DR. IRFAN SYED
DR. AMBER SYED
3584 OLD MILTON PKWY
ALPHARETTA, GA 30005
PHONE: 678-691-3388
FAX: 678-395-7702
www.medassocga.com

PATIENT INFORMATION

NAME:_____ Email :_____
(first) (middle initial) (last)

Preferred Name:_____

ADDRESS: _____
(number and street) (apt #) (city) (state) (zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____ ok to leave msgs? YES NO
(cell or home) (cell or home)

BIRTH DATE: _____/_____/_____ SEX: □Female □Male MARITAL STATUS: _____

RACE: _____ PRIMARY LANGUAGE: _____ SS #: _____

ETHNICITY: □Hispanic or Latino □Non-Hispanic or Latino □Unknown □Declined

HOW DID YOU HEAR ABOUT US?: _____

PHARMACY WE CAN SEND PRESCRIPTIONS TO: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE#: _____ ALTERNATE PHONE#: _____

HEALTH INSURANCE INFORMATION

*please be aware that MAG is not responsible for verification of in-network participation with your insurance carrier _____ (**initial**)

PRIMARY INSURANCE

_____
ID# GROUP#

_____
POLICY OWNER NAME

_____
POLICY OWNER DOB & RELATIONSHIP TO PATIENT

_____

SECONDARY INSURANCE

_____
ID# GROUP#

_____
POLICY OWNER NAME

_____
POLICY OWNER DOB & RELATIONSHIP TO PATIENT

_____

I hereby authorize Medical Associates of Georgia to release medical information necessary for insurance reimbursement. I hereby authorize and assign payment directly to MAG for insurance benefits herein specified and otherwise payable to me. I understand that I am financially responsible to MAG for all charges incurred regardless of potential insurance benefits. I understand it is my responsibility to understand my own insurance benefits and financial responsibilities in relation to my copay, coinsurances, deductibles and coverages.

X_____ X_____ MRN #_____
Signed Date

New Patient Medical History* - *Please complete this form prior to your first appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Diagnosed*	*Condition / Disease*	*Year Diagnosed*
❑ Hypertension		**Other Medical Conditions:**	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Sexual Orientation: _____	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to any STD's? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

- ❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Echocardiogram	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Hepatitis C testing	
HIV Test		Chest X-Ray		Metabolic Testing	

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DISCLOSURE OF HEALTH CARE INFORMATION NOTICE

I understand that as part of my healthcare, Medical Associates of Georgia, Inc. originates and maintains paper and/or electronic records describing my demographic information as well as records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information may serve as:

- ✓ A basis for planning my care and treatment.
- ✓ A means of communication among the many health professionals who may contribute to my care.
- ✓ Information for applying my diagnosis and surgical information.
- ✓ A means by which a third-party payer can verify that services billed were actually provided.
- ✓ A tool for routine healthcare operations such reviewing the competence of healthcare professionals and assisting quality.
- ✓ A means by which to contact me regarding my treatment, follow-up, and various test results.

I understand that I have the following rights and privileges:

- ✓ The right to review the "Notice of Information Practice" prior to signing this consent.
- ✓ The right to object to the use of my healthcare information for directory purposes.
- ✓ The right to request restrictions as to how my healthcare may be used or disclosed to carry out treatment, payment or healthcare operations.
- ✓ The right to revoke any prior consent, as provided in writing, except to the extent that the organization has already taken action.

I understand that Medical Associates of Georgia is not required to agree to the restrictions requested. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Medical Associates of Georgia reserves the right to change their notice of privacy practices. I will be notified of the changes in writing, upon my next visit.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax and/or e-mail.

In the event Medical Associates of Georgia refers me to a SPECIALIST, I hereby authorize Medical Associates of Georgia to release my medical records to the SPECIALIST and also to authorize the SPECIALIST to release my medical records and SPECIALIST REPORTS back to Medical Associates of Georgia.

I wish to implement the following limitations or allowances regarding the use or disclosure of my healthcare information:

_____

_____

I fully understand and ❑ ACCEPT ❑ DECLINE the terms of this consent. (Please check one)

_____ _____

Patient or Guardian Signature Date

FOR OFFICE USE ONLY:

- ❑ Consent received by:_____
- ❑ Consent refused by patient, and treatment refused as permitted
- ❑ Consent added to the patient's medical record on _____

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PAYMENT AND INSURANCE POLICY

Medical Associates of Georgia, Inc requires that all co-payments and/or deductibles are paid in full prior to service. Medical Associates of Georgia will collect the amounts in which we have agreed upon with your Insurance Company. If those amounts are not available, you will be charged our rate and refunded once your insurance company has completely processed the claim. Medical Associates of Georgia will submit the necessary claim forms to your health insurance company for processing. In the event that your insurance company suspends the claim due to information needed from you, you will be responsible for the total bill until you provide that information and the claim is processed. From our experience, we have found that few insurance plans cover the complete cost involved. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating your claims. All charges not covered by your insurance company will be billed to you. Payment will be due upon receipt of statement. All statements not paid will be turned over to a collection agency. Medical Associates of Georgia requires patients without insurance to pay the full charges prior to service. Medical Associates of Georgia accepts cash and credit cards as payment.

ASSIGNMENT OF BENEFITS

I hereby authorize all payments for services rendered to dependents or myself, which are payable to me under the terms of my insurance policy, to be paid directly to Medical Associates of Georgia for services provided. I further authorize the release of any necessary information, including medical information form this office, to my insurance carrier. I understand and agree that I am fully financially responsible for charges not paid by my insurance company.

HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have been offered the opportunity to receive a copy of the "Notices of Privacy Practices" that explains when, where, how, and why my confidential health information may be used or disclosed.

CONSENT FOR TREATMENT

I hereby consent, for myself or dependent, to diagnostic and/or therapeutic medical treatment, procedures, photographs, digital, or other images deemed necessary by the physician(s). I acknowledge that there is no guarantee as to the results of procedures and medical treatments performed.

CONSENT TO BE CONTACTED

I hereby consent to allowing, Medical Associates of Georgia or any contracted agencies used, to contact me to discuss information relative to my medical treatment or services in which I have received.

I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage etc. constitutes fraud.

_____ _____

Signature of Patient/ Guardian Date

_____ _____

Name of Patient/ Guardian (Please Print) MRN

2019 UPDATED OFFICE POLICIES

No Show policy: We strive to honor appointment times and respect patient's schedules. For this reason, patients who do not call to cancel or reschedule their appointments within 24 hours of their appointment time will be charged a $25 no show fee. Patients who do not call and cancel appointments or fail to show up repeatedly may be considered for dismissal from the practice. _____ (initial)

Rx Refills: Prescription refills are generally handled during your office visit by Dr. Syed himself. The office staff does not refill medications by phone. All prescriptions are electronically sent to your pharmacy by the close of the business day. All patients must have been seen within 3 months to obtain refills unless otherwise noted by Dr. Syed. _____ (initial)

Referrals: Please note that it may take up to 48 hours to obtain a referral to a specialist. In most cases, referrals can be given the same day. In the case of HMO policyholders, patients are responsible for obtaining referrals for specialist visits. Backdated referrals will not be processed so please be certain your referral has been approved by your insurance before making any specialist appointments. _____ (initial)

Lab Results: Lab results are usually available within 1 week depending on the type of testing being completed. The physician may require you to schedule an additional office visit to go over test results in the case of abnormalities _____ (initial)

Insurance and Billing: Patients are responsible for a co-payment, co-insurance or deductible which is due at the time of your visit. Deductibles are expected in full unless special arrangements are made. We do not want issues of payment to keep you from taking care of yourself and your health; we will make arrangements through our office which can be discussed at the time of your visit. Monthly statements on past due amounts will be mailed monthly. _____ (initial)

Medical Records: Request for your medical records from our office requires your signature on the Medical Release form. Medical records are available with adequate notice. If you would like to request a copy of your records please complete the form while at our office or request the form to be faxed or emailed to you. There will be a charge depending on how many pages please call for rates. Charges for copying are in accordance with State provisions. There is no charge if your records are to be copied and sent to a physician or medical facility. _____ (initial)

By initialing/signing I agree to the above terms.

_____

Patient Signature

_____

Patient Name Print

_____

Date

_____

DOB