SOUTH GEORGIA HEALTH GROUP
Multi-Specialty Clinics

Patient Information

Patient Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) ____- _____ Work Phone: (___) ____- _____ Cell Phone: (___) ___ - _____

Email Address: _____ Date of Birth: ___/___/____ Social Security #: ___-___-_____

Marital Status: (circle one) Single Married Divorced Widowed Other _____ **Gender**: Female Male

Employer: _____ City: _____ Phone: _____

Accident Information: (if applicable) Date: _____ Related to: (circle one) Work Auto Other: _____

Primary Care Physician: _____ Referred By: _____

Insurance Information

Primary Insurance Company: _____ Address: _____

ID #: _____ Group Name: (if there is one) _____ Group #: _____

Phone #: _____ Subscriber's Name: _____

Secondary Insurance Company: _____ Address: _____

ID #: _____ Group Name: (if there is one) _____ Group #: _____

Phone #: _____ Subscriber's Name: _____

Responsible (or primary insured's) Party's Information

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____- _____ Work Phone: (___) _____- _____ Cell Phone: (___) ____ - _____

Date of Birth: ___/___/_____ Social Security #: ___-____-_____ Relationship to Patient: _____

Employer: _____ City: _____ Phone: _____

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NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Last First M.I

Allergic to Medication? (circle one) YES NO If Yes, please list _____
_____
_____
Emergency Contact: _____
Phone Number: _____ Relationship to Patient: _____

Please list ALL of your current medications, dosages, and dates.

Medication	Dosage	Date Medication was started

Name of your current pharmacy: _____

Please Circle **Y** (yes) or **N** (no) to indicate whether you have ever had any of the following:

ADHD	Y / N	Epilepsy	Y / N	Chronic Back Pain	Y / N
Asthma	Y / N	Heart Disease	Y / N	Chronic Neck Pain	Y / N
Diabetes	Y / N	High Cholesterol	Y / N	Any Chronic Pain	Y / N
Hepatitis	Y / N	Heart Defects	Y / N	STD's	Y / N
Bleeding Tendency	Y / N	Stroke	Y / N	Ulcers	Y / N
High Blood Pressure	Y / N				

Other Medical Conditions? _____

Do you use Tobacco? _____ If yes, how often? _____
Do you use Alcohol? _____If yes, how often? _____
Hospitalizations for illness other than surgery _____
_____
Operations: _____
Have you been injured in an auto accident in the past 12 months? _____

Family History – Has **ANY** member of your family ever had any of the following? If yes, what relation?

Cholesterol Problems	Y / N	_____
Cancer	Y / N	_____
Diabetes	Y / N	_____
Heart Disease	Y / N	_____
High Blood Pressure	Y / N	_____
Tuberculosis	Y / N	_____

For Women Only: Date of Last Period _____ # of Children _____

SOUTH GEORGIA HEALTH GROUP
Multi-Specialty Clinics

814 Northwood Park Dr. Valdosta, GA 31602
Tel. (229) 259-0032 Fax (229) 259-0068

PAYMENT POLICY

TO OUR PRIVATE INSURANCE PATIENTS:

If you have a yearly deductible on your health insurance policy that you have not met, payment for your visit will be due at the time of service. We will file your claim with your insurance company and apply your billed amount to your deductible. If you do not know the amount of your deductible or do not know if you have one, we will be glad to check with your insurance provider. Your patience during this process is appreciated. If we cannot verify the amount of your deductible, your insurance will be billed for the cost of this office visit. Any amount not paid by your insurance will be billed to you separately. Thank you for cooperation in this matter.

TO OUR CASH/UNINSURED PATIENTS:

You must have a means of payment available to you at the time of service. If you cannot afford to pay a minimum fee at the time of service, you may seek care in the Emergency Room. The hospital receives government support to assist low income patients.

TO OUR MEDICARE PATIENTS:

Under some conditions Medicare may not pay for services, procedures or medications given in this office. Under these circumstances, you may be billed separately for these services. You must sign a waiver for this to occur and will be informed of the treatments which may not be covered at the time of service.

TO OUR MEDICAID PATIENTS:

If your Medicaid is assigned to another physician or medical office, we may need a referral number from them to treat you. A referral number lets your primary physician know what is being done for you and by whom. Under some conditions, we may be unable to collect a referral number from your physician. If this occurs, you may elect to wait and be seen at a later time by your primary doctor; have your Medicaid primary medical office changed to our facility or seek medical care in the Emergency Room.

Please ask if you would like to arrange a payment plan for any amounts you will be billed. We will be happy to work with you.

Please sign below acknowledging that you have read, understand and will abide by this office policy

_____ _____

Patient Printed Name Date

_____

Patient/Parent/Legal Guardian Signature

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Fees Policy/ No-Show Policy

It is the policy of this office to collect payments as follows:

Co-Pays: Co-pays, and/or deductibles that apply, will be collected at the time of service.

Self-Pay Patients: We collect $130 up front at every office visit from patients without insurance. Depending on the type/length of office visit there may be additional fees for the office visit and/or for other services provided during the visit. We will send you a bill if those additional amounts are owed. Our Outstanding Balance policy will apply to those balances (please see below paragraph Outstanding Balances).

Outstanding Balances: Outstanding balances should be paid off before 120 days. Patients who cannot pay their balances before 120 days should contact the Billing office at 229-259-0032 EXT 1107. Exceptions can be made but only by completion of the appropriate paperwork (financial hardship letter) to be reviewed and approved by the Medical Director. Outstanding balances after 120 days will be sent to collections. Patients who are sent to collections will be responsible for all outstanding balances, legal fees, and any other additional fees associated with the outstanding balance.

No-Show Fees: Patients who fail to keep their scheduled appointments, office visits, and tests a no-show fee of $25.00 will apply. Cancellations must be done 24hrs in advance to avoid the no-show fee. Any patient who is a no-show for two consecutive appointments may be dismissed from our practice.

Bounced Check Fee: Patients who write a check that is returned for in-sufficient funds will be charged a $35.00 returned check fee. Additionally, the patient will no longer be able to make payments by check.

Please sign below acknowledging that you have read, understand and will abide by this office policy

_____ _____

Patient Printed Name Date

_____

Patient/Parent/Legal Guardian Signature

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CONSENT FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

In this document, "I" and "my" refer to the patient and "Provider" refers to South Georgia Health Group. I consent to the use or disclosure of my protected health information my the Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations of my Provider. I understand that analysis, diagnosis or treatment of me by the Provider may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Provider is not required to agree to the restrictions that I request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider and I have the right to evoke this consent, in writing, at any time, except to the extent that the Provider has taken action in reliance on this consent.

My "protected health information: means health information, including my demographic information, collected from me and created by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices and understand that I have a right to a copy of the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider.

The Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and request a revised copy be sent in the mail or asking for one at the time of my next appointment.

Please sign below acknowledging that you have read, understand and will abide by this office policy

_____ _____

Patient Printed Name Date

_____

Patient/Parent/Legal Guardian Signature

SOUTH GEORGIA HEALTH GROUP
Multi-Specialty Clinics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Facility Releasing Information:

_____
_____
_____
_____
_____

Facility Receiving Information:

South Georgia Health Group, LLC
814 Northwood Park Drive
Valdosta, GA 31602
Office (229) 259-0032
Fax (229) 259-0068

The purpose of this release of information is to provide continuity of my care, for processing an insurance claim, or to meet another specific desire of mine. This information may _____, may not _____ include treatment for drug and/or alcohol abuse, psychiatric illness. HIV test results, or AIDS diagnosis, and/or other communicable diseases. I specify that this release is to include:

_____	Office Visit Summary	_____	History and Physical Exam
_____	Laboratory Report	_____	Consultation Report
_____	Radiology Report	_____	Pathology Reports
_____	Immunization Reports	_____	Others (Specify Below)

_____

This authorization specifically pertains to information related to my treatment, which occurred on the following dates: _____ to _____.

To assist in identification and location of my records. I am providing the following information.
Name used when treatment occurred: _____
Address given at that time: _____
_____
_____

Date of Birth: _____/_____/_____ SS#: _____/_____/_____
This authorization expires 60 days from the below date and covers only treatment prior to that date.

X _____
Patient or person authorized to consent for minor or patient who is unable to sign

Date: _____ Witness: _____

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PRIVACY POLICY

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully. This Notice describes the privacy practices at our office.

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the notice currently in effect

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to South Georgia Health Group.

Treatment: We may use and disclose your health information for your treatment and to provide you with treatment related healthcare services. For example, we may disclose your health information to doctors, nurses or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment. The undersigned also agrees that South Georgia Health Group with or without notice, may assign, transfer and convey to any attorney its right, title and interest of any balance due. If suit is filed, patient agrees to pay whatever additional costs, attorney fees, court fees and expenses incurred in pursuing such claim which may be determined as reasonable by the Court.

Health Care Operations: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Please sign below acknowledging that you have read, understand and will abide by this office policy

_____ _____

Patient Printed Name Date

_____

Patient/Parent/Legal Guardian Signature

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MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

NAME: _____ **DATE OF BIRTH:** _____

RELEASE OF INFORMATION

[ ] Please check any that apply

[ ] Information is not to be released to anyone.

I authorize the release of information including claims information, diagnosis, records and examinations rendered to me.

[ ] This **DOES NOT** include records or information involving treatment for mental illness, alcoholism, drug dependence, AIDS and/or STD testing or if the records include information regarding pregnancy and/or abortion.

[ ] This **DOES** include records or information involving treatment for mental illness, alcoholism, drug dependence, AIDS and/or STD testing or if the records include information regarding pregnancy and/or abortion.

This information may be released to:

Please check all that apply and provide **name(s) and date(s) of birth.**

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

This ***Release of Information*** will remain in effect until terminated by me in writing, in the case of a minor on his/her 14th birthday or until the following specified date ___/___/_____.

Messages

Please call my [ ] Home [ ] Work [ ] Cell number _____

If unable to reach me you may: (please check one)

[ ] Leave a detailed message

[ ] Leave a message asking me to return your call

[ ] Other_____

The best time to call is (circle one) Mon. Tue. Wed. Thurs. Fri. in the (circle one) morning afternoon.

_____ _____

Patient Printed Name Date

_____

Patient Signature (if 14 years of age or older)/Parent/Legal Guardian (if UNDER 14 years of age)

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay South Georgia Health Group, LLC, Douglas Moss, M.D., Melissa Milicevic, A.N.P., Barbara Pearce, A.N.P., & Veronica Hanna Russ, P.A.-C., as well as all employees, employers, representatives, and agents thereof; as well as all laboratories, pharmacies, clinics, hospitals, and equipment suppliers used by or referred by Healthcare Provider (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, equipment, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. It is also my intention that Healthcare Provider shall possess any and all anti-retaliation protections that I may have under 29 U.S.C. § 1140 whenever Healthcare Provider is exercising my rights or acting on my behalf, or as my assignee, in anyway whatsoever.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing, and in such case, can only be revoked for future services, test, etc. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____ , 20 ____.

X_____
(patient signature)

_____
(please print patient name)