Cherokee Internal Medicine, P.C.

Maho Akamatsu, M.D. Courtney Maniatis, D.O.

PATIENT INFORMATION Today's Date: ________________________

Last Name ____________________________ First __________________________________ M.I. _______________

Address ____ Apt. # _____________

City ____ State _____________________________ Zip _____________

Home Phone (_____) _____-______ Cell Phone (_____) _____-______ Work Phone (_____) _____-______ Ext. _____

Email Address: ____@ ______________________________

D.O.B. _______________ Sex: M ____ F _____ Marital Status (Please Circle) S M D W

Race: American Indian/Alaska Native – Asian – Native Hawaiian – Black or African American – White – Hispanic
Pacific Islander – Other Race – Unreported/Refused to Report

How did you hear about the practice? ____

Emergency Contact Information:

Name: ____ Relation: __________________________________

Home Phone: __________________________________ Work Phone: ________________________________

Employer Information:

Employer Name: _________________________________ Occupation: _______________________________

Employer Address ____

Brief Description of Daily Activities at Work ____

Insurance Information:

Insurance Name & Address: ____

Name of Insured: ____ Relation: ___________________________

D.O.B. ______________________ ID/Contract # ___________________________ Group # _______________

Do we have permission to:

Discuss your medical information with your spouse? NO YES

Name: ___________________________________ Number: ______________________________

Leave test results on your home answering machine? NO YES

Preferred Pharmacy:

Name ____ Location ______________________________________

Phone ____ Fax ____

I hereby grant permission to Cherokee Internal Medicine to view my prescription history from external sources.

____

Patient, Parent or Guardian Signature (if child is under 19 years old) Date

NAME: ____

MEDICATIONS: List prescription medications being taken regularly including dosage:

NAME	DOSAGE	FREQUENCY
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

NON-PRESCRIPTION MEDICATIONS: List all non-prescription drugs and frequency of usage.

____

____

____

ALLERGIES: List all allergies to medications, immunizations, foods, etc.

MEDICATION	REACTION
______________________	______________________
______________________	______________________
______________________	______________________

ADVANCE DIRECTIVE:

Do you have a living will?	NO	YES	(If yes, please provide a copy)
Do you have a Power of Attorney?	NO	YES	(If yes, please provide a copy)

PAST MEDICAL HISTORY: (circle all that apply)

Alcohol Dependency	Colitis	Hernia	Skin Disorder
Anemia	Colon Polyp	High Blood Pressure	Sleep Disorder
Anorexia/Bulimia	Diabetes-onset _________	High Cholesterol	Thyroid Problems
Arthritis	Diverticulitis	HIV Positive	Tuberculosis
Asthma	Emphysema	Jaundice	GERD/Reflux
Back Trouble	Epilepsy/Seizures	Kidney Stone	Urinary Tract
Bleeding Disorder	Glaucoma	Migraine Headaches	Infection: bladder or or kidney
Blood Clots/Phlebitis	Gout	Mononucleosis	
Bone Disorder	Hay Fever	Osteoporosis	Stomach ulcers
Breast Lump	Heart Attack – date _______	Pneumonia	
Bronchitis	Heart Failure	Prostate Problems	
Cancer _________________	Heart Murmur	Rheumatic Fever	
Cardiac Arrhythmia/ Pacemaker	Hemorrhoid	Sexually Transmitted Disease	
Cataracts	Hepatitis/Liver Disease	Sinus Disease	

NAME: ____

HOSPITALIZATIONS/SURGERIES:

List Illness or operation and approximate year:
____
____
____

Indicate any major childhood illnesses:
____
____
____

INVESTIGATIONS:

Please note if you have had any of the following:

Date /Location of Facility/Result

	Date /Location of Facility/Result		
Bone density testing	________________________	Mammogram	_________________________
Colonoscopy	________________________	Pneumonia Vaccine	__________ Prevnar_________
Eye exam	________________________	Tetanus Vaccine	__________ Tdap___________
Flu Vaccine	________________________	Shingles Vaccine	_________________________
Hepatitis A Vaccine	________________________	Hepatitis B Vaccine	_________________________
BCG Vaccine	________________________	TB Skin Test	_________________________
Cardiac Stress Test	________________________	EKG	_________________________
Hearing Test	_______________________	HIV Test	_________________________

WOMEN ONLY:

Date of last normal menstrual period _________________ Date of last PAP smear _________________________

Breast lumps NO YES Breast Pain NO YES Discharge from Breast NO YES

Heavy bleeding during menses NO YES Hot Flashes NO YES Extreme Menstrual pain NO YES

Irregular Menses NO YES Missed Periods NO YES Painful Intercourse NO YES

Painful Menses NO YES Any Abnormal Pap Smears? NO YES History of HPV? NO YES

Vaginal Discharge/Itching NO YES Vaginal Bleeding Between Periods NO YES

Number of pregnancies _________ Number of miscarriages/abortions _______ Are you pregnant now NO YES

Birth Control Method _____________________________

MEN ONLY:

Do you perform self-testicular exams? NO YES Date of last prostate exam _____________________

Difficulty Initiating Stream NO YES Dribbling after urination NO YES Hard Testicle NO YES

Hernia NO YES Hypospadias NO YES Lump in Groin NO YES

Penile Discharge NO YES Rash or blister on penis NO YES Scrotal Pain NO YES

Scrotal Swelling NO YES Undescended testicle NO YES Last PSA Test ______________

PERSONAL HABITS: How much of the following do you use per day?

Do you exercise regularly? NO YES Times per week __________ Type _______________

Do you chew tobacco? NO YES Packs per week __________ No. of years _________

Do you drink alcohol? NO YES Drinks per day __________ Per occasion ____________

Do you now or have you ever smoked? NO YES Packs per day ____________ No. of years ___________

If you have quit, how long ago? ________________ _____ How soon after waking up do you a smoke? ____________________

Are you interested in quitting?______ NO YES

Are you exposed to second-hand smoke? NO YES

Do you use illicit drugs? NO YES

Do you feel you have a dependency on any prescription drugs? NO YES _____________________________________

Name: ______________________________

Little interest or pleasure in doing things

☐ Yes

☐ No

Feeling down, depressed, or hopeless

☐ Yes

☐ No

If you answered YES to either of the above questions please answer the following questions

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

NAME: ____

FAMILY MEDICAL HISTORY

Relation	Age	Health	Age of death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Has your blood relative ever had any of the following?	
Disease	**Relationship to you**
Arthritis	
Asthma	
Cancer (location)	
Chemical dependency/ Mental Illness	
Diabetes	
Heart Disease/Stroke	
High Blood Pressure	
Tuberculosis	
Osteoporosis	
Thyroid	
Seizures/Migraines	
Anemia	

Please circle any symptoms you have had in the last month: Name: ___________________________________

DOB:___________________ Date:_________________

GENERAL/CONSTITUTIONAL
Change in appetite
Chills
Fatigue
Fever
Headache
Lightheadedness
Night Sweats
Sleep Disturbances
Weight gain
Weight loss

ENT
Blocked ears
Decreased hearing
Decreased sense of smell
Difficulty swallowing
Dry mouth
Ear pain
Nosebleed
Ringing in the ears
Sinus pain
Sore throat
Swollen glands

CARDIOVASCULAR
Chest pain at rest
Chest pain with exertion
Leg cramps when walking
Toes/fingers turn blue
Difficulty breathing while lying flat
Dizziness
Shortness of breath w/exertion
Fluid accumulation in legs
Irregular heartbeat
Skipping/rapid heartbeat

SKIN
Acne
Blistering of skin
Dry Skin
Eczema
Hives
Itching
Moles / Changing Moles
Rash
Scaly lesions of skin / scalp
Skin Cancer
Skin lesions
Skin oozing
Sun sensitivity
Keloid formation

ALLERGY/IMMUNOLOGY
Blistering of skin
Congestion
Cough
Hives
Itching
Rash
Sneezing
Watery Eyes
Wheezing
Allergic to indoor allergens
Allergic to outdoor allergens

ENDOCRINE
Cold Intolerance
Difficulty sleeping
Dizziness
Excessive sweating
Excessive thirst
Frequent urination
Heat intolerance
Weakness
Weight change

GASTROINTESTINAL
Abdominal pain
Blood in stool
Change in bowel habits
Constipation
Decreased appetite
Diarrhea
Difficulty swallowing
Exposure to hepatitis
Heartburn
Vomiting blood
Nausea
Vomiting

NEUROLOGIC
Balance difficulties
Difficulty speaking
Dizziness
Fainting
Gait abnormality
Headaches
Irritability
Loss of strength
Loss of use of extremity
Memory loss
Seizures or Tics
Tingling / Numbness
Transient loss of vision
Tremors

OPHTHALMOLOGIC
Blurred vision
Discharge
Dry eye
Flashes of light
Floaters
Itching and redness
Pain
Red Eye
Decreased vision

RESPIRATORY
Chest pain
Cough
Coughing up blood
Pain with inspiration
Shortness of breath at rest
Shortness of breath with exertion
Phlegm production
Wheezing

GENITOURINARY
Abdominal pain/swelling
Blood in urine
Difficulty urinating
Frequent urination
Pain in lower back
Painful urination
Four Odor to Urine
Genital Discharge / Rash
Incontinence

MUSCULOSKETAL
Carpal tunnel
Joint stiffness
Leg cramps
Muscle aches
Pain in shoulders
Painful joints
Sciatica
Swollen joints
Trauma to arms/hips/knees/ankles
Weakness

PSYCHIATRIC
Anxiety
Auditory/visual hallucinations
Delusions
Depressed mood
Difficulty sleeping
Eating disorder / Loss of appetite
Mental or physical abuse / Stressors
Substance abuse / Suicidal thoughts

INSURANCE DISCLAIMER/FINANCIAL POLICY/CONSENT FOR TREATMENT:

- To assure that your insurance claims are processed correctly and in a timely manner, **please make sure you advise us of any changes to your insurance information prior to being seen.** Incorrect information will result in your claim being denied.
- I certify that the above information is correct and hereby authorize the release of medical information to my insurance company and/or to my referring physician.
- I assign to, Cherokee Internal Medicine, PC (Maho Akamatsu, MD or Courtney Maniatis, DO) any and all payments for services rendered to me (or my dependents).
- A copy of this authorization may be used in place of the original.
- Insurance will be filed if the physician is covered under my plan.
- ***It is my responsibility to obtain a referral/order if required. I understand that I will be responsible for all non-covered services, co-payments and deductibles.***
- **All fees which are your responsibility are due at the time of your appointment.** These include any co-payments, co-insurances, deductibles, or any other charges not covered by your insurance. Failure to pay the time of your appointment will result in an additional **$25.00 administrative service fee** to be added to your bill.
- **$50.00 Fee** will be charged when a patient fails to provide us with **at least 24 hour notice of cancellation**, or is a "No Show".
- I agree to be evaluated and treated by one of the providers of CIM, P.C. I the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to CIM, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Signature Date

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Heath Information
Your protected health information will be used by Cherokee Internal Medicine, P.C., or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the disclosure of your protected health information.

Cherokee Internal Medicine, P.C., may or may not agree to restrict the use or disclosure of your protected health information.

If Cherokee Internal Medicine, P.C., agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Cherokee Internal Medicine, P.C., Reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to Cherokee Internal Medicine, P.C. to use and disclose my health information in accordance with it.

____
Name of Patient (Print or Type)

____
Signature of Patient **Date**

____
Signature of Patient Representative **Relationship to Patient**

Cherokee Internal Medicine, P.C.

Informed Financial Consent Policy
Effective October 1, 2011

Patient Cancellation and No Show Policy
In order to provide all our patients with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive at least 15 minutes early for your appointment.

If you need to reschedule or cancel an appointment, we require ***a minimum of 24 hour cancellation notice.*** Adequate notice allows us to offer the appointment to another patient who needs to see the physician. **Please remember that confirmation reminders from us are only a courtesy. Our failure to confirm your visit does not relieve you of your responsibility to cancel your appointment.**

To cancel or reschedule, please call our office at:
*****678-238-0301 option 1*****

$50.00 Fee will be charged when a patient fails to provide us with at least 24 hour notice of cancellation, or is a "No Show".

Failure to Pay at Time of Service
All fees which are your responsibility are due at the time of your appointment. These include any co-payments, co-insurance, deductibles, or any other charges not covered by your insurance. Failure to pay at the time of your appointment with result in an additional **$25.00 administrative service fee** to be added to your bill.

Fees for Forms
To offset the runaway costs of the extensive administrative functions required by our physicians and staff, we are obliged to charge of completion of the tasks listed below. Please refer to the fees indicated for applicable requests.
No forms will be completed prior to the payment of fees.

$75.00 Fee or Free if completed at the time of an Office Visit with Physician:
- Nursing home entrance forms
- Adoption forms
- Disability forms
- Assisted Living forms
- FMLA

$40.00 Fee or Free if completed at time of Office Visit with Physician:
- School Physical Education forms
- Pre-Operative Forms

Medical record requests are priced individually. Please call our medical records Department to determine your costs.

Signature of Patient ______________________ Date ______________________

Patient Date of Birth ______________________

CHEROKEE INTERNAL MEDICINE, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________, have read/received a copy of CHEROKEE INTERNAL MEDICINE, P.C.'s Notice of Privacy Practices.

____ ______________________

Signature of Patient/Guardian Date

CHEROKEE INTERNAL MEDICINE, P. C.
1192 Buckhead Crossing, Suite C
Woodstock, GA 30189
678-238-0301

Maho Akamatsu, M.D. **Courtney Maniatis, D.O.**

Name: ____

Address:____

City, State, & Zip ____

Home # ___________________________ Cell # _________________________ Work # ____________________

Date of Birth: __________________________________ Social Security # ________________________________

May we leave information /messages on home phone number? Yes No

Email Address:____@________________________

To be HIPAA compliant we must ask that you authorize anyone you would like us to speak to, if their name is not on this form they will be advised that *you* must call to obtain any medical information.

I authorize Cherokee Internal Medicine to speak with the following person/people in regard to my protected health and financial information:

Name: ____

Relationship: ____ Phone# ___________________________

Name: ____

Relationship: ____ Phone# ___________________________

Assignment of Benefits: In consideration of these medical services, I hereby assign, transfer and set over to Cherokee Internal Medicine all my rights, title and interest to medical reimbursement benefits under my insurance policy (s) as indicated below. If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to Cherokee Internal Medicine, with regard to my treatment and care with this practice.

Consent for treatment: I hereby acknowledge and understand that, in presenting myself for treatment and continuing medical care at Cherokee Internal Medicine, PC that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the provider (and/or designated assistant) and carried out by members of Cherokee Internal Medicine staff and personnel. Minors must be accompanied by a parent/legal guardin for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

Patient Signature: ____ Date:______________________

CHEROKEE INTERNAL MEDICINE, P.C.
1192 Buckhead Crossing, Suite C
Woodstock, Georgia 30189
P: 678-238-0301 F: 678-238-0323

Maho Akamatsu, M.D. **Courtney Maniatis, D.O.**

Authorization for Release of Medical Information

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize the above mentioned physicians to receive certain PHI about me from:

Former PCP-____ OB-GYN-____
Urologist-____ Podiatrist-____
Cardiologist-____ Orthopedic-____
Dermatologist-______________________________________ Ophthalmologist-____
Surgeon-____ Gastroenterologist-______________________________________
Nephrologist-_______________________________________ Pain Specialist-____
Pulmonologist-______________________________________ Oncologist-____

____ The contents of my medical records, laboratory data, EKG/x-ray, prescriptions.

____ The contents of my medical file consisting of mental health records. Psychiatrist-_____________________________________

____ Hospital discharge summary, cardiac tests, labs and x-rays.
Date of service: ______________________________ Where____

The information will be used or disclosed for the following purposes:

____ To aid in the diagnosis and/or continuing treatment of the patient.

____ At the request of the individual.

____ Other (please specify): ____

I understand that if the person or organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying the provider named above in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to who this authorization is furnished may not condition its treatment of me on whether or not I sign it.

This authorization expires one year from today _____________________, 20_____, unless specified otherwise by me to the provider.

THIS FORM MUST BE COMPLETED BEFORE SIGNING

____ ____
Print Patient's Name Date of Birth

____ ____
Patient or Legal Guardian Signature Date

Patient/Legal Guardian must be provided with a copy of this form.