fever	[ ]	Paralysis	[ ]
Allergies	[ ]	Polio	[ ]
Angina	[ ]	Mental Illness	[ ]
Cancer	[ ]	Alcoholism	[ ]
Tumor	[ ]	Depression	[ ]
Blood Disease	[ ]	Nervous Breakdown	[ ]
Leukemia	[ ]	Migraine	[ ]
Heart Trouble	[ ]	Gout	[ ]
Varicose Veins	[ ]	Hemorrhoids	[ ]
Phlebitis	[ ]	Prostate Problems	[ ]
Hypertension	[ ]	Sexual Problems	[ ]
Stroke	[ ]	Gonorrhea	[ ]
Ulcers	[ ]	Syphilis	[ ]
Jaundice	[ ]	Diabetes	[ ]
Skin Trouble	[ ]	Bladder Trouble	[ ]
Gallstones	[ ]	Kidney Stones	[ ]
Liver Trouble	[ ]	Kidney Infection	[ ]
Hepatitis	[ ]	Dysentery	[ ]

ALLERGIES

____
____
____
____

DIABETICS ONLY

When were you diagnosed? ____________________

What is your average blood sugar? ____________________

Would you be interested in nutritional counseling to help control your diabetes? [ ] **Yes** [ ] **No**

ADVANCED HEALTHCARE CENTER

FAMILY HISTORY LIST ANY DISEASES WHICH RUN IN YOUR FAMILY

RELATIVE	AGE (LIVING)	AGE (AT DEATH)	CAUSE OF DEATH	ILLNESS
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
MATERNAL GRANDMOTHER				
MATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
PATERNAL GRANDFATHER				

SOCIAL HISTORY (CHECK THE BOXES AND FILL IN)

Height ______________ **Current Weight** ____________ **Have you recently gained weight?** ________________________

Mental Work [ ] Heavy [ ] Moderate [ ] Light Hours Per Day _______________

Physical Work [ ] Heavy [ ] Moderate [ ] Light Hours Per Day _______________

Exercise [ ] Heavy [ ] Moderate [ ] Light Hours Per Day _______________

Smoking [ ] Heavy [ ] Moderate [ ] Light Hours Per Day _______________

Alcohol Beer, Liquor, Wine/ week ______________ No. of Years _________________

Caffeine (Coffee, Tea, Cola) Cups/Day ____________________________ No. of Years _________________

Aspirin No./ Day ______________________________ No. of Years _________________ Other _____________

CIRCLE YOUR LEVEL OF PAIN ON A 1-10 SCALE:

How bad are your symptoms now?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
None Moderate Severe

How bad have they been in the past?

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
None Moderate Severe

MARK THE AREAS OF YOUR SYMPTOMS BELOW

Aches: xxx Numbness: ## Pins/ Needles: * Stabbing: ✦

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name: ______________________ **Last Name:** ________________________________

Email : ____

Cell Phone #: ______________________________ **Cell Provider:** ______________________

DOB: ______/ _____/___________ **Gender:** Male/ Female **Preferred Language** __________

Smoking Status (Circle One): Every Day Smoker/Occasional Smoker/Former Smoker/Never Smoked

CMS requires providers to report both race and ethnicity

Race (circle one): American Indian or Alaska Native/ Asian/ Black or African American/ White (Caucasian)

Native Hawaiian or Pacific Islander/ Other/ I decline not to answer

Ethnicity (circle one): Hispanic or Latino/ Not Hispanic of Latino/ I decline not to answer

Are you currently taking any medications? (please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5 mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

[ ] I choose to decline receipt of my clinical summary after every visit
(These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signatures: ______________________________ Date: __________________

For office use only

Height: _____ Weight:____________ Blood Pressure: ______/ __________

Advanced Healthcare Center Controlled Substance Agreement

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

_____2.) Refills of controlled substance medications

_____a) Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.

_____b) Will not be made as an "emergency", such as a Thursday afternoon because I suddenly realized that I will run out tomorrow and the office will be closed. I will call at least (72) hours in advanced if I need assistance with a controlled medication prescription.

_____3) I understand the importance of following my treatment plan as directed by my physician/provider and agree:

a) To keep my appointment (including follow-up and any referrals

b) To permit urine drug screening once a month and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____4) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

______5) Fails to comply with medical evaluation and recommended treatment options of pain complaints ordered by AHSI providers such as: Diagnostic tests requested (e.g., Radiology tests, NCV/EMG, EKG) physical therapy, Durable Medical Equipment, Compound topical creams, chiropractic care, pain management, etc.) Your prescriptions for controlled medications may be terminated immediately.

______6) I understand that all the controlled substances must be obtained at the same pharmacy, when possible.

Pharmacy Name: ____

Phone Number: _____________________________________

______ 7) I understand that if I violate any of the conditions listed below, my prescriptions for controlled medications may be terminated immediately and may be subject to dismissal from this facility. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, or sharing/permitting others (including your spouse or family members, who have access to any controlled substance that you have been prescribed). I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

NOTE: We are capable of monitoring your medications through The Georgia Prescription Drug Monitoring Program. If we suspect, or feel you have compromised your controlled substance contract with Advanced Healthcare & Spine Institute, we are obligated to use the website for confirmation.

DRUG SCREENS: Urine specimen is collected in the clinic. Patients should not wear coats and other outer clothing or take purses, bags, backpacks into the bathroom. The nurse or provider should confirm promptly that the specimen is appropriately warm and should send it directly to the lab, not give it to the patient to deliver. Drug screens with abnormal results such as:

- ***Prescriptions patient reports taking daily are not detected on screen.***
- ***Patient tests positive for controlled substances not prescribed by clinic.***
- ***Patient tests positive for illicit substances, particularly cocaine – patients should be referred for drug treatment.***
- ***Patient's drug screen shows negative for drugs prescribe.***

After retrieving lab confirmation, it will be determined if the patient should be terminated immediately or may be subject to dismissal from this facility.

Due to the recent law signed by Governor Nathan Deal, concerning controlled substances, we at Advanced Healthcare & Spine Institute, will be instituting the following policies effective immediately. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with

****This includes the following:***

- ***All forms of hydrocodone – (Vicodin, Lorcet, Lortab, Norco, Ect.)***
- ***All forms of oxycodone- (Percocet/Percodan, OxyContin, Tylox)***
- ***Most muscle relaxers- (Valium, Soma, Etc.)***
- ***Duragesic, Fentanlyl patches***
- ***Most sleeping agents- (Ambien (Zolpidem), Lunesta, Ect.)***
- ***All Benzodiazepines- (Klonopin (clonazepam), Restoril (temazepam), Serax (Oxazepam), Xanax (Alprazolam)***
- ***Codeine Preparations (Tylenol # 3, Tussionex)***
- ***Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)***

INCLUDING: (Concerta, Ritalin (methylphenidate- any brand), Adderall, Dextroamphetamine , and Vyvanse. We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature ____ Date: __________________________

HIPAA Notice of Privacy Practices
Advanced Healthcare Center
391 S 1st St, Jesup, GA 31545
912-427-8433

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read and review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information that my identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of your physicians practice, and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians' practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations includes as Required by Law; Public Health Issues as required by law; Communicable Disease Health Oversight, Abuse, or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Worker's Compensation; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.
Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as directed in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided by this notice.

Complaints
You may complain to personnel at our office or the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy contact with your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our privacy practices.

Print Name: ______________________________________

Signature: ____ Date: ___________________

Notice of HIPAA Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received and reviewed this notice of our privacy practices.

Print Name: ____

Signature: ____ Date: ____________________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release information to the family members indicated below. This consent form will allow Advanced Health Care to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize Advanced Health Care to release my medical/billing information to the following individual(s).

1.____ Relationship to patient:______________________

2.____ Relationship to patient:______________________

3.____ Relationship to patient:______________________

Patient Name:____

Patient Signature:____ Date:_____________________________

391 South First Street, Jesup, Georgia 31545

Phone (912) 427-8433 | Fax (912) 427-9851 | www.AHCforHealth.com

ADVANCED HEALTHCARE CENTER

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: ____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street Address

____
City, State and Zip Code

RE: Patient Name: ____

Date of Birth:__________________Social Security Number: _____________________

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- [ ] All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

- [ ] All physical, occupational and rehab requests, consultations and progress notes.

- [ ] All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

- [ ] All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ By checking this box, I acknowledge that the subject matter of this inquiry could cover areas of mental health care and other psychological or psychiatric medications, treatment, records and recordings of same. By checking this box I authorize the Health Care Provider identified above to release such records to the undersigned. All records are to be disclosed; any questions of inclusion must be resolved by disclosure, except for the following dates of service: ____.

If the health care provider has any questions about the scope of this disclosure, please contact the undersigned or my named representative as indicated herein before taking any action.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period______________to ______________.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes:____________________

____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of Advanced in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

____
Name of Representative

____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

Street Address

City, State and Zip Code

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi))

Witness Signature Date

Advanced Healthcare Center

391 South 1st Street
Jesup, GA. 31545

FAX: 912-427-9851

Phone: 912-427-8433

PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible patient care, and we want you to completely understand our financial policies.

Patients with Insurance
If you have insurance, we will gladly file your claim. Deductibles and co-pays are expected at the time of service. We can only estimate the amount you owe, which is based on the information your insurance carrier provides us. If your insurance carrier pays less than their estimated portion, you will be responsible for the remaining balance upon receiving your bill. Insurance claims outstanding 30 days or more will become your responsibility to pay.

Patients with no Insurance
Full payment is expected on the day of service.

Treatment Plans
Treatment plans are based upon an estimated calculation. It may be necessary to do additional treatments, which will result in a change of fees and the amount you owe.

Missed Appointments
We reserve the right to charge ***$25.00*** for appointments cancelled or missed without 24 hours notice. Example of appointments missed: Medical Follow Up, Diagnostic testing (Vascular, NCV/EMG, Diagnostic Ultrasounds, Etc.) and Physical Therapy. This charge must be paid before another appointment can be scheduled. Arriving ***5 minutes*** or more after your scheduled appointment could result in rescheduling your appointment **without a missed appointment charge.**

Returned Checks
Returned checks will be subject to a ***$35.00*** service fee and charges for any bank fees. This must be paid along with the amount of the check before another appointment can be scheduled. Legal action will take place after 30 days.

Statement of Services
Statement of Services is due upon receipt. We consider an account delinquent after 30 days, and may be assessed a $5.00 per month service charge. Accounts 60 days past due are transferred to collection status. We reserve the right to use outside sources to collect on any past due accounts. You will be responsible for all costs, including attorney fees, court fees, $100.00 administrative fee, etc.

Assignment and Release of Information
I assign the benefits from my insurance carrier to Advanced Healthcare & Spine Institute for the health benefits I am entitled for any services furnished to me. I authorize Advanced Healthcare Center & Spine Institute to release to my insurance carrier any information needed to determine benefits for my care.

Payment Plan Options:
Every patient at AHSI will receive a detailed financial consultation regarding their out of pocket expenses. We offer a variety of payment plan options including hardship agreements when applicable. We make care affordable for everyone.

Authorization
I, the undersigned, have read and agree to be bound by the financial policy's terms stated in the paragraphs above and accept full financial responsibility for the fees charged. I also understand and agree that such terms may be amended from time-to-time.

(Please Print)Name of Patient: ____________________________________

Signature of patient (or responsible party, if patient is a minor or has a legal guardian):

Signature: ____Date: ____________