Welcome to Immune Recovery Centers of America
Atlanta Clinic

At Immune Recovery Centers of America (IRCA), we value our patients and aim to provide not only the best possible care, but a smooth registration process. To expedite your registration, this packet contains helpful information, a map to our location, and several forms which you should fill out prior to your first visit.

It is important that you read all the forms enclosed in this packet. Please bring the flowing completed forms to your appointment:

- Patient Data Form
- Patient History Form
- Signature sheet that accompanies the Privacy Policy

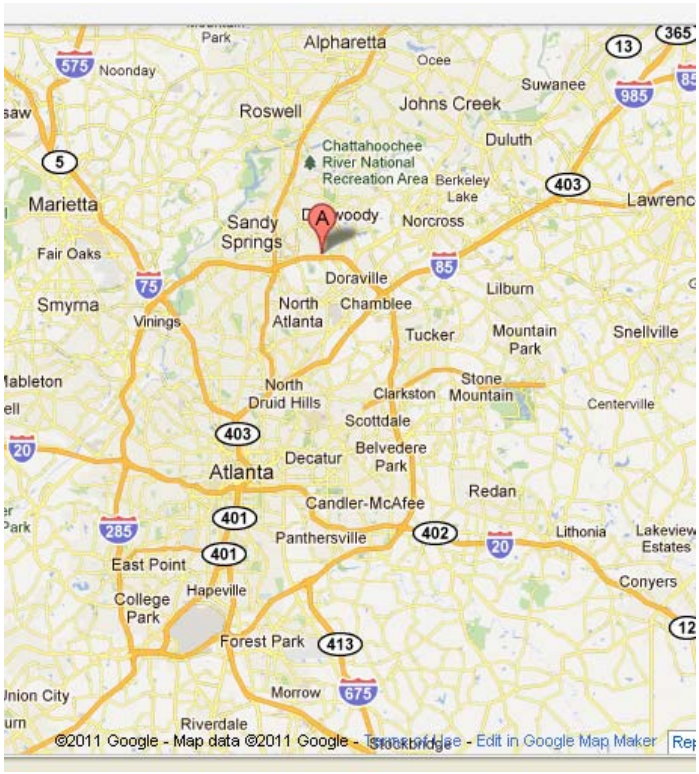
Many frequently asked questions are addressed in the Patient Tips brochure. For example, please allow ample time to get to the office. It is best to arrive 15 minutes ahead of your scheduled appointment. This allows time for us to review your completed forms, make copies of insurance information and take care of any other administrative details. If you have any questions after reviewing this information, please contact our office: 770-455-6100 during business hours.

We look forward to seeing you and thank you for the opportunity to participate in your health care.

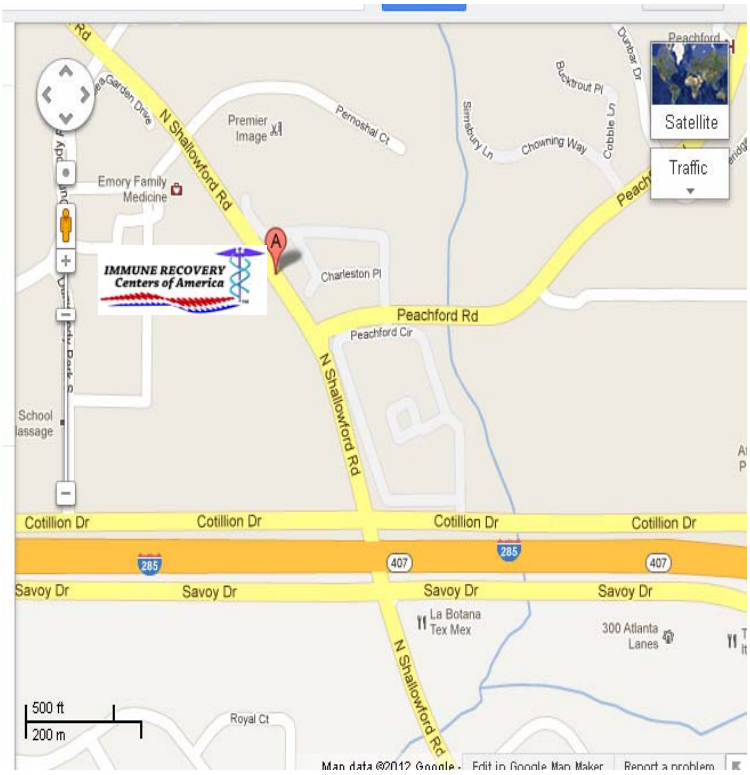
Sincerely,

The Providers and Staff of Immune Recovery Centers of America

Atlanta Metro Area Map



Street Level Map



Directions:

No matter where you are coming from, you will need to take either 285 East or 285 West towards the city of Dunwoody.

From 285 West:

- Continue on 285 West and take Exit 30 / Chamblee Dunwoody Exit
- At the exit ramp, go straight at the light
- Make a left at the next traffic light (N. Shallowford Rd.)
- Go under the 285 bridge and after the 2nd traffic light ((Peachford Rd) look on your left for Waterford Office Park)
- Make a left into the second entrance to 4488 Waterford Office Park
- You may park in the first parking lot to your left.
- You may take the elevator on the main floor or the stairs to go down to the first floor.
- Suite 100 will be at the end of the hallway

From 285 East:

- Continue on 285 East and take Exit 30 / Chamblee Dunwoody Exit
- Proceed straight and turn right at the 2nd traffic light (N. Shallowford Rd.)
- After you pass the 1st traffic light (Peachford Rd) look on your left for Waterford Office Park
- Make a left into the second entrance to 4488 Waterford Office Park
- You may park in the first parking lot to your left.
- You may take the elevator on the main floor or the stairs to go down to the first floor.
- Suite 100 will be at the end of the hallway.

PATIENT TIPS

At Immune Recovery Centers of America, our highly trained providers and staff are dedicated to providing you with the best possible care in a comfortable, compassionate setting. Please take a moment to read our patient tips and a member of our staff will be happy to answer any other questions you may have.

Office Hours

7:30AM to 4:00PM Monday through Thursday
7:30AM to 1:30PM Friday
Provider on call 24/7 (urgent situations only)

Patient Information

Please bring a photo ID and your most current insurance card(s).

Please bring all previous medical records such as lab work, x-rays and any other test results. If you do not have copies of these records, please contact your previous medical providers and have them mail or fax your records to us prior to your appointment.

Insurance Information

Immune Recovery Centers of America accepts Medicare, Medicaid and most major insurance and will bill such insurance for costs related to traditional medical care. All complementary alternative medical treatments **cannot** be billed to your insurance and therefore you will be responsible for procedures not covered by your insurance.

While we participate in most health plans, you should know the following about your specific plan:

- If the physician and facility are in-network
- Your annual deductible
- Your office visit co-payment
- If a referral is required

Payment

Payment is expected at the time of service. This applies to all co-payments, co-insurance and/or deductibles based on your insurance plan and that which is not covered by insurance.

We accept cash, checks and all major credit cards. If needed, payment plans can be arranged with the Assistant Office Manager.

PATIENT DATA FORM
FORM MUST BE COMPLETED IN FULL

Name_____ Date:_____
Home Address_____
Home Phone _____ Cell Phone:_____
Email _____
Social Security #_____ Date of Birth_____

Sex ☐M ☐F Race_____

Employer_____
Employer's Address_____

How did you hear about us?_____

EMERGENCY CONTACT

Name_____ Daytime Phone_____
Relationship_____

PREFERRED PHARMACY INFORMATION

Pharmacy name_____ Pharmacy Phone_____
Pharmacy address_____

PRIMARY, SECONDARY, AND TERTIARY INSURANCE CARRIERS

Primary Insurance_____ Name of Insured_____
DOB_____ Policy#_____ Group#_____

Secondary Insurance_____Name of Insured_____
DOB_____ Policy#_____ Group#_____

Tertiary Insurance_____ Name of Insured_____
DOB_____ Policy#_____ Group#_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

I certify that the above information is correct. I consent to be treated by the staff and providers of Immune Recovery Centers of America (IRCA). I authorize payment of medical benefits to IRCA and authorize them to release any medical information necessary to process claims. **I understand that I am responsible for co-payments, deductibles, co-insurance and services not covered under my insurance policy including the alternative components of my treatment which are *not* billable to insurance**.

Patient/Guarantor Signature_____ Date_____

IMMUNE RECOVERY Centers of America

PATIENT HISTORY FORM

1) **Name**_____ **Age**_____ **Date of Birth**_____

2) **Referred by** _____ **Primary Care Physician**_____

3) **Other physicians involved in your healthcare (Name, Phone and Specialty)**

_____
_____
_____

4) **Describe the reason(s) for your visit today**

_____
_____

5) **List the most recent date any of the following tests or procedures were performed**.
Labs_____ X-rays_____ CT Scan_____
MRI_____ Ultrasound_____ PET Scan_____
Other_____

6) **List ALL medications you are currently taking (use separate sheet if necessary)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

7) **List ALL supplements you are currently taking (use separate sheet if necessary)**

_____ _____
_____ _____
_____ _____
_____ _____

8) **List any allergies**

_____ _____
_____ _____

9) **SOCIAL HISTORY**
Provide details regarding current and/or past use of the following.

Alcohol (beer, wine, liquor) ☐Yes ☐ No Usage_____

Tobacco (cigarettes, cigars, chewing tobacco) ☐Yes ☐No Usage_____

I.V. or Recreational Drugs ☐Yes ☐No Usage_____

11) **SYSTEMS REVIEW**: Do you have or have you recently experienced any of the following?

Yes	No	DIGESTIVE SYSTEM
☐	☐	Difficulty in Swallowing
☐	☐	Heartburn/Esophageal Reflux
☐	☐	Nausea/Vomiting
☐	☐	Indigestion
☐	☐	Bloating/Belching/Gaseousness
☐	☐	Abdominal Pain
☐	☐	Gallstones/Gallbladder Disease
☐	☐	Hepatitis or Liver Disease
☐	☐	Crohn's Disease/Ulcerative Colitis
☐	☐	Irritable Bowel Syndrome
☐	☐	Gastrointestinal Bleeding
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Diarrhea/Loose Stool
☐	☐	Change of Bowel Habit
☐	☐	Rectal Bleeding (in stool, commode, toilet paper)
☐	☐	Black Stool
☐	☐	Mucus in Stool
☐	☐	Unintentional Weight Loss
☐	☐	Anal/Rectal Pain or Itching
☐	☐	Anal Spasm
☐	☐	Anal Fissures

Yes	No	ALLERGY/IMMUNOLOGY
☐	☐	HIV/AIDS
☐	☐	Blood Transfusion

Yes	No	CARDIOLOGY
☐	☐	Chest Pain
☐	☐	Pacemaker
☐	☐	History of Heart Attack
☐	☐	Mitral Valve Prolapse or Murmur
☐	☐	Artificial Heart Valve
☐	☐	Hypertension

Yes	No	EARS, EYES, NOSE, MOUTH, THROAT
☐	☐	Ear Pain/Ringing
☐	☐	Mouth Ulcers/Sores
☐	☐	Poor Dentition
☐	☐	Nose Bleeds
☐	☐	Visual Changes

Yes	No	ENDOCRINE
☐	☐	Diabetes
☐	☐	Thyroid Problem
☐	☐	Hormonal Problem

Yes	No	GENITOURINARY
☐	☐	Are you pregnant? Date of last period?_____
☐	☐	Recent/Frequent Urinary Tract Infection
☐	☐	Blood in Urine
☐	☐	Burning with Urination
☐	☐	History of Kidney Stone

Yes	No	LYMPHATIC/HEMATOLOGY
☐	☐	Enlarged Nodes/Swollen Glands
☐	☐	Anemia
☐	☐	Bleeding Problems

Yes	No	MUSCULOSKELETAL SYSTEM
☐	☐	Lupus, Scleroderma, Related Disease
☐	☐	Joint Pain/Arthritis
☐	☐	Back Pain
☐	☐	Problems Walking

Yes	No	NEUROLOGY
☐	☐	Seizure Disorder
☐	☐	Headaches
☐	☐	Stroke

Yes	No	PSYCHIATRY
☐	☐	Depression/Anxiety
☐	☐	Past Evaluation/Treatment

Yes	No	PULMONARY
☐	☐	Shortness of Breath
☐	☐	Asthma/Wheezing/Cough

Yes	No	SKIN
☐	☐	Dermatitis or Rash
☐	☐	Itching
☐	☐	Psoriasis
☐	☐	Jaundice (yellow eyes or skin)

OTHER _____
_____
_____

NOTICE OF PRIVACY PRACTICES

Immune Recovery Centers of America (IRCA) presents this Notice to our patients describing how your medical information may be used or disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information

IRCA uses health information about you for treatment, analysis procedures and lab results. We use information to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: IRCA will use and disclose your health information to provide you with medical treatment or services. For example, nurses, providers and other members of your treatment team will record information in your medical record and use it to determine the most appropriate course of action are. IRCA may also disclose this information by phone, fax, in person, or electronically. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

Payment: IRCA will use and disclose your health information for payment purposes. For example, IRCA may need to obtain authorization from your insurance company before providing certain types of treatment. IRCA will submit bills and maintain records of payments from your health plan.

Health Care Operations: IRCA will use and disclose your health information to conduct our standard internal operations, including proper administration or records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Release of Information to Family and Friends

IRCA knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to speak with us regarding your care or test results, please write their name and contact information on the "Notice of Privacy Practices Acknowledgement" form. IRCA will not release your information to any friend or family member without your written consent.

Special Uses

IRCA may use your information to contact you with appointment reminders by phone or mail. IRCA may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be sent to you via the methods listed above. If you have granted written permission, the above information may also be sent to you via email. If you wish to authorize the use of email as a method for IRCA to communicate with you, sign the proper section on the "Notice of Privacy Practices Acknowledgement" form.

Other Uses and Disclosures

IRCA may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, IRCA is permitted to give your health information without your written permission for the following purposes:

Required by Law

IRCA may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research

IRCA may use or disclose information for approved medical research.

Public Health Activities

As required by law, IRCA may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight

IRCA may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings

IRCA may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes

Subject to certain restrictions, IRCA may disclose information required by law enforcement officials.

Deaths

We may report information regarding deaths to coroners, medical examiners, funeral and organ donation agencies.

Serious Threat to Health or Safety

IRCA may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions

If you are a member of the armed forces, IRCA may release information as required by military command authorities. IRCA may also disclose information to correctional institutions or for national security purposes.

Workers' Compensation

IRCA may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Submit any concerns in writing to IRCA's compliance officer (see below).

Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. IRCA is not required to agree to such restrictions, but if we do agree. IRCA must abide by those restrictions.

Confidential Communications.

You may ask us to communicate with you confidentially. Please ask to see your IRCA Compliance Officer to initiate and document this request.

Inspect and Obtain Copies

You have the right to see or receive a copy of your health information. There may be a small charge dictated by Georgia Law for these copies.

Accounting of Disclosures

You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. A current version of our Notice is available at all times. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You will not be penalized in any way for filing a complaint.

If you have any questions, requests or complaints, please contact IRCA's Compliance Officer:

Immune Recovery Centers of America
ATTN: Compliance Officer
4488 N. Shallowford Rd.
Suite 100
Dunwoody, GA 30338

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT

I,_____, hereby acknowledge that IRCA has given me the opportunity to read a detailed notice of their Privacy Practices.

_____ Date_____
Patient/ Authorized Representative Signature

If not signed, please provide a reason why the acknowledgement was not obtained.

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative from IRCA to speak with family member(s) or companion(s) listed below regarding care or test results.

Name_____ Phone_____

Relationship_____

Name_____ Phone_____

Relationship_____

Is it OK to leave results or information on your voicemail? ☐ Yes ☐ No

_____ Date_____
Patient/ Authorized Representative Signature

CONSENT TO CORRESPOND ELECTRONICALLY

While IRCA takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic email to initiate contact with an IRCA provider or staff regarding my medical care, the provider and/or his/her representative has my permission to correspond via that email address.

I give permission for an IRCA provider or clinical staff member to email me at (please print neatly) _____@_____ regarding my medical care.

_____ Date_____
Patient/ Authorized Representative Signature
