

RUSSELL MEDICAL

Patient Information

Date of Birth: _____ Today's Date: _____

First Name: _____ MI: _____ Last: _____

Sex _____ Marital Status: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Emergency Contact:

Name: _____ Relationship: _____ Phone(_____) _____ - _____

Name: _____ Relationship: _____ Phone(_____) _____ - _____

Insurance Information:

Insurance Carrier: _____ Insurance Plan: _____

Policy/Member number: _____ Group: _____

Social Security #: _____ Contact Number: _____

Subscriber's Name: _____ Date of Birth: _____

Health Concerns/ Symptoms

Describe your main concerns (symptoms, onset, diagnoses, duration etc.)

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that proper record-keeping is essential for ensuring transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It highlights the need for a systematic approach to data collection and the importance of using reliable sources of information.

3. The third part of the document focuses on the analysis and interpretation of the collected data. It discusses the various statistical and analytical tools that can be used to identify trends, patterns, and anomalies in the data.

4. The fourth part of the document discusses the importance of communication and reporting. It emphasizes that the results of the analysis should be presented in a clear and concise manner that is easy to understand and interpret.

5. The fifth part of the document discusses the importance of ongoing monitoring and evaluation. It emphasizes that the data should be regularly reviewed and updated to ensure that the information remains current and relevant.

6. The sixth part of the document discusses the importance of maintaining the confidentiality and security of the data. It emphasizes that sensitive information should be protected and that access should be restricted to authorized personnel only.

7. The seventh part of the document discusses the importance of using the data to inform decision-making. It emphasizes that the information should be used to identify areas for improvement and to develop strategies to address any issues that have been identified.

8. The eighth part of the document discusses the importance of documentation and record-keeping. It emphasizes that all data and analysis should be properly documented and stored in a secure and accessible location.

9. The ninth part of the document discusses the importance of staying up-to-date on the latest developments in the field. It emphasizes that ongoing education and training are essential for ensuring that the information remains current and relevant.

10. The tenth part of the document discusses the importance of collaboration and teamwork. It emphasizes that working together with others can help to identify new opportunities and challenges and to develop more effective solutions.

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Russell Medical

Patient Acknowledgement Form For

Patient Name: _____
(Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize Russell Medical to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: Yes ___ No ___ Cell Phone: Yes ___ No ___
Text Message Yes NO
Voice Mail/Answering Machine: Yes ___ No ___ Work Phone: Yes ___ No ___

May we fax medical records for referrals? Yes ___ No ___

Please list names of people with whom we can discuss your medical care:

Spouse Name _____

Parent Name _____

Other Name(s) & Relationship _____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier: _____
(Last four digits of your social security number or mother's maiden name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

_____ Date: _____

If Personal Representative, give relationship to Patient:

1. The first part of the document discusses the general principles of the system and the objectives of the study. It highlights the importance of understanding the underlying mechanisms and the potential applications of the proposed method.

2. The second part of the document provides a detailed description of the methodology used in the study. It outlines the experimental setup, the data collection process, and the analysis techniques employed to evaluate the performance of the system.

3. The third part of the document presents the results of the study, including a comparison of the proposed method with existing approaches. The results show that the proposed method achieves superior performance in terms of accuracy and efficiency.

4. The final part of the document discusses the conclusions drawn from the study and the implications for future research. It emphasizes the need for further exploration of the system's capabilities and the potential for its application in various domains.

Handwritten signature or note

Russell Medical Financial Policy

Thank you for choosing Russell Medical as your health care provider. We are committed to providing the best medical care possible to our patients. As part of our professional relationship, it is important that you have an understanding of our financial policies.

1. Insured Patients

- a. As medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance policy is a contract between you and your insurance company and we are not a part of that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered medically necessary under your insurance benefits. All non-covered services will be your responsibility and payment is due at the time you receive your statement. It is your responsibility to know and understand the level of services covered by your insurance company.
- b. As a service to you, we do participate in most insurance plans and we will file your claim for you, if you agree to have the insurance company pay us directly.
- c. Outside laboratories are used for most blood work, biopsies, and cultures. These facilities handle filing of their own charges with your insurance carrier directly. It is your responsibility to notify the staff if your insurance carrier requires a specific outside lab.
- d. We recognize that in some instances, prompt diagnosis and treatment is necessary. In an effort to improve the quality of care you receive, we offer many diagnostic tests and therapeutic services to be performed in-house so that the results are available to you at the time of your visit. These services may not be covered by your insurance. In these instances, payment will be collected at the time of service. We will make every effort to provide our best estimate of cost before the service is provided.
- e. Major Medical Plans (PPO, POS, HMO) and Medicare Part B Plans – If you have a Part D Card please let us make a copy of this card so we file claims on your behalf for vaccines. If you do not have a Part D card and the vaccine is not covered, you will be responsible for the cost of the vaccine.
- f. HMO plans – Before receiving services, you must verify that our physician is listed as your primary care provider with your insurance company. If our physician is not listed as your primary care provider, payment will be due at the time of service.

2. Uninsured Patients

- a. Before receiving services, a \$100 deposit is required for patients who do not have an active insurance plan. Best estimates of anticipated charges will be made by our staff prior to your visit, however, you will be responsible for all services rendered, even if they were not part of the initial estimate. Full payment is due when services are rendered unless prior arrangements have been made with a billing representative.

3. General Policies

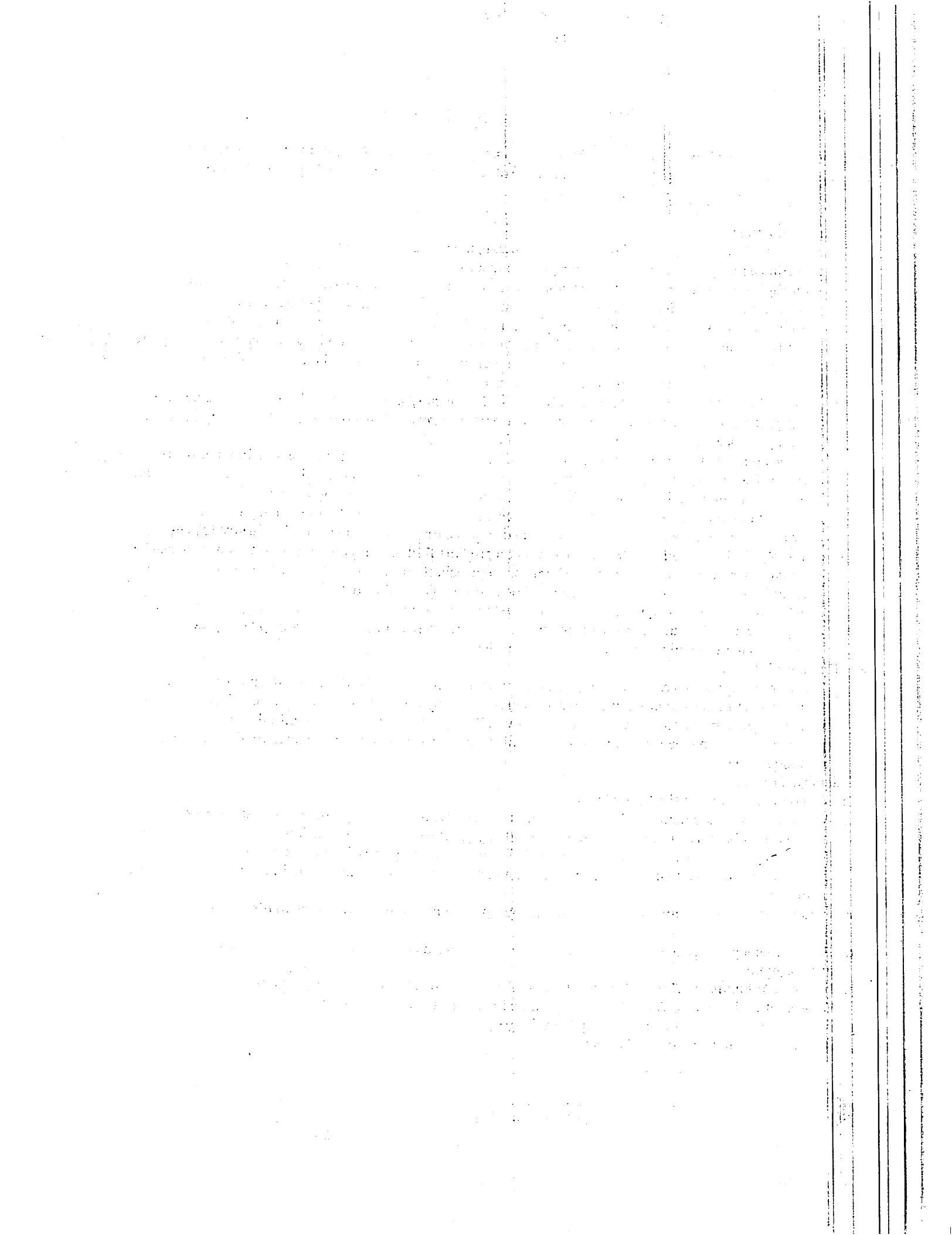
- a. All co-pays are due at the time of visit.
- b. We will send a statement (to the billing address you provide), notifying you of any balances you may owe. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts are subject to a \$10 monthly late fee and may be referred to a professional collection agency. You will be responsible to pay any collection costs incurred, including attorney fees if applicable.
- c. If you are not able to pay the balance in full, you must contact our billing office to discuss a payment schedule.
- d. Failure to keep your account balance current may require us to cancel or reschedule your appointment.
- e. Insufficient Funds – a \$30 fee for all returned checks will be charged to your account.
- f. We accept cash, checks, Visa, MasterCard, American Express, and Discover.
- g. There will be a \$25 charge for all No Shows.

I have read and understand this financial policy.

Patient Signature

Patient Name Printed

Date



Allergy Health Assessment

Patient Name: _____ DOB: _____

Were you referred by another doctor: Yes No Doctors Name: _____

Please check all recurrent symptoms:

- | <u>Nasal Symptoms</u> | <u>Sinus Symptoms</u> | <u>Chest/Throat Symptoms</u> | <u>Skin Symptoms</u> |
|---|--|--|--|
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Post nasal drainage | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Frequent throat clearing | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Sinus pressure | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Headache | <input type="checkbox"/> Cough | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Colored nasal mucous | <input type="checkbox"/> Wheezing with exercise | <input type="checkbox"/> Blisters |
| <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Stuffy ears | <input type="checkbox"/> Difficulty breathing at night | <input type="checkbox"/> Contact allergy |
| <input type="checkbox"/> Itchy ears | <input type="checkbox"/> Frequent sinus infections | <input type="checkbox"/> Frequent pneumonia | <input type="checkbox"/> Other |
| <input type="checkbox"/> Itchy throat | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Throat tightness | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Decreased taste or smell | <input type="checkbox"/> Snoring | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> _____ |

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any seasonal variation in your symptoms and if so, when are they worse? Yes No

Nasal _____ Sinus _____ Chest _____ Skin _____

What medications have you tried for your allergy symptoms? Circle the ones that have helped.

Your Environment

What environmental triggers have made your symptoms worse?

- Mowed grass Windy weather Dust Spending time outdoors Moldy places Sweeping or dusting
 Cigarette smoke Pollen Insect sting Exercise Respiratory infections Weather changes Laughing
 Cold air Nighttime Stressful events Animals (specify) _____
 Perfumes, cosmetics, odors, etc. (specify) _____

How long have you lived in this area? _____ Where else have you lived? _____

Are you better or worse in this area? Better Worse

Do you have any pets? Yes No Please list: _____

Are symptoms worse when around your pet? Yes No Any previous pets in the home? Yes No

Any smokers in the home? Yes No Type of Home: Apartment/Condo House

Has your home had water or flood damage? Yes No

THE HISTORY OF THE UNITED STATES

The first part of the history of the United States is the period of discovery and settlement. The second part is the period of the American Revolution and the formation of the Constitution. The third part is the period of the early republic and the expansion of the United States. The fourth part is the period of the Civil War and Reconstruction. The fifth part is the period of the Gilded Age and the Progressive Era. The sixth part is the period of the World Wars and the New Deal. The seventh part is the period of the Cold War and the Vietnam War. The eighth part is the period of the 1960s and the 1970s. The ninth part is the period of the 1980s and the 1990s. The tenth part is the period of the 2000s and the 2010s.

The history of the United States is a story of a young nation that grew from a small group of settlers on the eastern coast to a powerful superpower. The story is one of struggle and triumph, of hope and despair. It is a story that has shaped the world and continues to shape it today. The United States has been a land of opportunity and a land of promise. It has been a land where people have come from all over the world to seek a better life. It has been a land where people have fought for freedom and justice. It has been a land where people have built a great nation.

The history of the United States is a story that is still being written. The challenges of the future are many, but the spirit of the United States is strong. The United States will continue to be a land of opportunity and a land of promise. The United States will continue to be a land where people can live in freedom and peace. The United States will continue to be a land where people can build a better future for themselves and for their children.

What kind of work do you do? _____ Are symptoms worse at work? Yes No

Have you travelled out of the country in the past year? Yes No Where? _____

Are there other households you visit frequently? Yes No Explain: _____

Family members with allergies/asthma? Mother Father Siblings

Please list all current medications including inhalers, over the counter medications, vitamins, and supplements:

Any medications that you do not tolerate? Yes No If yes, list the medications and the reaction they caused:

Any foods that you do not tolerate? Yes No If yes, list the foods and the reaction they caused:

Medical History (check all that apply)

- Cataracts High blood pressure Acid reflux Stroke Glaucoma Coronary artery disease Irritable bowel
- Migraine headaches Hearing loss Irregular heart beat Inflammatory bowel disease Seizure disorder
- Frequent nose bleeds Enlarged heart Diabetes Kidney disease Nasal polyps Lung disease Thyroid disorder
- Cancer Eartubes Sleep apnea Pituitary disorder Arthritis Osteoporosis Other _____

Previous Allergy Treatment

Other doctors seen for allergies: ENT Allergist Pulmonologist Dermatologist Gastroenterologist

Have you had nasal or sinus surgery? Yes No When and what were the results? _____

Have you been treated in urgent care or ER with asthma? Yes No Last Visit Date? _____

Have you had allergy tests? Yes No When and where? _____

Have you had allergy shots? Yes No When and where? _____


Social History

Do you now or have you ever smoked? Yes No How much & how long? _____

Is there anything else you would like to share regarding your allergies?

If you could fix one thing about your allergies, what would it be?

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RUSSELL  MEDICAL

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

Name of Doctor/Office: _____

Address: _____

Phone Number: _____ Fax Number: _____

To release healthcare information of the patient named above to:
Russell Medical
4355 Browns Bridge Road, Cumming, GA, 30041
P: 770-771-5050 F: 770-771-5051

This Request and Authorization applies to:

All records

Records relating to the following treatment, condition or dates:

Patient Signature: _____ Date: _____

This authorization expires ninety days after it is signed.

