MILES H. MASON, III, M.D.
AND
MASON PRIMARY CARE

Last Name: _____ First Name: _____M.I. ____

Address: _____City _____

State: _____ ZIP: _____ Email: _____

Primary Phone: _____ Alternate Phone: _____

Birth Date: _____ SS Number: _____

Please Circle:

Male or Female Marital Status: Single or Married or Separated or Widowed or Divorced

Race: Asian or African American or Native American or Pacific Islander or White, or More than one race

Preferred Language: _____ Ethnicity: Hispanic or Non Hispanic

Emergency Contact:

Name: _____

Phone Number: _____Birth Date: _____

Insurance:

Primary Plan: _____Phone:_____

ID # _____ Group # _____

Secondary Plan: _____ Phone: _____

ID# _____ Group #_____

IF PATIENT IS A MINOR, COMPLETE THE NEXT TWO LINES

Father's Name: _____ Phone: _____

Mother's Name: _____ Phone: _____

In order to maintain continuity of care, I give permission to release my medical records to any specialists, hospitals or medical facilities associated with my care plan. I understand that Mason Primary Care or Miles Mason, III, MD abides by HIPAA regulations and that only the records pertinent to the visit will be released.

Signed: _____ Date: _____

FINANCIAL AGREEMENT

This is an agreement between Mason Primary Care and the patient/Debtor named on this form. In this policy the words "you," "your," and "yours" mean the Patient/ Debtor. The word "account" means the account that has been established in your name to which the charges are made and payments credited. The words "we," "us," and "our" refer to Mason Primary Care.

Insurance: We participate in most insurance plans, including Medicare. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage.

Proof of Insurance: All patients must complete our demographic form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance card at the time of your appointment, you may have to be self-pay for your appointment.

Coverage Changes: If your insurance changes, please notify us when you check-in for your appointment. This is so that we can help you receive your maximum benefit.

Co-payment, Deductible, and Co-Insurance: It is your responsibility to pay any deductible, co-pay, co-insurance or any portion of the charges as specified by your plan. This is your contract with your insurance company.

Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurers. You agree to pay any portion of the charges that are not covered by insurance.

Claim Submission: As a courtesy to you, we will submit your claims and assist in any way we reasonably can to help get your claims paid. We will file to both your Primary and Secondary Insurance policy only. We do not file to Tertiary plans. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not respond within 60 days you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Payments: Unless other arrangements are approved by us you are responsible to pay your balances within 30 days of services being rendered. Once we send you a statement the balance on your statement is due and payable upon receipt.

Non-Payment: If your account is over 90 days past due, your account will be referred to a collection agency.

Returned Checks: There is a fee for any checks that are returned from the bank (currently $35).

Motor Vehicle Accident Claims: Our policy is that we do not get involved with motor vehicle claims. All patients being seen regarding a motor vehicle accident will be self-pay and must file their own paperwork with any 3rd party insurance company.

Effective Date: Once your have signed this agreement you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Please be aware we only verify that you have active insurance and we can file a claim on your behalf. Our office does not verify what your specific plan covers.

Patient _____ Date of Birth _____

Signature _____ Date _____

Responsible Party (if not the patient) _____ Date _____

HIPAA
Mason Primary Care

On April 14, 2001, the Health Insurance Portability and Accountability Act became law, with an effective date of April 14, 2003. This law impacts on many aspects of the healthcare industry and expands your rights as a patient to the protection of your Individually Identifiable Health Information (IIHI). We have posted a detailed policy letter on our web site (www.masonprimarycare.com) which you are encouraged to read. Copies will be available, upon request, at your visit.

Our Responsibility:

Our practice is dedicated to maintaining the privacy of your IIHI. In conducting our business, we will create electronic medical records regarding you and the treatment and services we provide to you. We are required by law to provide you with this important information concerning our procedures relative to the use of your IIHI, your rights a to know how we will use or disclose your IIHI, your privacy rights in your IIHI, and our obligations concerning the use and disclosure of your IIHI.

We may use and disclose your Personal Healthcare Information (PHI) in the day-to-day operations of our office as pertains to Treatment, Payment, and Operations (TPO). This relates to the continuum of care between primary care givers and consulting physicians as well as healthcare issues or payment events. Or we may use your PHI within our practice to evaluate our quality of care, conduct cost management, or business planning activities.

Further, we may use your IIHI to contact you for medical purposes, appointment reminders, to inform you of certain treatment options/alternatives or as directed by you to release information to family or care giving personnel.

We may, from time to time, be required to release your PHI as a result of federal or state mandate or by competent legal directive.

Your Rights:

You have a right to request that we communicate with you in a certain manner or location such as work or at home.

You have the right to request a restriction to use or disclose of your IIHI to certain individuals or entities.

You have the right to inspect or obtain a copy of the IIHI, less psychotherapy notes. This request must be made in writing.

You may ask to amend health information, if you believe that it is incorrect or incomplete, and you may ask for amendment of your PHI, subject to restrictions as established by the HIPAA law.

You have the right to request an accounting of the disclosures of your PHI the request must be in writing.

This represents a summary of our legal mandate with the details to be found in the published Policy Statement. You can be assured that we will make every attempt to honor your privacy and to maintain our record of confidentiality. You may contact our office with any questions you may have regarding new law.

Missy Martin
HIPAA Compliance Officer

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights (HIPAA) .

_____ _____

Print Patient Name Date

_____

Patient Signature

PATIENT RECORD OF DISCLOSURE
MASON PRIMARY CARE

Patient Name:_____ Date of Birth:_____

I authorize the following individuals to have full access to my health information.

Print Name	Relationship	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give my permission for you to leave any medical/lab information for me at the following phone numbers:

Primary #_____

Secondary # _____

Patient Signature	Date
_____	_____

MEDICAL HISTORY

MASON PRIMARY CARE

P.O. Box 248
3500 McClure Bridge Road
Duluth, GA 30096
(770)476-3636 / FAX (770)476-5845

DATE _____ NAME _____

PAST MEDICAL HISTORY

Please check if you have ever had:

CARDIAC	PULMONARY	GASTROINTESTINAL	RHEUMATOLOGIC
____ High Blood Pressure ____ Heart Attacks ____ Congestive Heart Failure ____ Arrhythmias ____ Murmur ____ _____	____ Emphysema ____ Asthma ____ Pneumonia ____ Tuberculosis ____ _____	____ Gallstones ____ Hepatitis ____ Diverticulosis/itis ____ Colonic Polyps ____ Ulcers ____ Hemorrhoids ____ _____	____ Arthritis ____ Chronic Fatigue Syndrome ____ Polymyalgia Rheumatica ____ Fibromyalgia ____ Lupus ____ _____
DERMATOLIGIC	**HEMATOLOGIC / ONCOLOGIC**	**ENDOCRINOLOGIC**	**PSYCHIATRIC**
____ Psoriasis ____ Eczema ____ Skin Cancers ____ _____	____ Cancer, Type _____ Treatment _____ ____ Anemia ____ Blood Clots ____ _____	____ Diabetes ____ Hyper / Hypothyroidism ____ Elevated Cholesterol ____ Osteoporosis ____ _____	____ Depression ____ Anxiety ____ _____
NEUROLOGIC	**RENAL**	**INFECTIONS**	**ACCIDENTS / INJURIES**
____ Strokes ____ Seizures ____ Headaches ____ _____	____ Urinary Tract Infections ____ Kidney Stones ____ _____	____ Venereal Diseases (Gonorrhea, Chlamydia, Warts, Syphilis) ____ Rheumatic Fever ____ _____	____ _____ ____ _____

ALLERGIES

SURGERIES *(List type, year, anesthesia, complications)*

IMMUNIZATION / HEALTH CARE MAINTENANCE LIST *(List dates and abnormal findings)*

□ Hepatitis B	□ Flexible Sigmoidoscopy
□ Pneumovax	□ Spool Check for Blood
□ Flu Shot	□ Cholesterol Check
□ Tetanus Booster	□ Prostrate Check / PSA Level
□ TB Skin Test	□ Last EKG (electrocardiogram)
□ Hepatitis A (Series of 2 completed)	□ Last Chest X-ray
□ Meningitis (esp. college bound)	□ Polio Immunization
□ Gardasil (Cervical Cancer Vaccine)	□ Varicella (Chicken Pox) Vaccine (or Serologic Proof of Immunity)
□ MMR (Rubella screen especially important for Child-bearing age female)	□ Eye Exam, intraocular pressure check

FAMILY HISTORY *(Parents, grandparents, siblings)*

Family Member *Age of Onset:*	*Family Member* *Age of Onset:*
□ Cancer	□ Strokes
□ High Blood Pressure	□ Drug or Alcohol Addiction
□ Heart Disease	□ Glaucoma
□ Diabetes	□ Bleeding Diseases
□ Other:	

MEDICAL HISTORY

MASON PRIMARY CARE

P.O. Box 248
3500 McClure Bridge Road
Duluth, GA 30096
(770)476-3636 / FAX (770)476-5845

DATE _____ NAME _____

MEDICATIONS *(Dosage, frequency)*

FEMALES ONLY / GYNECOLOGIC HISTORY

Pregnancies _____ Births _____ Miscarriages _____

1st Day of Last Menstrual Period _____ Method of Birth Control: _____

Age at Onset of Periods: _____ Frequency: _____ Length of Period: _____

□ Leakage of Urine _____ □ Abnormal Discharge _____

□ Prolonged or Abnormal Bleeding _____ □ Abnormal PAP Smear, type or treatment _____

□ Pelvic Pain _____ □ Gynecologic Surgeries and reason why_____

Last PAP _____ Last Mammogram _____ Last Breast Exam _____

PERSONAL HABITS / RISK FACTORS

Smoking: □ No □ Yes # Packs per day _____ # of years _____ Quit: _____

Alcohol: □ No □ Yes Type: _____ Amount per week: _____

Drugs (marijuana, cocaine, crack, etc.) □ No □ Yes Type: _____

Have you engaged in activity putting you at risk of getting AIDS? □ No □ Yes

Do you wish to be tested for AIDS? □ No □ Yes

Have you ever worked with hazardous materials, asbestos, chemicals? □ No □ Yes

History of Blood Transfusions? □ No □ Yes Year _____

Are you in a relationship in which you have been hurt by your partner? □ No □ Yes

Are you experiencing any sexual dysfunction/dissatisfaction? □ No □ Yes

PHYSICIAN NOTES