Atlanta Arthritis Center, P.C.

**** WELCOME ****

Thank you for choosing our practice. We strive to provide the best possible healthcare. To help us meet all of your needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we are happy to help!

NOTE – ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE ID AND AN INSURANCE CARD BEFORE SEEING THE DOCTOR.

(PLEASE PRINT)

Last Name_________________________________ First Name_________________________________ MI________

Address____ City___________________ State_____ Zip___________

Phone (Home)____________________ Phone (Cell)____________________ Phone (Work)____________________

Email Address____

SSN______-______-________ Birth Date_____________________ Sex (M)___ (F)___ Marital Status: S M W D

Race (check one): ____American Indian / Alaska Native ____Asian
____Black / African American ____Native Hawaiian / Pacific Islander
____White / Caucasian ____Other ____Decline

Ethnic Group: ____ Hispanic / Latino ____Non-Hispanic / Latino ____Decline

Insurance Carrier____ Insured's SSN______-______-________

Insured's Name____ Insured's Birth Date__________________

Insured's ID Number______________________________ Insured's Group Number____________________________

Claim Address ____

Insured's Employer_______________________________ Insured's Relationship to Patient_____________________

Employer's Address____

Secondary Insurance Carrier_____________________________________ Insured's SSN______-______-________

Insured's Name____ Insured's Birth Date__________________

Insured's ID Number______________________________ Insured's Group Number____________________________

Claim Address ____

Pharmacy Name_____________________________ Mail Order: Y / N Member ID Number___________________

Pharmacy Phone Number____________________________ Pharmacy Fax Number____________________________

Emergency Contact Name________________________________ Relationship to Patient_______________________

Emergency Contact Phone Number____________________________

Referring Physician____

Atlanta Arthritis Center, P.C.

** FINANCIAL POLICY **

We appreciate the opportunity to provide medical services to you this year. Our goal is to keep your financial arrangements as simple as possible by timely filing all claims and by using the following guidelines:

1) You are ultimately responsible for payment of charges for services rendered at our office.
2) A fee of $25 will be added to your account for any check dishonored by your bank.
3) It is your responsibility to provide us with your current address, phone number and insurance information at each visit.
4) It is your responsibility to confirm with your insurance carrier that our doctor is "in-network" prior to seeing the doctor. If you choose to see a provider who is not on your plan, you are responsible for payment in full.
5) If you have an HMO insurance policy that requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to service. If you fail to obtain the required referral, you will be responsible for payment in full.
6) All co-pays and deductibles are due at the time of service. Failure to pay your co-pay at the time of service will result in an additional $25 fee added to your account.
7) All balances are due within 30 days. Failure to pay your balance within 45 days may result in a $25 late fee being charged to your account.
8) Having an account balance that is more than 60 days past due may result in denial of services (further doctor visits, medication refills, etc.), collection activities, and/or discharge from practice.
9) If you miss your appointment or cancel the appointment on the date of the appointment, a fee of $75 will be added to your account and you may be discharged from the practice.
10) An ASF (Administrative Service Fees) may be paid annually at $25 per year to cover all of your administrative forms for one year. Or, you may choose a "fee per form" status and fees will be assessed at the time the forms are completed. These "per-form" fees range from $25-$75. Examples of these forms are:
    a. Work/School Release
    b. FMLA
    c. Disability
    d. Parking Permits

    Remember – If you do not elect to pay the ASF fee today, you will be charged the administrative fees whenever services are rendered.

    Please initial your choice below:

    ______ I elect to pay the ASF annual fee today, or

    ______ I elect to pay a "per form" fee at the time services are rendered.

By signing below, I acknowledge that I understand and agree with the terms of this financial policy. Furthermore, I authorize payment of benefits to the Atlanta Arthritis Center, P.C. for services rendered under the terms of my insurance policy and I authorize the Atlanta Arthritis Center, P.C. to release any medical information necessary to process insurance claims.

➔ Responsible Party Signature____ Date____________________

Atlanta Arthritis Center, P.C.

** CONSENT TO DISCLOSE PRIVATE HEALTHCARE INFORMATION **

Please initial all that apply:

______ I consent to have detailed messages left on my voicemail at home.

______ I consent to have detailed messages left on my voicemail at work.

______ I consent to have detailed messages left on my cellular voicemail.

______ I consent to have my care discussed with my spouse.

______ I consent to have my care discussed with my immediate family members.

______ I consent to have my care discussed with ____.

______ I do not consent to have my care discussed with anyone other than myself.

By signing this authorization, I acknowledge that I have been given the opportunity to review AAC's privacy practices and I am aware that I may revoke that above designation(s) at any time via written request.

➔ Responsible Party Signature_______________________________________ Date___________________

Atlanta Arthritis Center, P.C.

** PATIENT RIGHTS AND RESPONSIBILITIES **

YOU HAVE THE RIGHT:

- To be treated with respect and consideration at all times.
- To receive assistance in a responsible manner.
- To receive information about your health including associated risks that may be involved in your procedures and medical alternatives including associated risk that may be involved in your healthcare.
- To know that the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternatives and likely consequences of your decision.
- To express a complaint to the Manager, Physician, or staff.

YOU HAVE THE RESPONSIBILITY:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of you insurance plan services and procedures for obtaining coverage. This includes knowing the referral process for your plan, laboratory restrictions, and outpatient facilities covered by your plan as well as co-pay and deductible requirements.
- To always carry your insurance plan identification card and be prepared to show it at each office visit. Patients will be required to pay for all services at the time of service if the patient does not provide all insurance information or if the insurance information is inaccurate.
- To pay all charges for co-pays, deductibles, and non – covered services at the time of your visit.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep the appointment.
- To understand that later arrival for an appointment may result in the need to reschedule that appointment. Every effort will be made to accommodate the patient's needs without compromising the interest of our other patients.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of the medical provider and consider the alternatives and/or likely if you refuse to comply.
- To treat all office personnel respectfully and courteously.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.
- To understand that there may be times that the physician may require you to return to the office for additional treatment/testing to aid in the diagnosis of your exam.

Failure to comply with these policies may result in fees being assessed, or ultimately discharge from the practice.

By signing this authorization, I acknowledge that I have been given the opportunity to review AAC's policy of Patient Rights and Responsibilities and that I accept responsibility as described. Furthermore, I give my consent to obtain treatment from AAC and their staff.

➔ Responsible Party Signature_______________________________________ Date____________________

Atlanta Arthritis Center, P.C.

** AUTHORIZATION FOR RELEASE OF INFORMATION **
** FROM AAC **

Please list all physicians with whom you would like AAC to routinely share your records:

Physician / Practice Name	Specialty	Fax Number
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________
______________________________	______________________	___________________________

Information to be released:

____ All Records ____ Lab Results ____ Office Notes ____ Radiology Results

I understand that this authorization may be revoked at any time (revocation must be in writing) except for information that has already been released.

➔ Responsible Party Signature___________________________________ Date_________________

Atlanta Arthritis Center, P.C.

** AUTHORIZATION FOR RELEASE OF INFORMATION **
** TO AAC **

Name of Physician / Practice / Facility____

Address ____

City ____________________________________ State __________ Zip Code_______________

Telephone Number __________________________ Fax Number __________________________

Purpose of this release:

____ Continued Care

____ Other Reason ____

Patient's Name ____________________________________ Date of Birth ____________________

Address ____

City ____________________________________ State __________ Zip Code_______________

Information to be released:

____ All Records	____ Only for dates from ____________ through ____________
____ Lab Results	____ Consultation Reports
____Radiology Reports	____ Discharge Summaries
____ Progress / Office Notes	____ Other (please describe) ___________________________

I authorize the release of all necessary medical records to:

Atlanta Arthritis Center, P.C.
1305 Hembree Rd. Suite 101
Roswell, GA 30076
Phone: 678-867-0000 Fax: 678-867-0003

➔ Responsible Party Signature______________________________ Date_______________