6501 PEAKE RD, SUITE 400,
MACON, GA 31210

Southern Primary Care

101 Willie Lee Pkwy, Suite 400,
Warner Robins, GA 31088

OFFICE (478) 477 -0966 FAX (478) 254 – 3146

WWW.SOUTHERNPRIMARYCARE.COM

PATIENT INFORMATION FORM

LAST NAME:_____ FIRST NAME:_____ M.I. _____

ADDRESS: _____

HOME PHONE:_____CELL PHONE:_____

EMAIL ADDRESS:_____

SSN:_____ BIRTHDATE:_____SEX: M or F

RACE(circle): ASIAN/AFRICAN/HISPANIC/WHITE/REFUSE/OTHER_____ MARITAL STATUS: S M W D

PREFERRED LANGUAGE:_____ ETHNICITY(circle):HISPANIC/NOTHISPANIC/REFUSE

PATIENT EMPLOYER_____OCCUPATION_____

EMPLOYER'S ADDRESS:_____

EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE NUMBER:_____

INSURANCE CARRIER:_____INSURED'S SSN:_____

INSURED'S NAME:_____INSURED'S BIRTHDATE:_____

RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE CARRIER:_____INSURED'S SSN:_____

INSURED'S NAME:_____ INSURED'S BIRTHDATE:_____

PHARMACY NAME/LOCATION:_____

IF PATIENT IS A MINOR, COMPLETE THE NEXT SECTION

FATHER'S NAME:_____NUMBER:_____

MOTHER'S NAME:_____NUMBER:_____

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO SOUTHERN PRIMARY CARE TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS OR MEDICAL FACILITIES ASSOCIATED WITH MY CARE PLAN. I UNDERSTAND THAT SOUTHERN PRIMARY CARE ABIDES BY HIPAA REGULATIONS AND THAT ONLY THE RECORDS PERTINENT TO THE VISIT WILL BE RELEASED. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS.

PATIENT NAME:_____ BIRTHDATE:_____

RESPONSIBLE PARTY:_____CONTACT NUMBER:_____

SIGNATURE:_____ DATE:_____

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HIPAA POLICY

IT IS THE POLICY OF OUR PRACTICE THAT ALL PHYSICIANS AND STAFF MEMBERS PRESERVE THE INTEGRITY AND THE CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI) PERTAINING TO OUR PATIENTS. THE PURPOSE OF THIS POLICY IS TO ENSURE THAT OUR ENTIRE PRACTICE HAVE THE NECESSARY MEDICAL AND (PHI) TO PROVIDE OUR PATIENTS THE HIGHEST QUALITY MEDICAL CARE POSSIBLE. PATIENTS SHOULD NOT BE AFRAID TO PROVIDE INFORMATION TO OUR PRACTICE, PHYSICIANS, STAFF MEMBERS FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE PROCEDURES. OUR HIPAA POLICY IN ITS ENTIREY CAN BE OBTAINED THROUGH OUR OFFICE AT ANY TIME. LET US KNOW IF YOU WOULD LIKE TO RECEIVE A COPY PRIOR TO SIGNING THIS CONSENT. I HEREBY ACKNOWLEDGE THAT SOUTHERN PRIMARY CARE WILL SHARE MY MEDICAL INFORMATION, AS PERMITTED UNDER FEDERAL LAW (HIPAA) AND GEORGIA STATE LAW, WITH MY HEALTHCARE PROVIDERS THROUGH A HEALTH INFORMATION EXCHANGE. BY SIGNING THIS FORM, I AUTHORIZE THAT I FULLY UNDERSTAND THE RULES AND REGULATIONS PERTAINING HIPAA POLICY.

PRESCRIPTIONS

BY SIGNING THIS FORM, I AUTHORIZE THE REVIEW OF MY PRESCRIPTION HISTORY FOR REASONS OF EVALUATION AND TREATMENTS.

RELEASE AUTHORIZATION OF MEDICAL INFORMATION

ALSO, IT IS OUR EXPERIENCE THAT SOME PATIENTS MAY OR MAY NOT WISH FOR OUR STAFF TO DISCUSS MEDICAL CONDITIONS/INFORMATION WITH FAMILY MEMBERS. PLEASE SPECIFY ANY FAMILY MEMBERS WHO MAY OBTAIN OR CALL AND DISCUSS YOUR MEDICAL INFORMATION.

CONSENT FORM

DURING THE COURSE OF MY CARE AND TREATMENT, I UNDERSTAND THAT VARIOUS TYPES OF TESTS, DIAGNOSTIC OR TREATMENT PROCEDURES MAY BE NECESSARY. THESE PROCEDURES MAY BE PERFORMED BY PHYSICIANS, NURSES, TECHNICIANS, PHYSICIAN ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS (HEALTHCARE PROFESSIONALS) AT SOUTHERN PRIMARY CARE.I ALSO UNDERSTAND THAT VARIOUS HEALTHCARE PROFESSIONALS MAY HAVE DIFFERING OPINIONS AS TO WHAT CONSTITUES MATERIAL RISKS AND ALTERNATIVE PROCEDURES. THE PRACTICE OF MEDICAINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE OUTCOME AND/OR RESULT OF ANY PROCEDURES;THE HEALTHCARE PROFESSIONAL PARTICIPATING IN MY CARE WILL RELAY ON MY DOCUMENTED MEDICAL HISTORY, AS WELL AS OTHER INFORMATION OBTAINED FROM ME, FAMILY OR OTHERS HAVING KNOWLEDGE ABOUT ME, IN DERTERMINING WHETHER TO PERFORM OR RECOMMEND THE PROCEDURES THEREFORE, I AGREE TO PROVIDE ACCURATE AND COMPLETE INFORMTION ABOUT MY MEDICAL HISTORY AND CONDITIONS.BY SIGNING THIS FORM, I CONSENT TO HEALTHCARE PROFESSIONALS PERFORMING PROCEDURES AS THEY MAY DEEM REASONABLY NECESSARY OR DESIRABLE IN THE EXERCISE OF THEIR PROFESSIONAL JUDGMENT, INCLUDING THOSE PROCEDURES THAT MAY BE UNFORESEEN OR NOT KNOWN TO BE NEEDED AT THE TIME THIS CONSENT IS OBTAINED; AND I ACKNOWLEDGE THAT I HAVE BEEN INFORMED IN GENERAL TERMS OF THE NATURE AND PURPOSE OF THE PROCEDURES, THE MATERIAL RISKS OF PROCEDURES, AND PRACTICAL ALTERNATIVES OF THE PROCEDURES. I ALSO UNDERSTAND THAT I CAN AT ANY TIME ASK MY PHYSICIAN TO PROVIDE ME WITH ADDITIONAL INFORMATION.

PATIENT NAME:_____ BIRTHDATE:_____

RESPONSIBLE PARTY:_____CONTACT NUMBER:_____

SIGNATURE:_____ DATE:_____

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ADMINISTRATIVE POLICY

REFERRAL/PRIOR AUTHORIZATION/PRIOR CERTIFICATION

If your plan requires a referral, it is your responsibility to obtain this prior to being seen by a specialist. If we are required to obtain the referral or prior authorization/certification for you, please notify our office 5 days prior to the specialist's visit or procedure so that we have ample time to acquire this information from your insurance company. Per office policy, we do not back date referrals or prior authorization/certification.

REFILL REQUEST and NURSE CALLS

Please allow 3 business days for your refill request to be filled. Although we will try to return patient telephone request within 48 hours, we ask that you kindly give our staff 72 hours to return any requests. Please have the pharmacy fax the request to us at 1 (888) 291 - 5615. Most medication refills may require a follow-up visit with the physician. Antibiotics and pain medication will not be called in. An appointment with the physician will be required to replace lost or misplace prescriptions.

OFFICE POLICY ON MANAGED CARE INSURERS

We are pleased to meet the needs of our patients by enrolling with various managed care insurance programs. While we are able to provide you with this service, it is extremely difficult to keep track of all the individual insurance requirements of each plan. Even with the same insurance company, plans often may differ. Providing quality medical care for our patients is our primary concern, and we are more than willing to provide that care based on your insurance contract guidelines. We request at each visit that you advise us of your guidelines. Unfortunately, if you do not inform us of any special requirements in your contract and subsequently provide: Services, or order services such as label work or procedures that are not covered, the office will have no choice but to bill you directly for all said charges. All fees submitted and denied by your insurance carrier will become your responsibility. With your cooperation, you should be able to receive all benefits offered by your insurance plan, and we will be able to concentrate on caring for your medical needs.

I have read and understand the administrative policy stated above and agree to accept responsibility as described. And I am fully aware that the practice will provide any additional information needed from my end.

PATIENT NAME:_____ BIRTHDATE:_____

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SIGNATURE:_____ DATE:_____

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FINANCIAL POLICY

Welcome to our office. We are pleased to have you as a patient. We are committed to meeting your health care needs. It is our goal to provide you with the best possible health care and to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of services you rendered from our office. Please contact your insurance company to confirm coverage and benefits. We can never guarantee coverage for any service provided by our office. You are responsible for any services that the insurance does not cover, such as but not limited to well visits, procedures, injections and immunizations, balance left after all insurance payments and contracted adjustments.

2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit. If you do not have proof of current insurance at your visit, you will be considered a self-pay patient for that visit and payment in full will be due at the time of service.

3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan and that we are your primary care provider. If your insurance is a managed care plan, our Doctor must be listed as the PCP. If our Doctor is not listed as the PCP, your visit will be considered a self-pay patient for the visit and payment in full will be due at the time of service.

4. All co-payments and deductibles are collected at the time of service.

5. RETURNED PAYMENT FOR NON-SUFFICIENT FUNDS WILL BE CHARGED $35.00.

6. COLLECTION AGENCY ADMINISTRATIVE CHARGE WILL BE CHARGED $25.00+.

7. COMPLETION OF ALL FORMS (NOT LIMITED TO) WILL BE CHARGED $25.00+.

8. NO SHOWS WILL BE CHARGED $25.00+ AND WE NEED ATLEAST 24HR CANCELLATION NOTICE.

WITH YOU, OUR PATIENT, WE LOOK FORWARD TO A LASTING AND HEALTHY RELATIONSHIP AND WE THANK YOU FOR YOUR UNDERSTANDINH AND COOPERATION.

PLEASE NOTE: YOU MUST BE FAMILIAR WITH YOUR INSURANCE BENEFITS. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT AFTER 90 DAYS OF SUBMISSION OF CLAIM TO INSURANCE COMPANY, WHETHER YOUR INSURANCE HAS PAID OR NOT.

PLEASE UNDERSTAND: WE FILE INSURANCE CLAIM AS A COURTESY TO OUR PATIENTS. YOU HAVE A CONTRACT WITH YOUR INSURANCE COMPANY OF CHOICE. WE ARE NOT RESPOINSIBLE FOR HOW YOUR INSURANCE COMPANY HANDLES ITS CLAIMS OR FOR THE BENEFITS THEY PAY. WE DO NOT GURANTEE WHAT YOUR INSURANCE COMPANY WILL OR WILL NOT DO WITH EACH CLAIM. THIS IS PERFORMED AS A COURTESY TO YOU.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

PATIENT NAME:_____ BIRTHDATE:_____

RESPONSIBLE PARTY:_____CONTACT NUMBER:_____

SIGNATURE:_____ DATE:_____