



# NORTHSIDE HOSPITAL

English - Spanish

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**BY SIGNING BELOW I ACKNOWLEDGE AND AGREE THAT:**

**Consent To Routine Procedures.** I consent to medical care and procedures while I am a patient at one or more Northside Hospital affiliated medical practices ("Practice"). This includes non-invasive testing or procedures, such as routine exams, needle sticks, physical assessments and treatments, administration of medications, drawing blood, bodily fluids or tissue samples, insertion of tubes, imaging procedures or physical therapy ("Routine Procedures") recommended by my physician or other provider. I also consent to minor procedures performed under local anesthesia, such as bone marrow aspiration or removal of skin tags. ("Minor Procedures.")

The Routine Procedures may be performed by physicians, nurses, technicians, physician assistants or other healthcare professionals. The Minor Procedures are performed by a physician or qualified mid-level provider. While these Procedures are routinely performed without incident, there may be material risks associated with each. It is not possible to list every risk for every Procedure, but in rare circumstances, the procedures may cause infection, loss of limb or function, damage to tissue or implants, paralysis or death. If I have any questions or concerns regarding these Procedures, I will ask my physician for more information. If I do not consent to a procedure, I will tell my physician or other provider when they recommend the procedure.

**Testing And Disposition Of Specimens, Devices, Foreign Objects.** I consent to each Practice or any lab used by the Practice retaining any tissue specimens, medical devices, foreign objects, or fetal remains removed, expelled or otherwise separated from my body. I agree that these items may be examined by pathologists, used for scientific or teaching purposes, and disposed of or retained according to the discretion of the Practice or lab, unless I request otherwise in writing before the procedure. I will let the Practice know if I have other requests for handling specimens. Any items I do not retrieve within fourteen days after the Procedure will be disposed of.

**Consent To Download Prescription Records.** Each Practice may download my medication history from pharmacies, health plans, and other healthcare providers and include it in my electronic medical record to improve the coordination of my medical care. This may include information about medications prescribed to me for mental health conditions, sexually transmitted diseases, substance abuse disorders, and HIV/AIDS. If I do not want the Practice to obtain this information, I will cross through and initial this paragraph. Refusal to allow downloading prescription records does not prevent my physician from viewing records under the Georgia Prescription Drug Monitoring Program for narcotics.

**Testing For Blood-Borne Pathogens.** Georgia law allows testing for blood-borne pathogens in certain situations. (1) If a health care worker is exposed to my blood (e.g., suffers a needle stick), my blood may be tested for diseases including HIV/AIDS. Additional information about this test is available. I will be informed of test results. (2) If I am an obstetrical patient in the third trimester of pregnancy, the Practice may test me for HIV and syphilis as required by Georgia law. If I want to refuse HIV or syphilis testing, I will cross out and initial this sentence. 3) For all other patients, if my physician recommends an HIV test, he or she will notify me and I will have the right to refuse the test at that time.

**Students.** The Practice is engaged in health care education. At times care, examination and treatment may be delivered by students under the supervision of a physician or other authorized Practice personnel. Students will never have primary responsibility for my care; there will always be fully licensed health care professionals supervising the students and available to assist me. If I do not want students to participate or observe my care, I will cross through and initial this paragraph.

**Medications From Outside Source.** I agree to notify the Physician about medicines (including supplements and herbal products) that I am taking and to follow the Physician's instructions. If I bring medicine to a Practice for administration, the Practice may examine it so that it can be documented on my record, but the Practice is not responsible for the safety or proper dispensing of medication.

**Privacy, Individuals Involved In My Care.** I understand that, unless I request confidentiality, the privacy laws allow the hospital to communicate with family members or others who may be involved in my care. I agree that the providers can communicate with me in the presence of family members or others who come with me to my appointment. If I object, I will notify my provider and ask my family to leave when the provider is discussing care with you.

**Telemedicine** I consent to telemedicine consultations as recommended by my physician. My medical information may be discussed with Georgia licensed health professionals through telecommunication technology and, in some cases, a physical examination will be performed. A non-medical technician may be present to assist with the technology and, unless I object, audio or video recordings may be taken during the consultation. I can withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any Medicaid benefits to which you would otherwise be entitled. If I do not consent to a telemedicine consultation, some services may not be available at all Northside locations. All state and federal laws, including privacy and confidentiality, apply to records of the telemedicine consultation.

**PHOTOGRAPHY AND RECORDING.** Providers may take photographs or videotapes of patients for medical documentation or identification. Photographs and related information may be published in professional journals or medical books, or used for any similar purpose in the interest of medical education, knowledge or research; provided, however, that in any such publication or use, I will not be identifiable. No protected health information will be released without my consent.

Some or all of the health care professionals performing services in this facility are independent contractors and are not facility agents or employees. Independent contractors are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent contractors.



# NORTHSIDE HOSPITAL

Southeastern Neurosurgical Specialists

English - Spanish

Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(First) (Middle) (Last)

Gender (circle) Male Female Marital Status (circle) Single Married Divorced Widowed  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\*Preferred Phone Number  home  cell \_\_\_\_\_  
\*Email \_\_\_\_\_

Ethnicity  Hispanic or Latino  Not Hispanic or Latino  Unknown/Declined  
Race  American Indian/Alaskan Native  Asian  Black/African American  Native Hawaiian/Pacific Islander  
 White  Other  Unknown/Declined  
Preferred Language  English  Spanish  Chinese(Cantonese)  Chinese(Mandarin)  French  German  
 Italian  Japanese  Portuguese  Russian  Other

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Preferred Communication for Appointment Reminders:  Phone Call  Automated Text  Automated Email  
If this practice lacks the capability for text or email reminders, may we use the phone number for reminders  yes  no.

### Pharmacy Information

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy Address \_\_\_\_\_

### Guarantor if not the patient (financially responsible party for minor or incapacitated adult):

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
\*Preferred Phone Number  home  cell \_\_\_\_\_ \*Email \_\_\_\_\_

**\*Note:** By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal if available at the practice. To ensure the security of your information, it is against our policy to email patient information. You may complete the Request for Confidential Communications form to request limitations on the method or content of communication.

### Emergency Contacts Information and Relationship to Patient:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### Referring Physician Information:

Physician Name \_\_\_\_\_ Specialty \_\_\_\_\_ Office Name \_\_\_\_\_  
Address: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

### Primary Care Physician Information (if different than referring physician):

Physician Name \_\_\_\_\_ Specialty \_\_\_\_\_ Office Name \_\_\_\_\_  
Address: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Does your insurance require a referral? \_\_\_ YES \_\_\_ NO; if yes, please provide the referral to the receptionist

### Primary Insurance

Name of Insurance \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_  
Date of Birth of Policy Holder \_\_\_\_\_  
Policy/Member ID Number \_\_\_\_\_  
Group/Plan Number \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Effective Date of Policy \_\_\_\_\_

### Secondary Insurance

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

# A Northside Network Provider

English - Spanish

**[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]**

Name of Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

As a patient, you have the option to designate a spouse, family members, friends, or other persons with whom this practice can communicate with about your health care status. It will be necessary to complete a new form at each Northside medical practice where you receive care. While this form is not required in all circumstances for your doctor or others at Northside to be able to communicate with your family about your health care, designating certain individuals who you want to be informed about your care on this form will ensure that your provider can speak with those people whom you have designated below.

If you anticipate that you will need or want your health information to be verbally provided to your family members, friends or caregivers, please indicate that below so that we may best serve you. By signing below, you authorize the following persons to receive your verbal health information as requested, regarding your care and treatment. Updates to this form must be made in person. Signing this form is entirely voluntary and optional. This form does not authorize release of copies of your health records.

First and Last Name	Relationship

**I understand that this Consent can be revoked by submitting a written request to the Office Manager at the Northside Hospital Physician Office Practice identified at the top of this form.** I understand that I have the right to revoke this Consent in writing at any time except to the extent that action has already been taken in reliance on it. This Consent shall remain in effect until the date I revoke it in writing or sign a new form.

\_\_\_\_\_  
 Signature of Patient or Legal representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 AM/PM  
 Time

\_\_\_\_\_  
 Print name

\_\_\_\_\_  
 Relationship to patient

\_\_\_\_\_  
 Interpreter (if applicable)  
 Note to staff: if telephone interpretation provided,  
 record name of company and interpreter ID number.

\_\_\_\_\_  
 Reason patient unable to sign

**Please complete this form and return it to the Practice manager.**

FOR INTERNAL PURPOSES ONLY:  
 Date Consent Received: \_\_\_\_\_