Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ SSN# _____ [ ]Male [ ]Female

Employer _____

[ ] Asian [ ] Black [ ] Hispanic [ ] White [ ] Other [ ] Divorced [ ] Married [ ] Single [ ] Widow

Preferred Drug Store _____ Phone # _____

Request for Alternative Communications

Messages may be left for me by the following alternative mean:

Voice Mail [ ] Yes [ ]No Text [ ] Yes [ ] No

My messages and/or health information may be given to the following representatives:

Name	Relationship
_____	_____
_____	_____

Emergency Contact: List Persons that we can contact in case of an emergency.

Name	Phone	Relationship	Release Information
_____	_____	_____	Y/N
_____	_____	_____	Y/N

Primary Insurance Company: _____ Secondary Insurance: _____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance, and any other plans to Athens Area Internal Medicine. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure the payment. If I choose not to sign, I will still be responsible for all charges.

Signed _____ Date _____

1500 Oglethorpe Ave, Suite 3100 • Athens, Georgia 30606
Phone: 706.850.6383 • Fax: 706.850.6389
www.athenamedicalclinic.com

Health History

Patient Name _____

Today's Date _____

DOB: _____ Age: _____

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

When was your last physical? _____

Do you see other physicians? If so, please list: _____

1. Please list all ALLERGIES (FOOD, DRUGS, AND ENVIRONMENT) **[ ] Patient Denies any ALLERGIES**

_____ _____

_____ _____

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate the year these occurred.

2. PAST MEDICAL HISTORY - Have you ever had the following: **( ) Patient Denies any PMH**

	DATES		DATES		DATES
[ ] Abnormal heart rythm/palpitations		[ ] Diabetes		[ ] Liver disease	
[ ] Anemia		[ ] Diverticulitis		[ ] Macular degeneration	
[ ] Anxiety		[ ] Fibrocystic breast disease		[ ] Menopausal symptoms	
[ ] Arthritis/Type		[ ] GERD/indigestion		[ ] Osteoporosis/osteopenia	
[ ] Asthma		[ ] Glaucoma		[ ] Peptic ulcer disease	
[ ] Atrial fibrillation		[ ] Headaches		[ ] Prostate problems	
[ ] Blood clots DVT/PE		[ ] Heart attack		[ ] Seizures (Type)	
[ ] Cancer (Type)		[ ] Heartburn		[ ] Skin Cancer (Type)	
[ ] Congestive heart failure		[ ] Hemorrhoids		[ ] Thyroid problems	
[ ] COPD/emphysema		[ ] Hepatitis-A,B, or C		[ ] Urinary incontinence	
[ ] Coronary artery disease/angina		[ ] High blood pressure		[ ] Urinary tract infections/ recurrent	
[ ] Dementia/memory loss		[ ] High cholesterol		[ ] Sleep Apnea	
[ ] Depression		[ ] Irritable bowel syndrome		[ ] Migraines	
[ ] Other illness		[ ] Kidney stones			

3. PAST SCREENINGS - When have you had the following:

	DATE	ORDERING PHYSICIAN
[ ] Last bone density exam		
[ ] Last colonoscopy		
[ ] Last mammogram		
[ ] Last pap smear		
[ ] Last prostate exam		

4. PAST SURGICAL HISTORY - Have you ever had the following: **( ) Patient Denies any PSH**

	DATES		DATES		DATES
[ ] Appendix		[ ] Cosmetic (Type)		[ ] Hernia Repair (Type)	
[ ] Back Surgery		[ ] C-Section		[ ] Hysterectomy(Ovaries Removed)	
[ ] Breast Biopsy		[ ] D & C		[ ] Tubal Ligation	
[ ] Cataract		[ ] Gallbladder		[ ] Tonsils / Adenoids	
[ ] Joint Replacement		[ ] Other		[ ] Other	
[ ] Heart Bypass		[ ] Other		[ ] Other	

5. **FAMILY HISTORY** - Has any blood relative (parents, siblings, maternal/paternal aunts, uncles, grandparents) had any of the following:

	Relationship		Relationship
[ ] Cancer (Type)	_____	[ ] Kidney Problems	_____
	_____	[ ] Leg / Lung Blood Clots	_____
[ ] Depression	_____	[ ] Osteoporosis	_____
[ ] Diabetes	_____	[ ] Seizure Disorder	_____
[ ] Elevated Cholesterol	_____	[ ] Stroke	_____
[ ] Genetic Problem	_____	[ ] Thyroid Disease	_____
[ ] Heart Disease	_____	[ ] Other	_____
[ ] Hypertension	_____	[ ] Other	_____

6. **MEDICATIONS** - Please list all medications you are currently taking (Please continue on back of sheet)

CURRENT MEDICATIONS	DOSAGE	HOW OFTEN PER DAY	PRESCRIBING DOCTOR

7. **SOCIAL HISTORY:**

Tobacco: Do you use tobacco? [ ] Yes [ ] No [ ] Stopped When started?_____ When stopped? _____
What form of tobacco do/did you use? [ ] cigarettes [ ] cigars [ ] pipe [ ] dip [ ] chew [ ] snuff
Would you be interested in quitting tobacco in the next month? [ ] Yes [ ] No

Alcohol: Do you use alcohol? [ ] Yes [ ] No Describe: _____

Recreational Drugs: [ ] Yes [ ] No [ ] Stopped Describe:_____

Exercise: Do you exercise? [ ] Yes [ ] No
In the past 7 days, how many days did you exercise? _____
On the days you exercised, for how long did you exercise? _____ minutes
How intense was your typical exercise? (choose one)
[ ] Light (like stretching or slow walking) [ ] Heavy (like jogging or swimming)
[ ] Moderate (like brisk walking) [ ] Very heavy (like fast running or stairs)

State or country of birth: _____ Education: (highest degree in school) _____

Occupation: (before retirement) _____ Hobbies: _____

Do you use seat belts? [ ] Yes [ ] No Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Do you have a living will? [ ] Yes [ ] No If yes, please bring in a copy.

Do you have a durable power of attorney? [ ] Yes [ ] No If yes, please bring a copy.

Travel History: Have you traveled out of the country in the past one year? If yes, when and where:

_____

Nutrition: (please answer about the past seven (7) days):

How many servings of fruits and vegetables did you typically eat each day? _____
(1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables or 1 medium piece of fruit. 1 cup = size of a baseball)

How many servings of high fiber or whole grain foods did you typically eat each day? _____
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole grain or high fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal , or 1/2 cup of cooked brown rice or whole wheat pasta)

How many servings of fried or high fat foods did you typically eat each day? _____
(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, donuts, creamy salad dressings and foods made with whole milk, cheese, or mayonnaise)

How many sugar-sweetened (not diet) beverages did you typically consume each day? _____

8. IMMUNIZATIONS:

Tetanus	[ ] Yes	[ ] No	Date: _____	Flu	[ ] Yes	[ ] No	Date: _____
Gardasil	[ ] Yes	[ ] No	Date: _____	Hepatitis A	[ ] Yes	[ ] No	Date: _____
Hepatitis B	[ ] Yes	[ ] No	Date: _____	Pneumovax	[ ] Yes	[ ] No	Date: _____
Shingles	[ ] Yes	[ ] No	Date: _____	Prevnar (Available since 2015)	[ ] Yes	[ ] No	Date: _____

9. REVIEW OF SYSTEMS:

Please circle any of the following symptoms you have had in the last year.

Constitutional:	Fatigue	Unexplained weight loss	Loss of appetite			
Eyes:	Change/vision	Blurred vision				
HENT:	Sinus pain	Headaches	Sore throat	Postnasal drip	Dizziness	Vertigo
Breast:	Tenderness	Masses				
Cardiovascular:	Chest pain	Palpitations	Fainting	Shortness of breath	Lower extremity swelling	
Respiratory:	Shortness of Breath	Cough	Wheezing	Hoarseness	Blood in sputum	
Gastrointestinal:	Painful swallowing	Reflux	Bloating	Nausea/vomiting	Change in bowel habits	
Genitourinary:	Urgency	Frequency	Painful urination	Hematuria	Urinary incontinence	
Integument:	Rash	Itching	New skin lesion	Change in existing skin lesion		
Neurological:	Memory difficulties	Transient weakness	Tremors	Muscular weakness	Tingling/numbness	Incoordination
Musculoskeletal:	Back pain	Joint pain	Muscle pain	Joint swelling		
Endocrine:	Increased urination	Increased thirst	Hot flashes			
Psychiatric:	Anxiety	Depression	Difficulty sleeping			
Heme-Lymph:	Lymph node enlargement or tenderness					
Allergic-Immu:	Sinus	Allergy	Skin irritation			

_____ _____

Signature of Patient or parent if minor **Date**

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8-9: You have an average amount of daytime sleepiness.
10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.

ATHENA
MEDICAL CLINIC

Patient Name: _____

I authorize the use and disclosure of the above-named patient's protected health information as described below.

Organization authorized to release the information: _____

Release information to: _____

Purpose of request: _____

Information to be released for the following dates: From: _____ To: _____

I understand that information in my health record may include information relating to HIV/AIDS confidential information, and may include psychosocial, mental health or alcohol and drug use information and I also authorize the release of this information.

I understand this authorization may be revoked by me at any time. This must be in writing to the Director of Medical Records. This would not apply to information that has already been released prior to my written revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
I understand that information disclosed under this authorization may be subject to redisclosure by the recipient of such information and the information may no longer be protected under the terms of this authorization or by federal privacy laws.

I understand I may refuse to sign this authorization.

_____ _____
Signature of Patient or Legal Representative Date

Printed name of Patient/Legal Representative _____

If signed by Legal Representative, describe relationship to patient _____

Patient Name: _____

Date of Birth: _____ SSN _____

1500 Oglethorpe Ave, Suite 3100 • Athens, Georgia 30606
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ATHENA MEDICAL CLINIC

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

"Protected health information" (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present, or future payment for the provision of health care.

Your Rights Regarding Your PHI

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the future

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

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- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at info@cps-therapy.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share YOUr information ifwe believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Sharing of psychotherapy notes

Our Uses and Disclosures
IF you give us permission, how would we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you
- We can use your health information and share it with other professionals who are treating you.

Example: Your physician and I may need to coordinate your care.

Run our organization
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services
- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Acknowledgement

hereby acknowledge receiving a copy of this notice - *signature age is included in the intake Racket*

Athena Medical Clinic and Sleep Medicine Associates
Missed Appointment Policy

We understand that occasionally an appointment will need to be cancelled or rescheduled. To allow for the appointment time to be given to another patient, we require that all cancellations or reschedules be made with **at least 48 hours (business day) notice.**

Please contact our office at 706-850-6383 if you need to cancel or reschedule your appointment.
~~~~~~

I understand the above policy and hereby agree to be present at my scheduled appointment. In the event that I either miss an appointment or cancel with less than 48 hours notice, I understand I am responsible for that missed appointment, regardless of insurance coverage.

The fee for a regular missed appointment is $25.00 and the fee for a missed, late Cancellation or late Reschedule of Sleep Study appointment is $250.00.

Patient Signature: ______________________________ Date: ____________

Athena Medical Clinic and Sleep Medicine Associates
HIPAA – Health Insurance Portability and Accountability Act

I, ____________________________________, understand that a copy of the HIPAA Policy is available, should I want a copy. I have had the opportunity to ask questions and the notice has been explained to me.

Patient's Signature ______________________________________ Date ________________
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