Greater Athens Physicians, Inc
774 Athens Rd
Lexington, GA 30648-1908
Phone: (706) 743-8183
Fax: (706) 743-3233

PATIENT INFORMATION:

NAME: First_____Last_____MI_____

ADDRESS: _____

CITY _____STATE _____ZIP_____

GENDER: M ____ F ____ **MARITAL STATUS:** M ____ S ____ D ____ W ____

DOB: ___/___/____ **SSN:** _____-_____-_____

HOME PHONE: ( )_____-_____ **EMAIL:** _____

CELL PHONE: ( )_____-_____ **MOBILE CARRIER:** _____

WORK PHONE: ( )_____-_____ **EMPLOYER:** _____

STATUS: FULL TIME: ___ PART TIME: ____ RETIRED: ____ UNEMPLOYED: ____

STUDENT: Y ___ N ____ STATUS: F/T: ___ P/T: ___ **SCHOOL:** _____

HOW WOULD YOU LIKE TO RECEIVE CONFIRMATION OF YOUR APPOINTMENT?

TEXT: ____ EMAIL: _____ BOTH: _____ PHONE CALL ONLY: _____

Preferred Contact Number:
( ) ____-_____

EMERGENCY CONTACT:

NAME _____ CONTACT NUMBER ( ) _____-_____

INSURANCE INFORMATION:

COMPANY NAME _____ EFFECTIVE DATE ____/____/_____

IF YOU ARE A DEPENDENT (SPOUSE, CHILD, ETC) ON THIS INSURANCE POLICY, PLEASE LIST THE NAME AND DOB OF THE ACTUAL POLICY HOLDER.

POLICY HOLDER NAME: _____ DOB ____/____/_____

RESPONSIBLE PARTY FOR BILLING: SELF: _____ OTHER: _____

NAME _____ DOB ____/____/_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Greater Athens Physicians, Inc.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name:_____Date Of Birth:_____

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individuals regarding my condition or course of treatment: _____

Name:_____Relationship:_____Phone#_____

Name:_____Relationship:_____Phone#_____

Name:_____Relationship:_____Phone#_____

_____ _____

Individual Signature Date

As a personal representative, I have authority to act for the individual because I am the individual's

_____

Greater Athens Physicians, Inc
H. Philip Morris, MD
774 Athens Rd
Lexington, Ga 30648-1908
Phone: (706) 743-8183
Fax: (706) 743-3233

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of Greater Athens Physicians, Inc. on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of said Notice will be posted in the offices of Greater Athens Physicians, Inc.

I also understand that if I wish to receive additional copies of the Notice of Privacy Practices in the future or if I have any questions with regard to this Notices of Privacy Practices, I may contact:

Greater Athens Physicians, Inc.
Jan Lee
Practice Administrator
PO Box 409
Watkinsville, Ga 30677-4836
Phone: (706) 769- 6469

Signature of Patient:_____

Print Name: _____

Date: _____

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AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

I, the undersigned patient (person authorized to consent for patient), hereby authorize Greater Athens Physicians to release any medical information necessary to process my insurance claim to my insurance company.

The release of information to which I consent is for the purpose of processing my insurance claims.

I understand this authorization includes release of all medical records including HIV records, Psychiatric, Drug/Alcohol abuse records, Venereal disease, and any other statutory protected disease. I hereby assign and authorize payment to Greater Athens Physicians of all medical and / or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf, and I hereby accept responsibility, including but not limited to: payment of those fees and charges not directly reimbursed to Greater Athens Physicians by any insurance policy, self-insurance program or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. I understand that I have the right to receive a copy of this authorization.

_____ _____

Patient's (or legal representative's) Signature Date of Signature

_____ _____

Relationship to patient, if any Signature of Witness, if any

FINANCIAL POLICY
GREATER ATHENS PHYSICIANS, INC.

Greater Athens Physicians, Inc., participates with most major insurance plans as a convenience to our patients; however we expect patients to pay their share for our services, as outlined in your benefit contract. We will help you determine these amounts. All co-pays are due at sign-in.

We request payments of coinsurance and deductibles, etc., at the time of service. **WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD.**

To better serve you, if you have any changes in insurance carrier, employment, home address, home/work telephone numbers, name, etc., PLEASE inform our receptionist. IT IS YOUR RESPONSIBILITY TO INFORM OUR PRACTICE OF THESE CHANGES.

Your Insurance coverage is an agreement between you and your Insurance Carrier. It is your responsibility to make payments for charges denied by your Insurance Carrier.

We expect a denial from your Insurance company within 30 days of the initial claim. If an Insurance problem occurs, you will be asked to assist us in contacting your Insurance Carrier. We feel it is necessary to work together to resolve any Insurance problems.

In the event that your Insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of fees at the time of service.

Returned checks will be subject to additional collection fees.

All patients refusing to make payments after 60 days of notice, without pending Insurance or a financial arrangement made, will force us to limit their future credit until the previous balance is paid in full.

Our practice believes that a good Doctor/Patient relationship is based on understanding and good communications. Our staff will make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact our practice immediately.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

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CONSENT FOR MEDICAL TREATMENT

I hereby authorize and consent to medical treatment rendered by the physicians, nurse practitioner, or physician's assistant at Greater Athens Physicians, Inc. I also consent to diagnostic studies, x-ray examinations, labs and any other treatment relating to my diagnosis that the providers feel necessary.

_____
Patient or person giving consent

_____
Relationship to pt if not pt

Patient is unable to sign because of:_____

_____
Witness

Greater Athens Physicians, Inc.

It is the desire of the providers and staff at Greater Athens Physicians, Inc. to constantly provide the care and concern that each patient deserves. Over the past few months we have made changes to improve our overlal practice performance. In trying to meet the needs of every patient we looked at several areas. Please read the following new policies. If you have any questions or concerns, please do not hesitate to let us know.

LAB/DIAGNOSTIC TESTING RESULTS
Our medical assistants will notify you of abnormal results, depending on the test this could take several days. If you have not heard from us in two weeks, please call our office.

PRESCRIPTIONS
For prescription refills we will need 48 hours notice. Always call 2 days prior to your medicine running out. Have your pharmacy's telephone number ready when you call. No nerve pills, sleeping pills or pain pills will be filled on Fridays or after hours.

APPOINTMENTS
The providers and staff are working hard n an attempt to reduce your wait time. When you call for an appointment please be specific about why you wish to see the doctor. This will allow us to allot the time needed for you appointment. When you must cancel an appointment please call at the earliest possible time. We need at least 24 hours notice.

NO SHOWS
Appointments are booked weeks ahead of time. If you do not show up for your appointment, this leaves a time slot that could have been used by another patient. We have a new policy on no shows, you will now be charged for your appointment slot. This will not be billed to an insurance company, this will be the patients responsibility to pay. If you miss three appointments and have not called to cancel or reschedule, you may be dismissed from the practice.

TARDY
If you are late for your appointment you may be asked to reschedule.

INSURANCE
Are we your PCP (Primary Care Physician)? Check your insurance card. Please become familiar with your insurance. Know your BENEFITS. Know what laboratory you must use. Do you know what hospital your insurance requires? There are certain procedures, diagnostic testing, etc., that must be prior authorized or pre-certified before the test is performed. Do you know if your insurance requires prior authorization or pre-certification? All this information is very important. This is the patient's responsibility to know.

You will be asked at each visit to show your insurance card to verify the information we have on file. You may be asked to fill out a form to update your information. We know this can be annoying but keeping information updated can insure proper billing.

HOSPITAL SERVICES
The physicians of Greater Athens Physicians, Inc. utilize the hospitalists at St. Mary's and at Piedmont Athens Regional Medical Center. Hospitalists are physicians who specialize in caring for patients in the hospital 24 hours every day. Using the hospitalist enables your physician to be more available to you in the office with fewer interruptions and allows the hospitalist to be more available to care for you when you are at your sickest. Once you are discharged from the hospital you will return to your physician for all follow up care.

PAYMENTS
Co-payments, coinsurance and deductibles are payable at the time of service. If they are not paid at the time of service you will be charged a $4.99 fee for the cost of billing you.

CELL PHONES
Please turn your cell phone off when entering the office.

Thank you for your time spent reading our office policies. Please let us know if you have any questions:

Initial:_____

Date: _____