GREATER ATHENS PHYSICIANS, INC.
H. PHILIP MORRIS, JR M.D.
1450 B BARNETT SHOALS RD.
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: FULL TIME: ___ PART TIME: ___ RETIRED: ___ UNEMPLOYED: ___

STUDENT: Y___ N___ STATUS: F/T: ___ P/T: ___ SCHOOL: _____

CELL PHONE: ( )___-____ MOBILE CARRIER: _____

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 _____

FINANCIAL POLICY

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 benefits contract. We will help you determine these amounts.

We request payment of coinsurance and deductibles, etc., at the time of service. We accept CASH, CHECKS, or VISA/MASTERCARD.

To better serve you, if you have any changes in insurance carrier, employment, home address, home/work phone 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 or not paid by your insurance carrier.

We expect payment of denials 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 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 financial arrangement will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished.

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 office immediately.

I have read, understand, and agree to this Financial Policy:

_____ _____

Signature of Patient or Responsible Party Date

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 overall 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 in 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 your appointment.
When you must cancel an appointment please call at the earliest possible time. We need at least 24 Hours.

NO SHOWS
Appointments are booked weeks ahead. 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.

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 Athens Regional Medical Center. Hospitalists are physicians who specialize in caring for patients in the hospital 24 hours everyday. 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:

_____

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
P.O. Box 409
Watkinsville, GA 30677
706-769-6469

Patient Acknowledgment of Notice of Privacy Practices

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

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 Notice of Privacy Practices, I may contact:

Greater Athens Physicians, Inc
Denise Gattis, Site Coordinator
1450 B. Barnett Shoals Road
Athens, GA 30605
706-543-6443

_____
Signature of Patient

Print Name: _____

Date: _____

Effective Date: April 13, 2003
Date of Last Revision: April 13, 2003

Greater Athens Physicians, Inc.
1450-B Barnett Shoals Road
Athens, Georgia 30605
Phone: (706) 543-6443
Fax: (706) 543-8202

WELCOME TO THE GREATER ATHENS PHYSICIANS, INC. PATIENT PORTAL

We are required to give you access to our medical records by Medicare or your insurance company. You are not obligated to use it.

The Doctors and Staff wish to welcome you to our Patient Portal. The Patient Portal will provide a method of communication between the office and the patient. All communication between the office and yourself will be encrypted and your information is protected in the same manner as your other medical and personal information. We will use all current technology available to keep your information secure.

You will be provided with a username and temporary password. You will also receive a welcome email from the Patient Portal with an access link (if you have provided an email address). Save this link in your favorites list. If not we will provide you with the portal web address. Once you access the Patient Portal, you will be asked to select a new password. Do not worry if you forget it, you can call the office and have them reset your password. If you do not have an email address you will not be notified. No one can access your medical information without your login or password.

If you wish to contact the office without calling, you can send a message:

- To confirm appointments (all appointment requests or cancellations must be made by phone)
- To update demographic or insurance information
- Ask questions regarding your account

The staff may send you messages as well regarding:

- Normal lab results
- Appointments confirmations
- Information regarding your prescription requests
- The need to call the office and schedule an appointment
- Questions regarding your account

Due to the amount of phone calls we receive daily, we know you will enjoy this extra feature. This will increase the speed of service you receive and allow you to send a message straight to the nurse, receptionist, or insurance department.

DO NOT USE EMAIL TO COMMUNICATE EMERGENCY INFORMATION. CALL 911, GO THE EMERGENCY ROOM OR CALL OFFICE DIRECTLY AND IMMEDIATELY.

GREATER ATHENS PHYSICIANS, INC. PATIENT PORTAL

_____ I agree to the usage of the Patient Portal to enhance the communication process between Greater Athens Physicians, Inc. and myself. I also understand the Patient Portal is certified HIPAA compliant and that no one can access my medical information without my login and password.

Please print clearly

Email: _____ Phone: _____

Print Name: _____

Signature: _____ Date: _____

Date of Birth: _____

Username: _____

Temporary Password: Password1

Your new password will need to be at least 6 alpha characters and one number.

After activation, you will receive an email from portal@sevocity.com prompting you to change your password and activate the portal.

The portal website is: www.medicalofficeconnect.com/8444/PatientPortal/auth/sign-in

PATIENT PORTAL OPT OUT

_____ I would like to decline the ability to connect with my doctor using the Patient Portal. I understand that I can join the portal at any time in the future.

Print Name: _____

Signature: _____

Date: _____