



New Patient Packet

In order for our providers to be able to provide you with the best care possible, we must have the following items listed below prior to your appointment with us.

- New Patient Packet filled out prior to appointment scheduling
- Current and Valid Driver's License/Identification
- Current and Valid Insurance Cards
- List of your current medications
- Name and phone number of the prescribing physician if you are taking a blood thinner
- All Medical Records relating to your current pain (past 2 years)
- Any MRI's, CT Scans or X-rays to your visit

Please remember that all copayments, deductibles and any other patient responsibilities are due at the time of service.

We do not accept checks.

Thank you for your understanding and cooperation.

-Georgia Pain and Spine Care

<p><i>Newnan Office</i> 1665 Hwy 34 East, Suite 100 Newnan, GA 30265</p>	<p><i>LaGrange Office</i> 303 Smith Drive – 2nd Floor LaGrange, GA 30240</p>	<p><i>Peachtree City Office</i> 1975 Hwy 54 West, Suite 100 Peachtree City, GA 30269</p>
<p><i>Dr. Brownlow</i> <i>Dr. Remley</i> <i>Dr. Vaid</i> <i>Dr. Kassamali</i> <i>Dr. Kirschenbaum</i></p>	<p><i>Dr. Brownlow</i> <i>Dr. Remley</i></p>	<p><i>Dr. Brownlow</i> <i>Dr. Remley</i> <i>Dr. Vaid</i></p>

Dear New Patient,

Thank you for choosing Georgia Pain and Spine Care for your pain management needs. We are honored you have chosen us to fulfill the important role of caring for you.

Our clinic requires pre-registration for all of our new patients. This service allows our nurses to review your health information as well as enables us to verify all demographic and insurance information prior to your visit. Please be sure to arrive 30 minutes early to your appointment. Your new patient packet must be completed and turned into our New Patient Coordinator before we can schedule an appointment for you. Please also be mindful that all copayments, deductibles and any other patient responsibilities are due at the time of service. For your convenience we accept cash, Visa, MasterCard and Discover. **We do not accept checks.** Initial _____

Please contact our office 48 hours in advance to your scheduled appointment to ensure we have received any medical records that needed to be faxed or sent to our office. Initial _____

If at any time you are unable to make your scheduled appointment, please notify us **48 hours in advance**. We are glad to reschedule your appointment at a more convenient time for you. We greatly appreciate your time and consideration and look forward to seeing you at your appointment with us. Initial _____

Sincerely,

Georgia Pain and Spine Care Staff Members

Georgia Pain and Spine Care - Patient Information and Demographics

Personal Information:

Today's Date: _____ SSN: _____
First Name: _____ MI: _____ Last Name: _____
Street Address: _____ APT/STE#: _____ P.O. Box#: _____
City, State, Zip: _____ Date of Birth: _____
Age: _____ Gender: Male Female Primary Phone: _____
Secondary Phone: _____
Email: _____@_____.com
Marital Status: Married Single Divorced Widowed

In the event of an emergency, please contact:

Name: _____ Relationship to Self: _____
Primary Phone: _____ Secondary Phone: _____

Occupation/School Information:

Employer: _____ Occupation/Job Title: _____
Employment Address: _____

Do you currently attend school? Yes No
Are you a full time or part time student? Full time Part time

Insurance Information:

Primary Insurance: _____ Insured's Name: _____
Policy #: _____ Group #: _____
Patient's Relationship to Insured: Self Spouse Child Other
Employer: _____ SSN: _____ DOB: _____

Secondary Insurance: _____ Insured's Name: _____
Policy #: _____ Group #: _____
Patient's Relationship to Insured: Self Spouse Child Other
Employer: _____ SSN: _____ DOB: _____

Who referred you to our facility?

Physician: _____ Family Member Advertisement Other: _____



**Notice Regarding Insurance Claims and Payments
Financial Agreement**

If we are filing insurance for your visit, we must have complete information and any required information of the visit. If you are unable to provide this information, we will be unable to file your insurance and payment at the time of services rendered will be required. Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your deductible and/or co-insurance will be your responsibility. Procedures that are excluded from coverage based on your plan's determination of medical necessity will also be your responsibility. Your office visit co-pay is due **at the time of the visit** and in many cases, may only cover the office visit charge. Your insurance company will consider any procedures performed surgery and deductibles and co-insurance may apply. For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request. If your account is 61 or more days overdue or if your balance is less than \$200, you must pay in full before your next appointment can be scheduled.

By signing below, you agree and state that you have read and understand the above information in regards to Insurance, Payments and Financial Obligations and that you are solely responsible for payment for the services you receive.

Patient's Signature: _____

Date: _____

DESCRIPTION OF YOUR PAIN

Name: _____ DOB: _____ Height: _____ Weight: _____

Please fill out the form to help us learn more about your condition so we may better assist your needs.

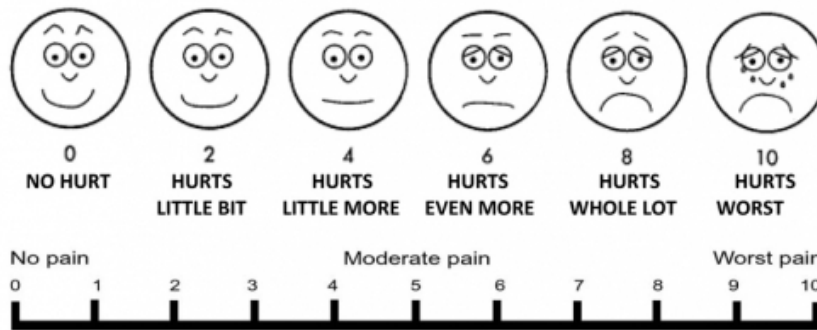
1. Where is your pain located? _____

2. How would you describe your pain in words? (Is it burning, aching, etc.)

3. How do you rate your pain on a scale of 1 to 10? _____

(Use the pain
below to help

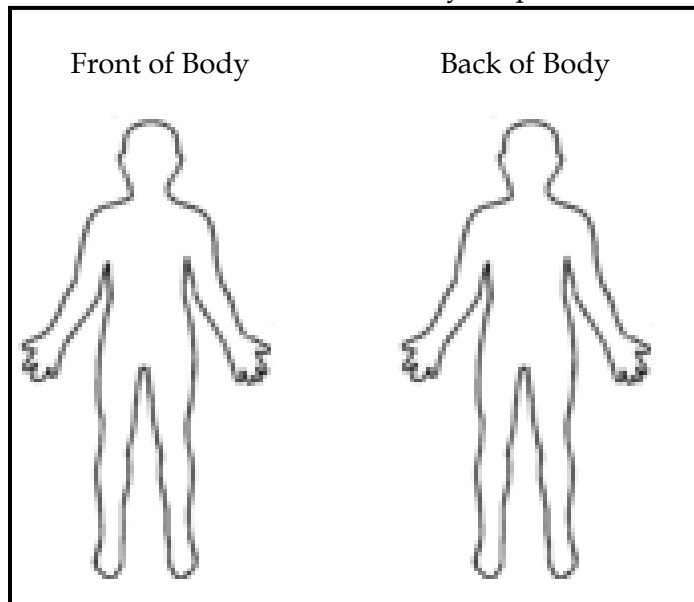
scale measurement
you decide)



4. Does your pain affect your daily activities? _____

5. Does your pain wake you up at night? _____

6. Please use the diagram below to circle or color in where your pain is located:



PATIENT HISTORY AND PAST TREATMENTS

Medication

1. Are you allergic to anything? Please also list any foods you have allergies to as well.

2. Do you take any anticoagulants or blood thinners?

Yes - Please list: _____ No

3. Please list all medications you are currently taking. (Please use the back of this page if you cannot fit all of your medications in the following list.)

Family and Personal Medical History

4. Please list which relative(s), including yourself, have had or have the following:

<p>Heart Attack <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Alcoholism <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Bipolar Disorder <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Heart Disease <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Lung Disease <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Rheumatoid Arthritis <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Acid Reflux <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p>	<p>Stroke (CVA) <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Cancer <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Diabetes <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Drug Abuse <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Neurologic (seizures, Parkinson's disease, etc.) <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Schizophrenia <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p> <p>Bleeding Ulcers <input type="radio"/> Self <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Sister <input type="radio"/> Brother <input type="radio"/> Other</p>
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5. Have you had any surgeries in the past two years? Yes - Explain: _____ No

Social History

<p>Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widow(er)</p>	<p>Do you smoke: <input type="radio"/> Yes - How often? _____ <input type="radio"/> No</p>	<p>Do you drink alcohol: <input type="radio"/> Yes - How often? _____ <input type="radio"/> No</p>
<p>Do you use recreational drugs: <input type="radio"/> Yes - Explain: _____ <input type="radio"/> No</p>	<p>Are you on a special diet: <input type="radio"/> Yes - Explain: _____ <input type="radio"/> No</p>	<p>Use of caffeine: <input type="radio"/> Yes - How often? _____ <input type="radio"/> No</p>

TREATMENT AGREEMENT

Medications prescribed by Georgia Pain and Spine Care (GPSC) providers can have serious side effects. In order to ensure your health and safety, something very important to us, we require your agreement to adhere to the following twelve guidelines. Please place your initials on the blank line next to each number to document your agreement to follow each of the twelve guidelines. Please ask for any clarifications before signing off if necessary.

1. _____ **Dosing Schedule:** I will follow the dosing schedule prescribed by my doctor.
2. _____ **Sharing, Exchanging, or Selling:** I will never share, exchange, or sell my medications with anyone for any reason.
3. _____ **Replacement Policy:** I understand that GPSC WILL NOT REPLACE LOST OR STOLEN MEDICATIONS.
4. _____ **Heavy Machinery:** I will not drive or operate heavy machinery while taking medications that may cause drowsiness or impair my cognitive functioning.
5. _____ **Adverse Side Effects or Dosing Problems:** I will notify GPSC if I experience any adverse side effects or dosing problems with my medications. If the doctor alters my medications, I understand that I may be asked to bring in any unused medications for proper disposal at GPSC.
6. _____ **Only One Prescribing Source:** I agree that if I receive controlled substances (i.e., narcotics, opioids) from GPSC prescribers that I will NOT request or accept any controlled substances or other pain medications from any other prescribers without my GPSC doctor's consent.
7. _____ **Only One Pharmacy:** I will only use one pharmacy for my pain medications. If very unusual circumstances require the use of an alternative pharmacy, I will notify GPSC immediately and provide the appropriate contact information for the alternative pharmacy.
8. _____ **Refills Require a Scheduled Appointment in Person:** Providers will NOT order refills or increase dosages of narcotic medications over the phone.
9. _____ **Checks for Proper Usage:** If you are using narcotic/opioid medications, GPSC can request that you complete a pill count or a urine drug screen (UDS) AT ANY TIME. These key checks for proper usage of these powerful medications will require you to GPSC all of your current medications and/or provide a urine sample at GPSC within four hours of the call that requests these vital checks. If either of these checks for proper usage reveals major deviations from the prescribed plan or positive tests for illegal substances, I understand that I may be dismissed from the practice immediately. I also agree to pay any cost that is not covered by my insurance for these important checks.
10. _____ **Altered Prescriptions.** If I used a forged, falsified, or altered prescription, then I will be dismissed from GPSC immediately; this serious breach of our agreement may also result in further law enforcement or legal action being taken.
11. _____ **Harassment.** Abusive or harassing behavior toward GPSC staff will not be tolerated. Such actions will be reviewed carefully and may result in dismissal from GPSC.
12. _____ **Behavioral Health Evaluations.** If I use narcotic/opioid pain medication for three months or longer, I understand that I will be required to meet with one of GPSC's behavioral health providers at least once per year – to consider other non-medical steps I could take to improve my health and well-being. Under some conditions, my doctor may request additional appointments with our behavioral health providers for me.

Failure to keep these appointments may cause a delay or discontinuation of my pain medications.

13. _____ **Alcohol Consumption:** Due to the possibility of negative interactions with various prescription medications, alcohol intake is not encouraged while under our care. In a review of your urine drug screening, your Provider may require abstinence from alcohol to avoid any potential negative side-effects. Failure to comply with your Provider's recommendations may result in medication weening and/or dismissal from our practice.

By signing below, I affirm that I have read, understood, and accept these terms. I understand that the use of these twelve components of the treatment agreement will help keep me healthier, as well as allow GPSC to stay firmly within the bounds of well-established best practices for pain management clinics – and within legal guidelines. Non-compliance with this agreement may result in my dismissal from Georgia Pain and Spine Care.

Your Printed Name _____

Your Signature _____

Pharmacy Name/Number _____

Date _____

HIPAA Policy for Georgia Pain and Spine Care

(Notice of Privacy Practices)

This Notice describes how medical information about you, the patient, may be used and disclosed and how you, the patient, may obtain this information. Please review the following Privacy Policy/HIPAA information carefully.

Any changes will apply to all PHI/HIPAA policies and guidelines and we will notify you, the patient, at the time of your next office visit following the change as well as post the changes within our facility and on our website for patients.

Permitted Uses and Disclosures of Protected Health Information (PHI)

We may use or disclose a patient's PHI in order to provide better care, treatment or diagnosis for the patient. (i.e. PHI may be shared with a healthcare provider who is currently seeing the patient outside of Georgia Pain and Spine Care/White Oak Surgery Center.)

We may use or disclose PHI in other situations without consent on a necessary basis such as the following:

- **Home Health:** PHI shared outside of our practice with home health agencies may be required in order to obtain this care.
- **Payments/Collections:** PHI may be disclosed in order to obtain payment for services rendered or in an attempt to collect a debt from the patient. On occasion, PHI may be shared to determine how services will be paid. (i.e. anesthesia)
- **If required by law:** PHI disclosures will be made in compliance with the law and will be limited to the relevant requirements of the law. (such as reporting a gunshot wound or suspicion of abuse/neglect in a patient)
- **Public health activities:** PHI disclosures will be made for the purpose of controlling disease, injury or disability as required by law and only to public health authorities permitted by law to collect or receive such information.
- **Health oversight agencies:** Disclosure(s) may be made for activities authorized by law, such as audits, investigations, or inspections and/or oversight of the health care system, government benefit programs, other government regulatory programs and civil rights law.
- **Legal proceedings:** PHI will be disclosed in response to a court order, subpoena, or other lawful process.
- **Police or other law enforcement:** PHI will be released to law enforcement agencies in accordance with all applicable legal requirements.
- **Coroners, funeral directors:** PHI will be released as authorized by law for the following purposes: identification, determining cause of death, or to allow the coroner/medical examiner to perform their assigned duties.
- **Medical research:** We may disclose your PHI to researchers for activities preparatory to research such as recruitment or determining the feasibility of conducting a study or when the research has been approved by an independent review board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We require the researchers to safeguard and maintain the confidentiality of your protected health information (PHI).
- **Training purposes:** We may utilize and share PHI for business activities known as "health care operations" (i.e. student, staff, or health care provider training, quality improvement processes, problem or complaint resolution)
- **Special government purposes:** PHI may be released to government officials for national security purposes, or to the military, under limited circumstances.
- **Correctional institutions:** If you are an inmate or under custody of law, we may release PHI which is necessary for your health/safety or for the health/safety of others.
- **Workers' compensation:** PHI may be released in order to comply with workers' compensation laws and other similar legally-established programs.
- **Business Associates:** We will only release the minimum amount of PHI necessary for a business associate to perform the contracted services. We require the business associate(s) to appropriately safeguard your PHI. Examples of business associates include billing companies and transcription services.
- **Health Information Exchange (HIE):** PHI may be made available electronically in order to provide necessary information to other healthcare providers outside of our practice who are involved in your care.
- **Appointment/Scheduling:** We may contact you as a reminder about an appointment or treatment at the telephone number(s) or e-mail address(es) you provided to us.

WE WILL NOT SHARE THE FOLLOWING WITHOUT YOUR (THE PATIENT'S) WRITTEN AUTHORIZATION:

- Psychotherapy/mental health notes for documentation of a private session

WE WILL NOT DISCLOSE PHI FOR MARKETING OR FOR ANY PURPOSE WHICH INVOLVES THE SALE OF YOUR PROTECTED HEALTH INFORMATION (PHI).

All other uses/disclosures not recorded in this notice will require written authorization in advance from the patient or the patient's legal representative.

Patient's Signature Acknowledging Receipt of HIPAA Policy: _____ Date _____

Nurse Practitioner/Physician's Assistant Policy

Georgia Pain and Spine Care uses physician's assistants and nurse practitioners for those aspects of practice that have been approved by the Georgia State Board of Medical Examiners. By initialing this policy, you are agreeing to be treated by physician's assistants or nurse practitioners, who are acting under the supervision of Dr. Charles Brownlow or any other MD at Georgia Pain and Spine Care. *Initial*_____

Urine Drug Screen Policy

Per Georgia state law, patients who are prescribed controlled substances must be drug tested *a minimum of four times per year*. If requested by your provider, you may be asked to perform more than four drug tests per year. Be prepared to offer a urine sample at every visit. If you are unable to provide a urine sample when requested, we will be unable to prescribe any pain medications. Please understand that your health and safety are top priorities at Georgia Pain and Spine Care. *Initial*_____

Lab Work

To ensure high quality care for our patients and identify pain at its root source, a CBC and CMP panel are required for all new patients. Unless outside bloodwork has been completed in the last 3 months or your provider deems lab work is not necessary, collection of lab work will be performed at a new patient visit. If lab work has been completed at an outside entity within the last 3 months, this medical documentation must be provided to our staff to add to your medical records. *Initial*_____

Walk-In Policy

We see all our patients by appointment and do our best to see them on time. We do **not** allow walk in appointments. We request that all patients call for an appointment time before coming to the office. Anytime you feel that you are experiencing a life-threatening emergency, the appropriate course of action is to *immediately* call 911. *Initial*_____

Late Policy

Georgia Pain and Spine Care is a thriving business that strives to see all of their patients on time. To make sure that we see all our patients and give them the proper care and attention they deserve, we will not see patients who show up more than 15 minutes late for their appointment. If you are more than 15 minutes late for your scheduled appointment you will need to reschedule and your account will be charged with a "no-show" fee. *Initial*_____

CANCELLATION & NO SHOW POLICY

You must provide at least 48 hours' notice if you want to cancel a scheduled office visit - *regardless of the reason for the change*. If no attempt is made to cancel a scheduled appointment within 48 hours of scheduled clinic office appointment time, your account will be charged a \$100 "no-show" fee. You must provide 72 hours' notice to cancel a scheduled office procedure. If no attempt is made to cancel a scheduled office procedure, within the 72 hour period, your account will be charged a \$250 "no show" fee. If you do not show for your appointment, you will be expected to pay the "no show" fee at your next appointment. Failure to do so will result in a cancellation of your appointment and no prescriptions will be given. *Initial*_____

Processing Fee Policy

Your insurance company may not cover the prescription that has been prescribed to you and it might need a prior authorization. In the past, Georgia Pain and Spine Care has not been processing prior authorizations. Due to increase in volume of requests for prior authorizations, Georgia Pain and Spine Care will start charging a \$20 processing fee. *Initial*_____

A Note to Our Procedure Patients:

Prior to your procedure, our scheduler will meet with you to determine what your insurance coverage is, and what your financial responsibility will be. *Initial*_____

Additional Charges

- No show charge \$100.00 if not notified within 48 hours prior to your schedule office visit
- No show charge \$250.00 if not notified within 72 hours prior to procedure appointment
- Should you have any forms that the doctor needs to sign off on, fill out or review, there may be an additional charge for these forms.
- We only accept checks on accounts through the mail and there is a \$100.00 return fee. *Initial*_____

Authorization to Release Information

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Georgia Pain and Spine Care any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action had already been taken due to a prior approval based on consent. *Initial*_____

Assignment of Benefits

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Georgia Pain and Spine Care, for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services. *Initial*_____

Guarantee of Payment

I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand that I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. *Initial*_____

Agreement to Payment Policy

I acknowledged that I received a copy of the practice's financial policy and agree to the terms of payment due. *Initial*_____

Written Acknowledgement of Privacy Practices

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of Georgia Pain and Spine Care *Initial*_____

By signing below, I am affirming that Georgia Pain and Spine Care and its affiliates has the full power to bind me to abide by these policies and that I have read, understood and accepted these terms. I understand if I do not comply with the policies I am at risk for dismissal from Georgia Pain and Spine Care.

Georgia Pain and Spine Care Policies and Terms

Patients' Printed Name: _____ Date: _____
Patients' Signature: _____ Date of Birth: _____ Responsible
Party Signature: _____ Relationship to Patient: _____





Authorization to Release Health Information/Medical Records
to Georgia Pain and Spine Care - New Patient Coordinator

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____ Phone _____

At my request, _____ may release the following information:

(Name of the entity)

- Entire record
Office visit notes
Financial records
Other: (Please list)

Entity or person who will receive the information:

Name: Georgia Pain and Spine Care

Address: 1665 Hwy 34 East, Suite 100

City, State, Zip Newnan, Ga 30265 Phone 770-252-7557 Fax 770-252-7513

Send the information electronically. Email address: N/A

Note: For email communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
I understand released information may include a communicable disease diagnosis such as HIV.

Signature of Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority (attach necessary documentation)





COMMUNICATION AUTHORIZATION

Georgia Pain and Spine Care would like to communicate with you in the ways you prefer. By signing below, you allow us to disclose your protected health information (PHI) as described on this form. PHI includes all information regarding your treatment and care. We may need to contact you for a number of reasons, including providing information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

I hereby request the following regarding the use and sharing of my PHI:

1. **Telephone Messages:** We may leave messages on answering machines or with individuals answering the phone at the numbers written in this section, including referral information, appointment reminders, benefits, and other information the facility determines to be appropriate to leave on voice mail or with the person answering the phone. Please provide the number(s) you would like us to use on the line below.

Primary Contact # _____
Alternative Contact # _____
Alternative Contact # _____

I DO NOT AUTHORIZE DETAILED MESSAGES LEFT ON VOICEMAIL FROM THIS FACILITY

2. **Sharing PHI with family and friends:** In addition to any individuals who may be handling messages left as allowed in Section 1 above, or individuals we may contact in emergencies or as otherwise allowed by law, you allow us to discuss PHI with the following family members, friends, or other individuals you list below and on any additional sheet attached to this form:

Printed Name _____ Relationship _____
Phone Number _____

Printed Name _____ Relationship _____
Phone Number _____

I DO NOT AUTHORIZE SHARING MY PHI WITH FAMILY AND FRIENDS FROM THIS FACILITY

2. **Email Communication:** If you would like for our facility to communicate with you via e-mail, please provide an e-mail address below:

E-mail Address: _____

I DO NOT AUTHORIZE TO COMMUNICATE VIA E-MAIL WITH THIS FACILITY

4. Patient Portal: We encourage all of our patients to register with our online Patient Portal. Using the patient portal you can communicate with our office through secure messaging. If you would like to register please notify staff so we can create an account for you.

Yes I would like to communicate with Georgia Pain and Spine Care through the Patient Portal.

No I would not like to communicate with Georgia Pain and Spine Care through the Patient Portal.

It is your responsibility to make sure that only authorized people are allowed to access your email, phone messages, and mobile devices. If individuals other than you receive your PHI sent in the ways allowed on this form, they may share it with others and state and federal privacy laws will not protect it.

It is your responsibility to update this form should any changes occur prior to the annual renewal

Patient Name (Printed) _____ **Date** _____

Patient/ Legal Representative Signature _____ **Date** _____

Legal representative printed name and description of relationship (if applicable):

Name of representative: _____ Relationship: _____

You may request a copy of this form.



Georgia PAIN and SPINE Care

<p>Newnan Office 1665 Hwy 34 East Newnan, GA 30265</p>	<p>LaGrange Office 303 Smith Drive – 2nd Floor LaGrange, GA 30240</p>	<p>Peachtree City Office 1975 Hwy 54 West, Suite 100 Peachtree City, GA 30269</p>
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VISIT OUR WEBSITE

WWW.GAPAINCARE.COM

OFFICE NUMBER

770-252-7557

FAX NUMBER

770-252-7513

