# Ghosn Family Medicine

73 Prestige Lane Ste 103 Dawsonville, Ga 30534
Phone: 706-265-8002 Fax: 706-429-0033

## Registration Form

Please Print

TODAY'S DATE:_____

PATIENT NAME:_____

CHECK ONE: SEX: M_____ F_____ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

RACE: _____ETHNICITY: _____EMAIL:_____

DATE OF BIRTH: _____SOCIAL SECURITY #:_____

PATIENT'S ADDRESS:_____
(Street) (City) (Zip)

HOME TELEPHONE #: (____) _____ CELL #: (____) _____

EMPLOYED BY: _____ OCCUPATION:_____ WORK # _____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE #: (____)_____

PRIMARY PHARMACY: _____ PHONE #: _____ LOCATION: _____

REASON FOR VISIT: _____

RESPONSIBLE PERSON IF OTHER THAN PATIENT: NAME_____

RELATIONSHIP_____PHONE NUMBER_____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY:_____

POLICY/ID#_____ GROUP #_____

POLICY HOLDER:_____RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY

NAME:_____

POLICY/ ID#_____ GROUP #_____

POLICY HOLDER:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ghosn Family Medicine 6002 Highway 53 East, Suite 100, Dawsonville, Georgia 30534, (706)-265-8002 or insurance company to release any information required to process my claims.

Patient/Guardian
Signature_____Date:_____

# GHOSN FAMILY MEDICINE

## OFFICE POLICIES & PROCEDURES

Thank you for choosing Ghosn Family Medicine. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Ghosn Family Medicine strive to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have listed our office policies. These policies enable us to better utilize time for our patients. Please feel free to contact our office if you have any questions regarding our policies.

### OFFICE HOURS

Our office is available Monday-Friday 8:00-5:00 Saturday 8:00-12:00 and may be reached at 706-265-8002. Please listen to the recording in order to ensure you are choosing the correct line to serve your needs. The phones are forwarded after hours for emergency needs only. **If you need prescription refill or test results, please call during regular business hours.**

### APPOINTMENTS

Ghosn Family Medicine is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance for follow-up due dates. Same day appointments are reserved for sick visits only and will not be utilized for medicine refills or check ups.

### CANCELLATION OF AN APPOINTMENT

We realize things do come up and schedules change. In order to be respectful of the medical needs of our patients and continue to run efficiently, please be courteous and call Ghosn Family Medicine promptly if you are unable to attend an appointment.

If it is necessary to cancel your scheduled appointment we require that you call (1) one business day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

### NO SHOW POLICY

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of $25.00 will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within (1) business day and advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical records. Three (3) "no-shows" with (1) calendar year will result in a temporary suspension of services. In order to reinstate services, you will be required to meet with your Primary Physician within 30 days of the third no show letter to evaluate your situation. In the event you do not respond and/or schedule and appointment within the 30 days, we will consider your patient status as terminated.

***Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.*

## INSURANCE

Ghosn Family Medicine accepts most insurance plans. If you have any questions please call our billing department at 706-429-1298. It is the patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

## PAYMENTS

Ghosn Family Medicine accepts cash, Mastercard, Discover, Visa and American Express. It is the policy of our practice to make all reasonable attempts to collect outstanding balances should they accrue.

## FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Ghosn Family Medicine will be happy to complete forms and write medical letters necessary upon your request. However, because this can be time consuming, an appointment may be necessary and please allow 7-10 days for completion of requested forms/letters.

## MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of $0.75 per page. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

## PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Ghosn Family Medicine of which Pharmacy use and update us if this should change. Please allow one to two business days for refill request. We encourage our patients to review their medications prior to their office appointments and request refills at that time, if needed.

**Please note that we do not fill Controlled (including narcotic) Medications or order Antibiotics over the phone, or by electronic request. These request require an appointment.**

## OFFICE BEHAVIOR

OUR OFFICE STAFF WORK VERY HARD TO PROVIDE EACH PATIENT WITH KIND AND CARING TREATMENT, THEREFORE, DISRESPECT AND AGGRESSIVE BEHAVIOR TOWARD THE STAFF OF GHOSN FAMILY MEDICINE WILL NOT BE TOLERATED AND IS GROUNDS FOR DISCHARGE.

# GHOSN FAMILY MEDICINE
# OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

## RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand and will comply with the policies and procedures explained in the Ghosn Family Medicine OFFICE POLICIES AND PROCEDURES FOR PATIENTS form.

_____
Printed Name

_____ _____
Signed Named Date

THANK YOU!
Ghosn Family Medicine

# *Medical Information Release Form*

## *(HIPAA Release Form)*

**Name:** _____ **Date of Birth:** ____/____/____

## ***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

## ***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

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# HIPAA PRIVACY POLICY

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION

### INTRODUCTION

Ramzi Ghosn, M.D. is required by law to maintain the privacy of "protected health information." Protected health information includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the healthcare you received, or payment for your healthcare.

As required by law, this notice provides you with the information about your rights and our legal duties and privacy practices with respect to the privacy protected health information. This notice also discusses the uses and disclosures we will make of you protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time to make revised notice effective for all protected health information we maintain.

### PERMITTED USES AND DISCLOSURES

We can use or disclose your protected information for the purposes of treatment, payment and healthcare operations. For each category, we will explain what we mean and give some examples. However, not every use or disclosure will be listed.

***Treatment*** means the provision, coordination or management of you healthcare, including consultations between healthcare providers regarding your care and referrals for healthcare from one healthcare provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

***Payment*** means activities we undertake to obtain reimbursement for the healthcare provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide your health plan information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill your health plan for services rendered to you, we can provide them with the information regarding your care if necessary to obtain payment.

***Health care operations*** means the support functions of our practice related to treatment and payments, such as quality assurance activities, case management, receiving and responding to patient complaints, physical reviews, compliance programs, audits, business planning, development management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your health information so that others can use this de-identification information to study health care delivery without learning who you are.

Signature (patient/legal representative): _____ Date: _____

Relationship to patient (if applicable): _____

GHOSN FAMILY MEDICINE

73 PRESTIGE LANE, STE 103
DAWSONVILLE, GA 30534
PHONE (706) 265-8002 FAX (706) 429-0033

Consent Form To Release/Receive Medical Records
Authorization for Release of Information

I, _____, DOB: _____

SSN: _____ Phone: _____

Address: _____

Do hereby give my consent and authorize _____ to Release unto: Ghosn Family Medicine 73 Prestige Lane Set 103 Dawsonville, Ga. 30534.

Medical Information contained in the medical record for treatment dates: _____

The following information is requested for release of information:

| | | |
|---|---|---|
| _____ H&P | _____ Consultations | _____ Pathology Reports |
| _____ Imaging/Xrays | _____ Lab | _____ Office Notes |
| _____ Entire Medical Record | _____ Other | |

This information may include, but is not limited to, treatment related to psychiatric or psychological, drug and/or alcohol, or Acquired Immune Deficiency Syndrome/HIV

I understand that this information is to be disclosed for the following purpose and that purpose only: Continuity of care

I understand that this consent is subject of revocation by me at any time, and unless an earlier date is specified, the consent will automatically expire 12 months after the date below. I also understand that this information may be bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records. Redisclosure of this information to any other party other than the one listed is prohibited without any additional written consent on my part.

Signed (patient/authorized party) _____ Date: _____

Signed (witness) _____ Date: _____