GREATER ATHENS PHYSICIANS, INC.
855 GAINES SCHOOL RD, STE G
ATHENS, GA 30605

PATIENT INFORMATION:

NAME: FIRST ________________ LAST ______________ MI ______

ADDRESS: ____

CITY: __________________ STATE: ________ ZIP: __________

GENDER: M _____ F _______ MARITAL STATUS: M ___ S ___ D ___ W___

DOB: _____/_____/_____ SSN: _____-_____-_____

HOME PHONE: ( ) ____- ________ EMAIL: ____________________

WORK PHONE: ( ) ____- ________ EMPLOYER: _________________

STATUS: F/T ____ P/T _____ RETIRED ____ UNEMPLOYED _____

STUDENT: Y _____ N_____ F/T _____P/T____ SCHOOL _____________

CELL PHONE: ( ) ____-__________ CELL PROVIDER: _____________

HOW WOULD YOU LIKE TO RECEIVE REMINDERS OF YOUR APPOINTMENT?

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

EMERGENCY CONTACT:

NAME: __________________ CONTACT NUMBER ( ) ____- ________

INSURANCE INFORMATION

COMPANY NAME: ______________ EFFECTIVE DATE: _____/_____/_____

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

____