Above & Beyond Healthcare, LLC
dba Beyond Health Group

Nancy A. Hurlock, AGPCNP-BC

Please complete the attached patient information sheet along with current copy of Primary and Secondary Insurance cards (front and back) and return:

By email:

info@beyondhealthgroup.com

By Mail to:

430 Northside Drive E
Ste 160
Statesboro, GA 30458-4929

By Fax:
800 – 859 -1297

Please feel free to contact our office with any questions.

Thank you,

Beyond Health Group

Above & Beyond Healthcare, LLC
dba Beyond Health Group
Telephone: 912-481-3003
Fax: 800 -859 -1297
www.beyondhealthgroup.com

Personal Information

Full Name: ____
Last *First* *M.I.*

Address: ____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: ____________________ Mobile Phone: ____________________

Birth Date ____________ Sex: **M / F** SSN ____________

Smoke?

Y/N How many per day? ____________ Quit: Y/N When? ____________

Medicare #: ____________________ Is Medicare the Primary Insurance? Y/N

Other
Insurance ID #: ____________ Group ID # ____________

____

Health History

Allergies:	**Reactions to Allergen:**
Past Medical History:	
Past Surgical History:	
Family History	

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

Patient Name: ____ **D. O. B.** ____________________

I hereby authorize:

____

To release visit notes, laboratory results, radiographic findings and all important information pertaining to my medical care to:

Above & Beyond Healthcare, LLC
dba Beyond Health Group

430 Northside Drive E Ste 160

Statesboro, GA 30458-4929

(T) 912-481-3003 (Fax) 800 -859 -1297

Specify Dates (or date ranges) if necessary:

____

This request is for the purpose of: establishing medical care

____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in six months or on this date listed _________________________.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorization is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information or genetics. THIS INFORMATION WILL ALSO BE RELEASED UNLESS YOU INDICATE: _____________ DO NOT RELEASE (Indicate Check Mark)

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.

____ ___________________________________

Signature of Patient or Authorized Representative **Date**

____ ___________________________________

Representative Authority to Act on Behalf of Patient **Signature of Witness**

I hereby signed that I received and read the **Above & Beyond Healthcare, LLC dba Beyond Health Group** Notice of Privacy Practices (copy can be found on beyondhealthgroup.com)

Name:____ Date: ________________________________

Signature:____

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to **Above & Beyond Healthcare, LLC dba Beyond Health Group** for medical or surgical services or items rendered by **Above & Beyond Healthcare, LLC dba Beyond Health Group**. Should my insurance carrier deny **Above & Beyond Healthcare, LLC dba Beyond Health Group** payment, I understand that I am financially responsible for the charges. I authorize **Above & Beyond Healthcare, LLC dba Beyond Health Group** to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information.

Name:____ Date: ________________________________

Signature:____

I hereby authorize **Above & Beyond Healthcare, LLC dba Beyond Health Group** to provide medical care services to

Name:____ Date: ________________________________

Signature:____