2395 Thompson Road Dawsonville, GA. 30534 Phone: (706) 265-6866 Fax: (706) 216 8448

Thank you for choosing Chestatee Emergent Medical Care, LLC for your healthcare needs. Below we are asking you to provide personal information regarding your health. HIPAA Laws govern how we may use your medical information. We do from time to time need to share your healthcare information with other, approved and related practices and agencies. By signing this document you are authorizing the staff at Chestatee Emergent Medical Care, LLC to share your personal medical information with other entities and practitioners as may be necessary for your treatment.

What is the reason for your visit today? _____

Name _____ **Social Security Number** _____-_____-_____

Address _____ **City** _____ **State** ____ **Zip** ____

E-mail Address _____ **Date of Birth** _____

Age _____ **Sex M/F Home Phone** _____ **Cell Phone** _____

Okay to leave message on voicemail? _____ **Emergency Contact: Name** _____
Phone Number _____ **Relationship to Patient**_____

Are there any persons and/or organization/agencies that you DO NOT want your medical information shared with? Please list below.

_____

Are you allergic to any foods or medications? Please list below.

_____

Are you currently taking any medications daily? Please list names, dosages, and frequency below.

_____

_____

Please list any health conditions here:

_____

_____

Do you wish to receive a copy of the Privacy Policies? Yes/No

_____ _____

Patient or Responsible Party Signature Date

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Chestatee Emergent Medical Care, LLC and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Chestatee Emergent Medical Care.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Chestatee Emergent Medical Care, LLC Notice of Privacy Practices.
3. I agree to comply with the directions and orders received from the physician and to take any prescribed medication I may receive only as directed.
4. I agree to store medications I may receive from Chestatee Emergent Medical Care in a secure place and to not dispense them in any way.
5. I understand the staff and physician on duty are limited in their ability to diagnose severe or life-threatening conditions in this setting. I hold Chestatee Emergent Medical Care, LLC, the staff and physician on duty harmless for any outcome whatsoever, presently or at any time in the future, that may occur as a result of care or advise received at Chestatee Emergent Medical Care, LLC.
6. I agree to binding arbitration for any dispute or claim which may arise and understand this waives my right to a jury trial regarding said issue.
7. I understand that my medical record will be kept on the Dr. Chrono EMH Internet based medical record system. I understand that there is a possibility, however remote, that a total loss of information could occur. I hold harmless, Dr. Chrono and Chestatee Emergent Medical Care, LLC for any such loss of any nature from any source.
8. I have read this agreement and understand the conditions set forth herein. I agree to the terms included and desire treatment for my condition at Chestatee Emergent Medical Care, LLC.

_____ _____

Patient or Responsible Party Signature Date