Greater Athens Physicians, Inc.

Patient Demographics	
Name:	
Address:	
Nickname:	
Social Security	
Date of Birth	
Email	
Home Phone	
Cell / Other Phone	
Cell phone carrier	
Appointment Contact Method	Phone Email Text
Gender	Male Female
Marital Status	Single Married Divorced Widowed Seperated N/A
Employment Status	Full time Part time Retired N/A
Employer	
Work Phone	
Student Status	Full time Part time N/A
School	
Emergency Contact Name	
Emergency Contact Phone	
Insurance Policy Holder (if same as above can leave blank)	
Name	
Address	
Relationship to Patient	
Social Security	
Date of Birth	
Employer Name	
Home Phone	
Mobile Phone	
Work Phone	
Email	
Responsible Party (if different than policy holder)	
Relationship to Patient	
Name	
Address	
Social Security	
Date of Birth	
Home Phone	
Mobile Phone	
Work Phone	
Email	

Greater Athens Physicians, Inc.

Raymond Gilbert, Jr, MD
1550 Mars Hill Rd
Watkinsville, GA 30677

In an effort to improve patient care and provide access to care, this practice utilizes Physician Assistants. These clinicians are available to evaluate patients, provide counseling and initiate therapy under the supervision of the physician here. For immediate or acute care situations, patients are offered the first available appointments with any of the clinicians. For an appointment with the clinician of choice the next available appointment will be scheduled.

I understand the above information.

_____ _____

Signature Date

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

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.
Raymond Gilbert, MD
1550 Mars Hill Rd
Watkinsville, GA 30677
phone: 706-769-4852 fax 888-974-4029

Authorization Release of Medical Information

Patient Name:_____ Date of Birth:_____
Address:_____
_____
City/State/Zip:_____

I authorize GAP, Inc to RELEASE information to:
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

I authorize GAP, Inc to OBTAIN information from:
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

I hereby authorize the above Physician/hospital/facility to release information including, if any, psychiatric or psychological information, infections or contagious disease information (including HIV/AIDS) and or information about drug or alcohol abuse or treatment of the same from the health records.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibilty for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Reason for Release/Obtaining of Information:_____
_____

Patient/Legal Representative Signature:_____
Office Staff Signature:_____
Date:_____
Date request will expire:_____

Greater Athens Physicians, Inc.

Dr. Raymond L. Gilbert

Scott Martin, PA-C

Blakely York, PA-C

1550 Mars Hill Road Watkinsville, GA 30677

Phone (706) 769-4852

Fax (706) 769-8372

WELCOME TO THE GREATER ATHENS PHYSICIANS, INC. PATIENT PORTAL

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 create a unique username and we will provide you with a 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 wish to send a message to 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
- Request prescription refills

The staff may send you messages as well regarding:

- Normal lab results
- Appointment confirmations
- Information regarding your prescription requests
- The need to call the office and schedule an appointment
- Questions regarding your account
- Receipts for payments made

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 TO THE EMERGENCY ROOM OR CALL OFFICE DIRECTLY AND IMMEDIATELY.

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I, _____, agree to the usage of the patient portal to enhance the communication process between Greater Athens Physicians, Inc. and myself and further, I understand the patient portal is certified HIPAA compliant.

Name: _____ _____ _____
First **Middle** **Last**

Date of Birth:_____
Email:_____
Please print clearly

Username:_____
Temporary Password: Password1

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: https://www.medicalofficeconnect.com:8444/PatientPortal

RETURN THIS FORM TO RECEPTIONIST

Greater Athens Physicians, Inc.

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Scott Martin, PA-C
Blakely York, PA-C
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Watkinsville, GA 30677
Phone (706) 769-4852
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PATIENT PORTAL

To access your patient portal either log in to your email or follow the link below:

https://www.medicalofficeconnect.com:8444/PatientPortal

Username:_____

Temp Password: Password1

At first official login, you will be prompted to change your password to a more secure and private password. This password will be a password you create and only you will know this password.

KEEP THIS FORM FOR YOUR RECORDS