



PATIENT INFORMATION

PLEASE PRINT

PATIENT DEMOGRAPHIC INFORMATION:

Last Name		First Name		MI
Address				
City		State	Zip	
Social Security Number			Date of Birth	
Home Phone			Cell Phone	
Employer			Work Phone	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Not Reported/Refused				
Race: <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Latino <input type="checkbox"/> Multiracial <input type="checkbox"/> Native American Indian <input type="checkbox"/> Other				
Spouse's name <small>(if applicable)</small>			Spouse's Phone	
Guarantor			Guarantor DOB	
Email Address				

EMERGENCY CONTACT INFORMATION:

Name (first and last)	Relationship	Phone

CURRENT PHYSICIANS: Please list your current and referral physicians (first and last name) and their contact information

Physician Name	Specialty	Phone

____ I authorize HyOx Medical Treatment Center to leave a detailed voicemail message regarding my personal health information on the following phone number: _____

____ I **DO NOT** authorize HyOx Medical Treatment Center to leave any detailed voicemail messages.

Patient or legally authorized signature **Date**



PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING PRIVACY PRACTICES

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PREVIOUS NAME: _____

I understand that the patient's health information is private and confidential. I understand that HyOx Medical Treatment Center, Inc. (HyOx), Richard W. King, Jr., MD (Dr. King), and Marianne Taryla, MD (Dr. Taryla) work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that HyOx, Dr. King, and Dr. Taryla may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

HyOx, Dr. King, and Dr. Taryla have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

HyOx, Dr. King, and Dr. Taryla may update this Acknowledgment and "Notice of Privacy Practices". If I ask, HyOx and Drs. King and Taryla will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

HyOx and Drs. King and Taryla have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist HyOx and Drs. King and Taryla by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of HyOx and Dr. King's, and Dr. Taryla's "Notice of Privacy Practices".

Patient's or legally authorized individual's signature: _____

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.): _____

Date: _____

**HyOx Medical Treatment Center, Inc.
Richard W. King, Jr., MD**

2550 Windy Hill Road, Suite 110
Marietta, GA 30067
Tel: 678.303.3200 • Fax: 678.303.3205

500 Medical Center Blvd.
Suite 170
Lawrenceville, GA 30245

www.hyo.com



INFORMED CONSENT FOR WOUND PHOTOGRAPHY

In connection with the medical services which I am receiving from HyOx and from my physicians, Dr. Richard W. King, Jr. and/or Dr. Marianne Taryla, I consent that pictures may be taken of me or my body, under the following conditions:

- (1) The photographs may be taken only with the consent of my physician and at such time as may be approved by him.
- (2) The photographs shall become part of my medical record. I understand that the medical records, including photographs, may be released to other physicians involved with my care and/or representatives from my health plan, such as case managers and medical directors.
- (3) If in the judgment of my physician, medical research, education or science will be benefited by their use, such pictures and information relating to my care may be published either separately or in connection with each other, in professional journals, case studies or medical books or transmitted by television or other device for viewing or used for any other purpose which he may deem proper in the interest of medical education, knowledge, or research; provided, however, that it is specifically understood that in any such publication or use I shall not be identified by name and that my anonymity will be preserved.

Patient's or legally authorized individual's signature:

Name (please print):

Date of Birth:

Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.):



FINANCIAL POLICY

Thank you for choosing HyOx Medical Treatment Center as your health care provider. We will do our best to meet your expectations and to offer you the best care possible. Because there is often a lot of confusion concerning health insurance and managed care, we feel it is necessary to explain some of our financial policies.

We participate with many insurance companies that offer custom designed health plans for thousands of employers across the region. Each plan can differ in the benefits it provides and the services it covers. For that reason, it is impossible for us to know what benefits you have been provided or have purchased. That responsibility is yours. We will do everything we can to assist you in obtaining the benefits that you are entitled to, but you are ultimately responsible for the payment of charges for the services we provide you.

We will accept assignment of insurance as a service to you, not inclusive of any deductibles or coinsurance. Payment arrangements can be made on an individual basis. If we receive payment from the insurance company after you have paid, we will issue you a refund. Please note that failure to pay your bill in a timely manner may result in interest, collection and/or attorney fees being added to the outstanding balance. These charges will be your responsibility.

If you are experiencing personal circumstances that will make the payment of our charges a problem, please ask to speak with our Patient Account Representative.

Summary:

- Review and understand your insurance coverage and benefits.
- Learn and understand the rules for your particular insurance plan. If you fail to follow them, you become responsible for charges they refuse to pay. If you have any questions, contact your insurance company for clarification.
- Always carry your insurance card with you and present it when you receive services.
- Be prepared to pay all co-payments, deductibles and non-covered services at the time of service. For your convenience, we accept cash, checks, Visa, MasterCard and American Express.

ASSIGNMENT OF BENEFITS TO HYOX MEDICAL TREATMENT CENTER AND PHYSICIAN

I hereby authorize payment of all medical and/ or surgical benefits to HyOx Medical Treatment Center, Inc. and Richard W. King, Jr., MD, including Medicare, Medicaid, private and commercial insurance, and any other health plans.

I further authorize HyOx Medical Treatment Center, Inc., and Richard W. King, Jr., MD to release to Medicare and its agents, my insurance company or my health plan any information needed to determine benefits payable to related services.

I certify that I have read and agree to the financial policy and the assignment of benefits as stated above and that all questions concerning the above policy have been answered to my satisfaction. I understand insurance will be filed as a courtesy to me; however, I am financially responsible for my account and any charges not covered by insurance. I am over 18 years of age.

Patient's signature: _____

Name (please print): _____

DOB: _____

Date: _____

AUTHORIZATION TO TREAT

I consent to examination, treatment and procedures which may be performed during my office visits including emergency treatment considered necessary by the physician and/or his designated provider.

Patient's signature: _____

Name (please print): _____

DOB: _____

Date: _____



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records to:

Richard W. King, Jr., M.D.
Marianne Taryla, M.D.
HyOx Medical Treatment Center

2550 Windy Hill Rd., Suite 110
Marietta, GA 30062
Phone: 678.303.3200
Fax: 678.303.3205

500 Medical Center Blvd, Suite 170
Lawrenceville, GA 30046
Phone: 678.672.1640
Fax: 678.672.1647

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____