North Atlanta Women's Care

PATIENT INFORMATION

PLEASE GIVE COMPLETE LEGAL NAME

Last Name _____ MI ____ First Name _____

Maiden Name _____ Address _____

City _____ State ____ Zip _____ SS# _____ Date of Birth _____/_____/_____

Home Phone ____-_____-_____ Cell Phone ____-_____-_____ Marital Status: S M D W(Circle One)

Race _____ Employer_____ Work Number _____

E-Mail Address _____

Primary Care Physician _____ Referring Physician_____

Preferred Pharmacy _____ City _____ Phone Number _____

BELOW ARE QUESTIONS CONCERNING THE PRIMARY INSURANCE HOLDER
(IF DIFFERENT FROM PATIENT)

Last Name _____ MI ____ First Name _____

Address _____ City _____ State _____ Zip _____

SS# _____ Date of Birth _____/_____/_____ Home/Cell Phone _____-_____-_____

EMERGENCY CONTACT

Last Name _____ First Name _____ Relationship _____

Home Phone ____-_____-_____ Cell Phone ____-_____-_____ Work Phone ____-_____-_____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug, and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review of quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to North Atlanta Women's Care PC for all medical and/or surgical benefits, including major medical policies, to which I am entitles under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of any financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to North Atlanta Women's Care PC by any insurance policy, self-insurance program or other benefit plan.

This Authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature_____ Date _____/_____/_____

Alternative Contact Authorization

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me or leave messages for me at my place of work.

Initial _____ Date _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me at my E-mail address.

E-Mail Address if authorized: _____

Initial _____ Date _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me by text.

Cell Phone Number if authorized: _____

Initial _____ Date _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to discuss my appointments. Medical evaluation, treatment and results to relatives or other persons as indicated:

Authorized person(s)/relationship _____

Initial _____ Date _____/_____/_____

I hereby authorize North Atlanta Women's Care PC to leave messages on my home answering machine/voicemail regarding appointments and to inform me that lab work or ultrasound results are available. I realize I must call the office to obtain the results.

Initial _____ Date _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to leave messages on my home answering machine/voicemail to inform me if my lab work or ultrasound results are **normal**. I realize that I must call the office if I have any concerns or questions regarding the results.

Initial _____ Date _____/_____/_____

I acknowledge that I have received a copy of the "NOTICE OF PRIVACY PRACTICES" and "PATIENT RIGHTS & RESPONSIBILITIES" for my records.

Initial _____ Date _____/_____/_____

I have been provided with a copy of the Clinic's Grievance Policy.

Initial _____ Date _____/_____/_____

North Atlanta Women's Care

North Atlanta Women's Care is a multi-physician practice. This means on some occasions if your physician is called away to an emergency, you may be seen by another physician that day or rescheduled to another day. Unfortunately due to our patient care policy we cannot allow the transfer of permanent care between physicians. Thank you for your understanding and continued support of our practice.

_____ _____

Patient Name **Date**

_____

Patient Signature

North Atlanta Women's Care

6300 Hospital Pkwy., Suite 375 Johns Creek, GA 30097
4040 Old Milton Pkwy., Suite 200, Alpharetta, GA 30005
Phone: 770-771-5270 Fax: 770-771-5279

Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment and services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the Physician and you (the Patient). Our contract is with you only. We will not compromise you medical care to satisfy ANY insurance company. Please bear in that insurance is meant to help defray the cost of medical care and is NOT intended to dictate you treatment.

Payment is due in full at the time services are rendered. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy, we are happy to assist you in the filing of most insurance claims and completing insurance forms and insurance precertification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being property billed, the entire balance will be your responsibility. The ULTIMATE RESPONSIBILITY for the filling and processing of claims to satisfy your insurance carrier REMAINS WITH YOU. If you are unsure of any specific requirements of you insurance, PLEASE ASK THEM. As the insured client, you are in the best position to follow up with your insurance carrier to ensure payment is being processed. It is your responsibility to inform us in cases of any change of your insurance or policy type, failure to do so results in you being responsible for the amount.

You will receive a monthly statement requesting payment of any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but are unable to assist if you do not contact us to discuss your account. Nonpayment will result your account turned to collection agency and discharge from the practice. You will be responsible for collection charges born by collection agency on top of the amount due from North Atlanta Women's Care PC.

There is a fee (currently $35) for any checks returned by the bank. **Appointments and procedures not cancelled with 24 hours notice may result in charges for time reserved. This will be billed directly to you and will involve a standard fee of $25 for appointments and $250 for procedures.**

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while delivering quality health care to you.

I have read and understood the above policies. I understand that I may receive a copy of this form upon request.

Patient Name_____ Date_____/_____/_____

Signature of Patient or Responsible Party _____

OB PAYMENT PLAN

We are pleased to welcome you as an OB patient.

The purpose of this letter is to give you a brief explanation of you OB payment policy.

If your insurance plan has deductible, you are required to meet your deductible by the 30th week of pregnancy. Please make sure that we have you updated insurance information, copy of your insurance card and the amount that you have met towards your deductible.

If you leave our care before delivery, you will only be charged for services rendered while a patient. In that case if the amount paid as deductible exceeds amount of services rendered we will refund the difference.

If you have any pre-existent condition on your insurance, and if the insurance company denies payment because of that, then you will be responsible for the fee for the service rendered.

If you do not have any insurance coverage, your entire account will be due by the 30th week of pregnancy 50% of which will be collected by the 20th week of pregnancy. Nonpayment will result in discharge from the practice.

Once again thank you for the choosing North Atlanta Women's Care for your obstetrical care. We look forward to helping you during the months to come.

_____ _____

Due Date Amount Due

_____ _____

Patient Signature Date

_____

Patient Name

_____ _____

Office Manager Date

North Atlanta Women's Care

6300 Hospital Pkwy, Ste 375
Johns Creek, GA 30097

4040 Old Milton Pkwy, Ste 200
Alpharetta, GA 30005

Phone: 770.771.5270 Fax: 770.771.5279

Authorization for Release of Medical Information

Patient's Name _____ Date of Birth _____/_____/_____

Address _____

City/State/Zip Code _____

SS# Patient's Phone #

FOR OFFICE USE ONLY

Date of Request _____/_____/_____ **Date Needed** _____/_____/____

☐ I authorize North Atlanta Women's Care to **release** information to:	☐ I authorize North Atlanta Women's Care to **obtain** information from:
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City/State/Zip Code	_____ City/State/Zip Code
Phone # _____ Fax # _____	Phone # _____ Fax # _____

Purpose for the Request: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care ☐ Other

Type of Record Requested: (Check one)

☐ Immunization History ☐ Administered by the Clinic Only ☐ Include Records Submitted to the Clinic ☐ All Medical Records Related to a Specific Illness or Injury_____
Specify Illness / Injury Date(s) of Treatment

☐ Treatment Summary (includes history / physical, laboratory test & x-ray reports, operative reports, pathology)

☐ Specific Information (Select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ Laboratory Test Results

☐ X-ray Reports ☐ Other _____
(Please Describe)

☐ Entire Copy of the Record Checked Above

Authorization Valid For: (Check one)

☐ This Request Only

☐ One Year from the Date of this Authorization.

☐ This Request **and** for Medical Records of any **Future** treatment of the Type Described Above Until _____(insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical Records are Faxed in Cases of Medical Necessity Only.

Signature of Patient or Representative _____Date _____/_____/_____

Relationship to Patient (*if requester is not the patient*) _____