**Hartley Health & Wellness Associates, LLC**

Shanda T. Hartley, FNP – C

In association with:

Michelle A. Huggins, MD

**Please complete the attached patient information sheet. Return it with the following:**

* **Current copy of Primary and Secondary Insurance cards (front and back)**
* **Current list of Medications (MAR – the facility can provide this for you)**
* **Copy of POA and DNR paperwork**

**or**

* **You can also go directly to hartleyhealthandwellness.org and complete your paperwork online.**
* **Please sign the lighted areas to complete your required paperwork.**

**You may return these via email** [**hartleyhealthandwellnessinfo@gmail.com**](mailto:hartleyhealthandwellnessinfo@gmail.com) **or fax 470-299-9936. Please feel free to contact our office with any questions.**

**Thank you,**

**Irene B. Kearse**

**Office Administrator**

|  |  |
| --- | --- |
|  | Hartley Health & Wellness Associates, LLC  Telephone Number: (678) 880-6698  Fax Number (470) 299-9936 |

# Patient Information Website: hartleyhealthandwellness.org

## Personal Information

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  |  |
|  | Last | First | M.I. |

|  |  |  |
| --- | --- | --- |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | City | State | ZIP Code |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: |  | Mobile Phone: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Birth Date |  | Sex: M F | | | SSN | |  | |
| Smoke? Y/N | How many per day? | |  | Quit: Y/N | | When? | |  |

|  |  |  |
| --- | --- | --- |
| Medicare #: |  | Is Medicare the Primary Insurance? Y/N |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance ID #: |  | Group ID # |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency/POA? |  | Relationship: |  |

## Health History

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Allergies: | Reactions to Allergen: | | Past Medical History: |  | | Past Surgical History: |  | | Family History |  | |
|  |

|  |  |
| --- | --- |
| **Name:** | **Relationship** |
| **Address:** | |
| **Telephone** | **Email:** |

## Billing Information

**POA/Billing:**

**AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D. O. B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***I hereby authorize:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release visit notes, laboratory results, radiographic findings and all important information pertaining to my medical care to:

Hartley Health and Wellness Associate, LLC

207 Crestmont Way

Canton, Georgia 30114

O: 678-880-6698 F: 470-299-9936

**Specify Dates (or date ranges) if necessary:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This request is for the purpose of: establishing medical care**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months or on this date listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorization is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ DO NOT RELEASE (Indicate Check Mark)

|  |
| --- |
| **FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.** |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Authorized Representative Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Representative Authority to Act on Behalf of Patient Signature of Witness**

I hereby signed that I received and read the Hartley Health and Wellness Associate LLC Notice of Privacy Practices (copy can be found on HartleyHealthandWellness.org)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Hartley Health and Wellness Associate LLC for medical or surgical services or items rendered by Hartley Health and Wellness Associate LLC. Should my insurance carrier deny Hartley Health and Wellness Associate LLC payment, I understand that I am financially responsible for the charges. I authorize Hartley Health and Wellness Associate LLC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Hartley Health and Wellness Associate LLC to provide medical care services to

(Resident’s Name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_