Cobb Internal Medicine Associates, PC
2655 Dallas Highway, Suite 340, Marietta, GA 30064
cobbinternalmedicine.com

Mohsin Hisamud-Din, M.D.
Seema Hisamud-Din, M.D.
Abby Starstrom, NP-C | Jennifer Flier, NP-C
Jada Lewis, NPC, DNP | Sarah Svedin, PA-C

Welcome!

We would like to start by saying thank you for choosing Cobb Internal Medicine as your Primary Care Provider. Attached you'll find our new patient information packet. Please take the time to review and complete information and return to office on your scheduled appointment.

If you have any questions or concerns please feel free to contact our office @ 678-797-9800.

Thank you,

Cobb Internal Medicine

SCHEDULING
Appointments can be scheduled through the Patient Portal available via the **HEALOW App** or online at: **cobbinternalmedicine.com**, by phone or in person at the office.

We ask that all patients arrive 15 minutes before scheduled time.

It is the patient's responsibility to give office staff any updated or changed information including, but not limited to insurance, address, phone number etc. Personal information may also be updated via the Patient Portal.

Insurance card should be brought to every visit. Cobb Internal Medicine CANNOT be held responsible for any fees incurred by patient failing to give updated information.

PAYMENT
Payment will be requested at the time of service for all services which are non-covered or determined to be the patient's responsibility, including co-payments and deductibles.

Accepted forms of payment are Visa, Master Card, Discover, Cash or Check. We have a $35.00 fee for all returned checks.

Cobb Internal Medicine
Policies & Procedures

MEDICATION REFILLS
Medications will NOT be refilled without required follow up visit.

Depending on your medical problems you may need to follow up every 1-6 months, as determined by your physician/provider (for instance typically for hypertension, diabetes, etc… 3-4 month follow ups are needed for medication refills). It is the patient's responsibility to make follow up visits before your medication runs out.

If for any reason a REFILL is needed between follow-up visits you should allow 48 hours for request to be into your pharmacy.

There are no exceptions to this policy. Please understand that this policy is for your safety and in your best interest. We care enough to be certain you are treated properly for your ongoing medical conditions.

PATIENT COPY

CANCELLATION POLICY
We realize patients may need to change their appointments; however, we require 48 notification of cancelled appointments so we may offer that time to another patient.

If you fail to cancel, without due notice, we reserve the right to charge a $25 cancellation fee. This fee will not be submitted to insurance, it will be your responsibility to pay.

AFTER HOURS
Visit: **cobbinternalmedicine.com** to access the Patient Portal or use the **HEALOW App** the for most prescription refills, appointment scheduling, and lab/test results. Other issues will be handled during routine office hours, which are as follows:

Monday	8 am – 5 pm (Lunch 1-2)
Tuesday	1 pm – 7 pm
Wednesday	8 am – 1 pm
Thursday	8 am – 5 pm (Lunch 1–2)
Friday	8 am – 5 pm (Lunch 1- 2)

If you have a life-threatening emergency, please call 911 or immediately go to the nearest emergency room. If you have an emergent need to reach the on call doctor you will be directed by our office line after hours.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

* **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

* **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending
a bill for your visit to your insurance company for payment.

* **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain issues and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree, in writing, to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this alternatively i.e. electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for information:	**For more information about HIPAA or to file a complaint:**
Cobb Internal Medicine	The U.S. Department of Health & Human Services
2655 Dallas Highway, Suite 340	Office of Civil Rights
Marietta, GA 30064	200 Independence Avenue, S.W.
Ph: (678) 797-9800	(202) 619-0257
Fax: (678) 797-9801	Toll free: 1-800-368-1019
cobbinternalmedicine.com	

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Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES"

You may complete this form online-Print & BRING TO YOUR APPOINTMENT to SIGN AT OUR OFFICE.

I, _____, D.O.B: ____/____ /_____acknowledge that I have received a copy of Cobb Internal Medicine Associates' "NOTICE OF PRIVACY PRACTICES" on the date set forth below. I grant permission to leave medical information in the specified manner and to the specified person(s) set forth below.

APPROVED PHONE NUMBERS FOR PERSONAL HEALTH COMMUNICATIONS (or opt out below)
You may leave PERSONAL MESSAGES INCLUDING LAB RESULTS on phone numbers below:

Mobile (_____) _____-_____ Home (_____) _____-_____ Work (_____) _____-_____

or opt out (enter "X")→____ No Personal Health Messages except appointment confirmations/changes

DESIGNATED PEOPLE WE MAY SHARE YOUR MEDICAL & ACCOUNT INFO WITH (or opt out below)
You may share medical and account information with this/these designated individual(s) as follows:
Name_____ Relationship to you? _____
D.O.B. _____ /_____ /_____ Phone (_____) _____-_____
Name_____ Relationship to you? _____
D.O.B. _____ /_____ /_____ Phone (_____) _____-_____

or opt out (enter "X")→____ Do not share information with anyone other than me.

If you provide your email address to Cobb Internal Medicine, your lab results will be available for you to review via SECURE Patient Portal accessible online or with the HEALOW app (available for ios or android devices). You will receive an email notification when results are available online.

Email Address _____

STOP PLEASE PRINT, BRING WITH YOU TO **SIGN IN PERSON** AT OUR OFFICE

After any lab testing, if you do not hear from the office within two weeks, please contact our office.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____

Assignment of Benefits/Consent for Treatment

I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications (including, but not limited to the use of the lab) as ordered by attending physicians. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____

Policies and Procedures

I have been provided the opportunity to read, or it has been read to me, the Policies and Procedures at Cobb Internal Medicine Associates. I have been provided with a copy of the Policies and Procedures at Cobb Internal Medicine Associates. I understand the Policies and Procedures of Cobb Internal Medicine Associates.

Patient/Guardian Signature _____ Date _____
Office or Other Witness Signature _____ Date _____

Patient Information ***Personal Information*** Cobb Internal Medicine Associates, PC

You may complete this form online
Print & BRING TO YOUR APPOINTMENT

Name→ Last _____ First _____ M.I. _____

D.O.B. _____ /_____ /_____ SS# _____-_____-_____ Gender/Sex: _____

Email Address _____

Street Address _____ Apt/Unit # _____

City _____ State _____ Zip Code _____

Mobile (_____) _____-_____ Home (_____) _____-_____ Work (_____) _____-_____

Marital Status
(enter "X") ____Single ____Married ____Divorced ____Widowed ____Partner ____Legally Separated

Mobile (_____) _____-_____ Home (_____) _____-_____ Work (_____) _____-_____

Name of Spouse or Partner: _____

Additional Demographics

RACE *(enter "X")*

____Asian
____Black
____Hispanic
____Non-Hispanic
____White
____Other - Please specify
_____

ETHNICITY *(enter "X")*

____Hispanic
____Non-Hispanic
____Other - Please specify
_____

LANGUAGE *(enter "X")*

____English
____Spanish
____Hindi
____Other - Please specify
_____

Employment Information

YOU MAY SKIP THIS SECTION IF YOU PRE-REGISTERED ONLINE

Employer _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Mobile (_____) _____-_____

Emergency Contact(s)

YOU MAY SKIP THIS SECTION IF YOU PRE-REGISTERED ONLINE

Please list at least ONE additional person we may contact in an emergency situation. This person will be notified of medical information in the event of an emergency ONLY.

Name_____ Relationship to you? _____

D.O.B. _____ /_____ /_____ Mobile (_____) _____-_____ Other (_____) _____-_____

Name_____ Relationship to you? _____

D.O.B. _____ /_____ /_____ Mobile (_____) _____-_____ Other (_____) _____-_____

You may complete this form online
Print & BRING TO YOUR APPOINTMENT

Name→ Last _____ First _____ M.I. _____

Preferred Pharmacy Information

Local Pharmacy Name_____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Fax Number: (_____) _____-_____

Mail Order Pharmacy Name_____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Phone (_____) _____-_____ Fax Number: (_____) _____-_____

Insurance Information

→**PRIMARY** Insurance Company Name_____

Policy # _____ Group Number/Name _____

Policy Holder Last Name _____ First Name _____

D.O.B. _____ /_____ /_____ SS# _____-_____-_____

Relationship to you: _____ *→ if "SELF" you may skip employer info if provided above*

Insured's Employer _____

Street Address _____ Suite # _____

City _____ State _____ Zip Code _____

Work Phone (_____) _____-_____

→**SECONDARY** Insurance Company Name_____

Policy # _____ Group Number/Name _____

Policy Holder Last Name _____ First Name _____

D.O.B. _____ /_____ /_____ SS# _____-_____-_____

Responsible Party/ Guarantor Information

Relationship to You _____ *→ if "SELF" you may skip the rest of this section*

Last Name _____ First Name _____

D.O.B. _____ /_____ /_____ SS# _____-_____-_____

Responsible Party's Employer Name _____

Employer Address _____ Suite # _____

City _____ State _____ Zip Code _____

Work Phone (_____) _____-_____

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PATIENT MEDICATION FORM

You may complete this form online
Print & BRING TO YOUR APPOINTMENT

Name→ Last _____ First _____ M.I. _____

D.O.B. _____ /_____ /_____

I consent to Cobb Internal Medicine obtaining my medication history from other providers/pharmacies:

Patient/Guardian Signature _____ Date _____

PLEASE LIST ALL MEDICATIONS YOU'RE TAKING

Name of PRERSCRIPTION Medications	MG/ Dose	How Often Taken?

Do you have any Allergies? ____YES ____NO If yes, please list all allergies

Allergies	Symptoms

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NEW PATIENT HISTORY FORM

You may complete this form online
Print & BRING TO YOUR APPOINTMENT

Name→ Last _____ First _____ M.I. _____

D.O.B. _____ /_____ /_____

PLEASE LIST ALL PREVIOUS SURGERIES

YEAR	PROCEDURE

PLEASE LIST ANY HOSPITALIZATIONS (OTHER THAN PROCEDURES NOTED ABOVE)

YEAR	REASON FOR HOSPITALIZATION

PLEASE PROVIDE ADDITIONAL INFO

	MOST RECENT DATE	DOCTOR WHO TREATED YOU
PAPSMEAR		
MAMOGRAM		
COLONOSCOPY		
EYE EXAM		