* **6070 Lakeside Commons Drive, Macon, GA. 31210**

*\*Traveling I-75 North* exit 172 (Bass Road) Turn Left off the Interstate. Go to the second red light (Bowman Road) and turn left. Lakeside Commons is the First Road on the right. We are in Building 6070

*\*Traveling I-75 South* exit 172 (Bass Road) Turn Right off the Interstate. Go to the second red light (Bowman Road) and turn left. Lakeside Commons is the First Road on the right. We are in Building 6070

* **679 West MLK JR Drive, Milledgeville, GA. 31061**

\*Across the street from Atrium Health Navicent Baldwin, next door to Oconee Sleep and Wellness Center

* **1654 Watson Blvd, Warner Robins, GA. 31088**

*\*Traveling I-75 South* to Georgia 247 Conn E/Centerville Road – Turn Left onto Watson Blvd. We are located across the street from Houston Medical Center’s main entrance and next to the Citgo Gas Station, look for the water tower. \*Additional parking at the rear of the building.

*\*Traveling I-75 North* to Georgia 247 Conn E/Centerville Road - Turn Right onto Watson Blvd. We are located across the street from Houston Medical Center’s main entrance and next to the Citgo Gas Station, look for the water tower. \*Additional parking at the rear of the building.

* **112 Corporate Square, Dublin, GA. 31201**

\*Our office is located inside Dr. Meyer’s cardiology office off Hillcrest, down from the Medical Center (Urgent Care)

* **321 South 9th Street, Griffin, GA. 30224**

\*Traveling from GA-16 - Take a Left onto 9th St

\*Traveling from Senoia – Take a Right onto 9th St

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (someone not living with you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

I HAVE NO HEALTH INSURANCE (PLEASE SIGN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Employer of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Tertiary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES & NOTICE OF INDIVIDUAL RIGHTS**

A copy of the "Notice of Privacy Practices & Notice of Individual Rights" is posted in our waiting room. I acknowledge by signing below that a copy of the "Notice of Privacy Practices & Notice of Individual Rights" Is available to me upon my request.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION UPDATE**

Our practice is committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information, or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail or an answering machine without your permission.

Under HIPAA regulations, we may provide this information to other healthcare entities involved in your care and insurance companies for billing purposes without your permission. A photocopy of this shall be considered as valid as the original.

**PLEASE INDICATE YOUR PREFERENCES BELOW:**

You may leave a message on my answering machine or voicemail: YES NO

You may provide private health information about me as indicated below: YES NO

You may give my test results, make appointments, and/or cancel appointments:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| NAME |  | RELATIONSHIP |  | PHONE NUMBER |
|  |  |  |  |  |
| NAME |  | RELATIONSHIP |  | PHONE NUMBER |
|  |  |  |  |  |
| NAME |  | RELATIONSHIP |  | PHONE NUMBER |
|  |  |  |  |  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Guardian (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

I hereby assume full responsibility for all charges incurred for professional service rendered by the practice unless the services are deemed "PAID IN FULL" as a result of a contractual agreement between the practice and my insurer. I understand copays are due at the time of service. Returned check fee will be applied for any returned check.

**SELF PAY**

Payment is due at the time of service. Prior payment arrangements can be made in advance by contacting the billing department at the number listed above.

**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

I hereby authorize My Provider’s to release any medical, psychiatric, infectious disease, or drug and/or alcohol-related information to my referring physician and any insurance company with whom I have medical benefits (now and with whom I may apply for benefits within the future) for the purpose of filing a medical claim also to include authorization to view my external prescription history via RxHUB service. I acknowledge that this authorization is valid until such time as all medical bill related 10 my treatment has been an aid. I further understand that I can withdraw (a written notice) this consent for the ease of information at any time.

**GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT BENEFITS**

I authorize my health insurance benefits to plan to pay directly to My Provider. If any, otherwise payable to me for their services as described on the attached claims but not to exceed the charges for those services described attached claims but not to exceed the charges for those services. I understand I am financially responsible to My Provider’s for charges NOT covered by this agreement. It is my responsibility to contact my insurance to verify network participation and obtain a referral if required.

**MEDICARE, CLAIM INFORMATION, AND PAYMENT REQUEST**

I authorize any holder of medical information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Relation pertaining to Medicare Assignments of benefits apply.

**COLLECTIONS**

I understand that non-payment of the claim/charge is my responsibility. If my (the patient’s) bill is not paid within a reasonable time, my account can be turned over to an outside collection agency.

**APPOINTMENTS**

I understand that if I am 15 minutes or later for an appointment, my appointment will be rescheduled so as not to inconvenience other patients.

No-show appointments that are not canceled 24 hours in advance will have a service charge of $25.00 that will be billed to the patient. This amount must be paid prior to your next appointment.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**24-HOUR CANCELLATION AND NO-SHOW ADMINISTRATIVE FEE POLICY**

Each time a patient misses an appointment without providing proper notice, another patent Is prevented from receiving care or diagnostic testing. MGH reserves the right to charge a fee for missed appointments ("no shows") and testing appointments not canceled with a 24-hour advance notice.

The following fees will be assessed for no-shows and late cancellations:

Office Visits and Office Visit Testing - $25.00

Nuclear Stress Testing - due to pharmacy order - $125.00

The fees will be billed to the patient. The fees are not covered by insurance and must be paid prior to the next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initials of Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

* Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
* Obtain payment from third-party payers
* Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices acknowledgment but was unable to do so as documented below.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_