



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**

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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 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.):

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: _____