NORTH ATLANTA MEDICAL CLINIC
REGISTRATION FORM
(Please Print)

Today's date:	PCP: VICTORINE MAFOUEKA NGUENA, MD

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

Cell phone No.:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]

❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Atlanta Medical Clinic or insurance company to release any information required to process my claims. I also authorize North Atlanta Medical Clinic to examine and treat me for present and future medical conditions. I acknowledge the practice of medicine is an inexact science and that no guarantees or assurances have been made to me regarding my care and treatment at North Atlanta Medical Clinic or the results of such care and treatment.

Patient or Guardian signature *Date*

NORTH ATLANTA MEDICAL CLINIC

3664 Club Drive, Suite 201
Lawrenceville GA 30044
Tel: 678 380 8433
Fax: 678 830 8437

Date:_____

Doctor: **Victorine Nguena**

PHYSICAL EXAM FORM

PLEASE COMPLETE ALL PARTS OF THIS FORM AND ACCURETLY.

NAME:_____ RACE(optional): _____

DOB: _____ SEX: M / F AGE: _____

PAST MEDICAL HISTORY: Please circle whichever item applies-

High blood pressure	Abnormal heart beat	Heart disease
Lung disease	Asthma	Kidney disease
Diabetes	High cholesterol	Thyroid disease
Esophageal reflux	Peptic ulcer disease	Liver disease
Bleeding disorder	Blood clots	Anemia
Arthritis	Rheumatoid arthritis	Osteoporosis
Depression	Mental illness	Seizure disorder
HIV/AIDS	Cancer	Gout

Please list any other medical condition:

PAST SURGICAL HISTORY:

_____

_____

FAMILY HISTORY: Your family – Mother, Father, Brothers, Sisters, Aunts, Uncles, Other family members.

Mother: _____ Father: _____

Family Health Problems: _____

SOCIAL HISTORY: MARITAL STATUS: _____ EDUCATION : _____

ALCOHOL USE: _____ TOBACO USE : _____

DRUG USE: _____ OCCUPATION: _____

EXERCISE (ACTIVITY,DAY PER WEEK):_____

IMMUNIZATION: TETANUS: _____ PNEUMONIA: _____ INFLUENZA: _____HEPATITIS B/A: _____

(shot) MMR: _____ VARICELLA _____HPV_____ OTHER: _____

OB HISTORY: NUMBER OF PREGNANCIES: NORMAL _____ C-SECTION _____

NUMBER OF CHILDREN: _____ NUMBER OF MISCARRIAGES/ABORTIONS: _____

AGE OF CHILDREN: _____

PLEASE TURN TO THE NEXT PAGE

Doctor: **Victorine Nguena**

PREVIOUS TESTS: PLEASE INDICATE DATE OF PAST DIAGNOSTIC TESTS:

DATE OF LAST PAPSMEAR _____ NORMAL OR ABNORMAL

DATE OF LAST MAMMOGRAM: _____ NORMAL OR ABNORMAL

BONE DENSITY: _____ STRESS TEST: _____

COLONOSCOPY: _____ ECHO TEST: _____

ALLERGIES: Please indicate any allergies to medication that you have and describe type of reaction:

_____

REVIEW OF SYSTEMS: Please circle if you have any of the following symptoms, and give a brief description-

General: Weight gain or loss, loss of appetite,fever,chills,fatigue,nightsweats_____

Head: Headache,diziness,masses,seizures_____

Eyes: Visual changes, eye pain _____

Ears: Tinnitus, vertigo, hearing loss_____

Nose: Nose bleeds, discharge, sinus diseases_____

Mouth and Throat: Dental disease, hoarseness, throat pain_____

Cardiovascular: Chest pain, palpitations, murmur, edema _____

Respiratory: Shortness of breath, wheezing,, cough, sputum color,_____

Gastrointestinal: Abdomen pain, nausea, vomiting, constipation, diarrhea, rectal bleeding, swallowing difficulty_____

Genitourinary: Pain with urination, increase frequency, hesitating, dribbling, bleeding, incontinence, prostate issues, penile discharge _____

Gynecologic: Breast masses, pain, discharge_____

Vaginal bleeding, pain, disharge_____

menopause_____ Date of last menstrual period(frequency, duration): _____

Menstruation problems _____

Any Birth control use ?Yes/No_____ Are you sexually active? Yes / No_____

Is there any chance you could be pregnant now? _____

Any history of STD _____

Neuropsychiatry: Weakness, seizures, memory changes, depression, loss of balance/coordination, anxiety, hallucinations, sleeps disturbances _____

Endocrine: Excessive thirst, increase urination, heat/cold intolerance, skin or hair changes , fatigue _____

Skin: Any rashes or lesions, changes in moles _____

Blood and Lymph: Easy bruising, anemia, lymph nodes enlargement_____

Allergic and Immunology: Wheezing, eczema, itching, hives_____

Musculoskeletal: Joint pain or swelling, arthritis, muscle ache, numbness or tingling,back pain_____

Other problems: _____

PLEASE SIGN FORM HERE: Patient: _____ Date: _____

Physician: _____ Date: _____

Notice of privacy practices

Effective date: 12-01-09

North Atlanta Medical Clinic L.L.C

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:
Dr. Victorine Mafoueka Nguena at 3664 club drive, suite 201, Lawrencevile, GA 30044; Phone Number 678-380-8433.

C. We may use and disclose your PHI in the following ways:
The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Dr.Victorine Mafoueka Nguena, 3664 club drive, suite 201, Lawrenceville Ga 30044 Phone Number 678-380-8433** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Dr. Victorine Mafoueka Nguena, 3664 club drive, suite 201, Lawrenceville Ga 30044 Phone Number 678-380-8433**. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Dr. Victorine Mafoueka Nguena, 3664 club drive, suite 201, Lawrenceville Ga 30044 Phone Number 678-380-8433** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Dr. Victorine Mafoueka Nguena, 3664 club drive suite 201, Lawrenceville Ga 30044 Phone Number 678-380-8433**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Dr. Victorine Mafoueka Nguena, 3664 club drive, suite 201, Lawrenceville Ga 30044 Phone Number 678-380-8433**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you

request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Dr. Victorine Mafoueka Nguena, 3664 Club drive, suite 201 Phone Number 678-380-8433.**

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Dr. Victorine Mafoueka Nguena, 3664 Club drive, suite 201 Lawrenceville Ga 30044 Phone Number 678-380-8433** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Dr. Victorine Mafoueka Nguena , 3664 club drive, suite 201 Lawrenceville Ga 30044; Phone Number: 678-380-8433.**

NORTH ATLANTA MEDICAL CLINIC

CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment,to obtain payment from insurance compagnies,and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notices of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I undertand that I have the right to request a restriction of how my protected health information is used.However,I also understand that the practice/clinic is not required to agree to the request.If the practice/clinic agrees to my requested restriction,they must follow the restriction(s).

I also undertand that I may revoke this consent at any time,by making a request in writing,except for information already used or disclosed.

Signature: _____Date:

Pateint ,parent or legal gaurdian

* If signed by pateint representative,state relationship to patient :