THE PHYSICIANS

www.thephysicians.com

PATIENT REGISTRATION SHEET

Patient **NAME**: _____
FIRST NAME MIDDLE NAME LAST NAME

What is your **MAILING ADDRESS**? _____ _____
STREET OR P.O. BOX APT#

_____
CITY STATE ZIP

What is your **EMAIL ADDRESS**? _____

May we contact you via email *(CIRCLE ONE)*? YES NO

What is your **HOME PHONE NUMBER**? _____

What is your **CELL OR DAYTIME PHONE NUMBER**? _____

What is your **DATE OF BIRTH**? _____

What is your **SOCIAL SECURITY NUMBER**? _____

Who should we contact in case of an **EMERGENCY**?

_____ _____
NAME PHONE NUMBER

Who **REFERRED** you to our practice *(CIRCLE ONE)*? PHYSICIAN FRIEND CASE MANAGER OTHER

_____ _____
NAME PHONE NUMBER

If a physician, what is his/her **SPECIALTY**? _____

What is your **CURRENT PHARMACY**? NAME: _____

ADDRESS _____ PHONE NUMBER _____

RACE: ( )Asian ( )Native Hawaiian ( )Pacific Islander/ Other
( )Black/ African American (NOT Hispanic or Latino) ( )American Indian/ Alaskan
( )Native White (NOT Hispanic or Latino) ( )Hispanic or Latino (ALL RACES) ( )More than one race

Ethnicity: ( ) Hispanic or Latino () Not Hispanic or Latino

Preferred Language: ( ) English ( ) Spanish ( ) Spanish

PRIMARY INSURANCE COMPANY: _____

What **ADDRESS** should claims be sent to? _____ _____
(BACK OF CARD) STREET OR P.O. BOX SUITE#

_____
CITY STATE ZIP

What is the **CUSTOMER SERVICE** phone number? _____

What is the **POLICY NUMBER**? _____

What is the **GROUP NUMBER**? _____

Who is the primary **POLICY HOLDER**? _____

What is your **RELATIONSHIP** to the policy holder? SELF SPOUSE CHILD OTHER

What is the policy holder's **DATE OF BIRTH**? _____

What is the policy holder's **SOCIAL SECURITY NUMBER**? _____

Was this insurance obtained through an **EMPLOYER**? YES NO

If yes, what is the **EMPLOYER'S NAME**? _____

When did this policy become **EFFECTIVE**? _____

If this is Workers' Compensation, what is your **DATE OF INJURY**? _____

SECONDARY INSURANCE COMPANY: _____

What **ADDRESS** should claims be sent to? _____ _____
(BACK OF CARD) STREET OR P.O. BOX SUITE

_____
CITY STATE ZIP

What is the **CUSTOMER SERVICE** phone number? _____

What is the **POLICY NUMBER**? _____

What is the **GROUP NUMBER**? _____

Who is the primary **POLICY HOLDER**? _____

What is your **RELATIONSHIP** to the policy holder? SELF SPOUSE CHILD OTHER

What is the policy holder's **DATE OF BIRTH**? _____

What is the policy holder's **SOCIAL SECURITY NUMBER**? _____

Was this insurance obtained through an **EMPLOYER**? YES NO

If yes, what is the **EMPLOYER'S NAME**? _____

When did this policy become **EFFECTIVE**? _____

I hereby certify that I have reviewed the above information and made any necessary corrections. I understand that the above coverage information is what was quoted directly from my insurance carrier and is not a guarantee of benefits. I understand that by signing below I am stating that this information is correct and I will be held responsible for any services denied for lack of coverage or inability to identify the patient and/or subscriber in the insurance carrier's system.

I hereby authorize my insurance benefits to be paid directly to The Physicians' realizing I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

_____ _____
PATIENT SIGNATURE **DATE**

PATIENT NAME PRINTED: _____
FIRST NAME MIDDLE NAME LAST NAME

THE PHYSICIANS

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New Patient History

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Location of Pain: _____

How does your pain feel (aching, burning, sharp, etc.)? _____

When did it begin?_____ Were you injured at work? ( ) Yes or ( ) No Date of injury _____

Was the pain caused by an injury? ( )Yes or ( ) No If yes, describe injury: _____

_____

Are you unable to work due to pain? ( ) Yes or ( ) No

What is the status of your claim? (please check one)

( ) N/A ( ) Retained attorney ( ) Claim Settled ( ) Currently in Litigation

What Treatments have you had in the past for your pain?

( ) Previous Medication to treat pain: please list _____

See reverse side for complete list of current medication

( ) Physical Therapy: When? _____

( ) Injections and Nerve Blocks: When? _____ Performed where? _____

( ) Surgery: When?_____ Name of Surgeon _____

( ) Diagnostic Imaging (MRI, X-ray etc) _____ Place of testing _____

List all previous surgeries: _____

_____

Medication Allergies:

Please check if you have an allergy to: ( ) Eggs ( ) Iodine ( ) Shellfish ( ) Latex

Medication Allergies:	Reaction:

	Patient History		Family History	
	yes	no	yes	no
Any contagious disease				
High blood pressure				
Diabetes				
Heart Disease				
Kidney Disease				
Arthritis				
Fibromyalgia				
Liver Disease				
Thyroid problems				
Bleeding disorders				

Other (please specify) _____

_____

Current Medication: List ALL Current Medications

Are you taking any blood thinners? ( ) yes or ( ) no If yes, please list below

NAME	STRENGTH	TAKEN HOW OFTEN

Social History:

Marital Status: ( ) Married ( ) Partnered ( )Single ( )Divorced ( )Widowed

Number of children: _____ Age of children_____

Current Occupation: _____ Circle one: Full Time/Part Time

Habits:

Check all that apply

( ) Cigarettes, Pipe, Nicotine chew, Chewing Tobacco (number per day: _____)

If used in the past, please indicate the date you quit:_____

( ) Coffee, Tea, Energy drinks or Soda with caffeine

( ) Alcohol: Circle one: moderate/occasional/daily
Circle all that apply: beer/wine/liquor

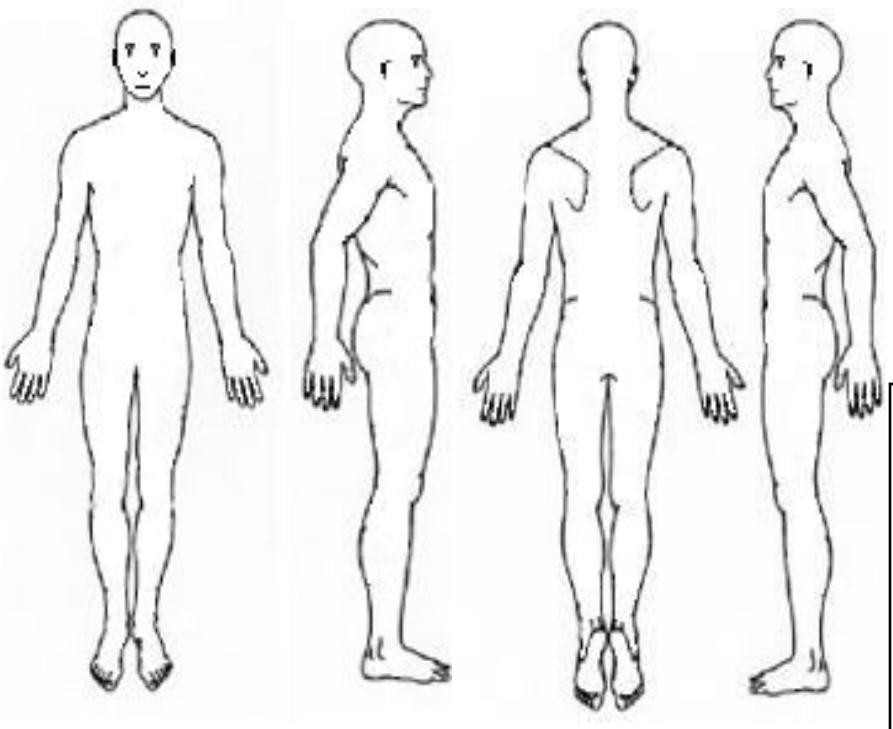
( ) Illegal or street drug use use: Please list: _____

The Physicians' Spine and Rehabilitation Specialists of Georgia, P.C.

Patient Name: _____ Birthdate: _____ Date: _____

1. Shade the areas where you are currently having pain on the diagram below.

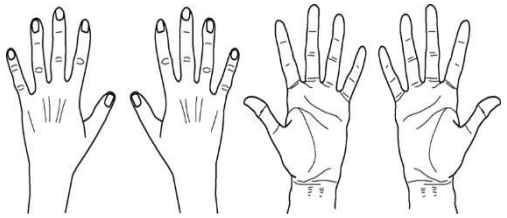
FRONT RIGHT SIDE BACK LEFT SIDE



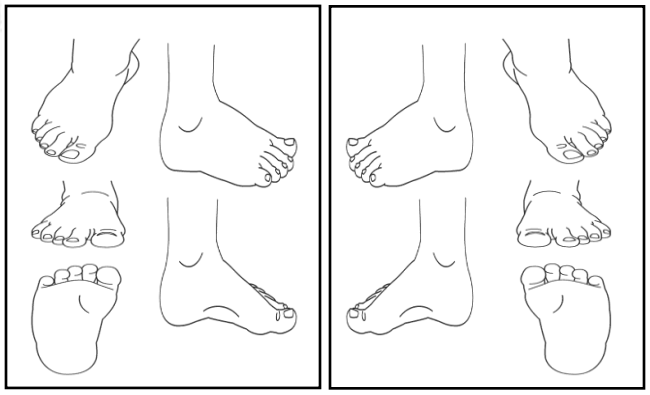
RIGHT LEFT LEFT RIGHT

HANDS:

LEFT RIGHT LEFT RIGHT



RIGHT FOOT LEFT FOOT



2. Please answer each of the following questions by placing an **X** at the appropriate place on the line.

a. What is your level of pain?

_____

No pain Worst Pain

b. How does the pain affect your level of activity?

_____

I can do anything I want I can't do anything at all

c. Does pain affect your sleep?

_____

No problem sleeping I can't sleep at all

The Physicians' Spine and Rehabilitation Specialists of Georgia, P.C.

AUTHORIZATION TO PROVIDE INFORMATION

I authorize the release of any medical information, including history, treatment, diagnosis, and prognosis and any information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care provided, health related utilization review or quality assurance activities.

I authorize any medical information including history, treatment, diagnosis, and prognosis to be released to:

The Physicians' Spine & Rehabilitation Specialists of Georgia, P.C.

Marietta
790 Church Street, Suite 550
Marietta, Georgia 30060
TEL 770 419 9902
FAX 770 419 7457

Rome
18 Riverbend Drive, Suite 100
Rome, Georgia 30161
TEL 706 314 1900
FAX 706-314-1901

Sandy Springs
5730 Glenridge Drive, Suite 100
Sandy Springs, Georgia 30328
TEL 404 816 3000
FAX 678 904 5797

Calhoun
150 Warrior Path NE, Suite 2
Calhoun, Georgia 30701
TEL 706 314 1900
FAX 706-314-1901

I understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) this protected health information is being used by The Physicians' for the purpose of providing treatment, and the business operations and billing that go along with this treatment.

Patient Name:_____ Date of Birth:_____

Signature of Patient:_____ Date:_____

THE PHYSICIANS

SPINE & REHABILITATION SPECIALISTS OF GEORGIA, P.C.

FINANCIAL POLICY – WE WANT YOU TO BE INFORMED!

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. As part of this commitment, we provide several services as a courtesy to you, the patient, as outlined below:

If you have:	**You are responsible for:**	**As a courtesy to you, our staff will:**
An **HMO, POS, PPO, or other insurance** with which we **are contracted**	1) Obtaining a referral from your PCP (if applicable) 2) Payment of Co-pays & Deductibles at the time of service	File an insurance claim on your behalf
An **HMO. POS, PPO or other insurance** with which **we are not contracted**	Payment must be made in full at time of service	Provide receipt for FSA account or tax purposes.
Commercial Plans or Plans in which we are **not contracted**, i.e. all Kaiser products, Medicaid as a "primary" insurance.	Payment is **REQUIRED** at time of service based on your **"out of network"** benefits. Many insurance companies base their payment on **"usual and customary"** charges. The patient is responsible for **ALL FEES** above **"usual and customary." (UCR)**	File an insurance claim on your behalf **or treat you as a "private pay" patient.** See below, to see if this is more beneficial for you.
Medicare **without secondary**	Payment of deductible and coinsurance at time of service	File an insurance claim on your behalf
Medicare, HMO, POS, PPO, and commercial ins. **w/secondary**	Payment of deductible and coinsurance at time of service if not covered by secondary insurance	File an insurance claim on your behalf, as well as any claims to your secondary
Private Pay Patients (Patients with no insurance, or those who choose **NOT** to use their "out of network" benefits, or patients that do not have out of network benefits, or those patient with high deductibles)	**PAYMENT MUST BE MADE AT TIME OF SERVICE.** The discount **DOES NOT** apply if payment is not made **IN FULL** at time of service. Patient will be responsible for 100% of **ALL** charges incurred that day.	Providing a 50% (office visits) - 60% (procedures) discount for paying at time of service. Patient or Provider **CANNOT** file charges from that date of **service unless discount is clearly noted on the claim**. Without notice, it could result in a fraudulent claim with your insurance company.
Workers Compensation	Provide us with the accident date, claim number, attending physician, employer, and adjuster information.	File an insurance claim on your behalf
Accident Related **(non Workers' Compensation)**	Payment must be made in full at time of service	Provide a receipt so you can file the claim

AS A COURTESY, we will also call your insurance company ahead of time to determine eligibility, deductibles, coinsurance, and obtain approval. **THIS DOES NOT GUARANTEE REIMBURSEMENT. The patient remains fully responsible for the entire amount of the bill.*

Billing Process and Notices – We want you to be informed!

We file insurance as a courtesy but this does not release the patient from financial obligation. Charges not covered by insurance company, as well as applicable co-payments and deductibles, are patient responsibility.

In order to help keep you informed, you will receive monthly statements or notices about your services with us as long as there is a balance on your account.
If we are filing insurance on your behalf, we will not send these statements to you until we have received payment or other information from your insurance. You may receive an EOB from your carrier, prior to our statements.

You will continue to receive statements monthly, as long as there is a balance. After 90 days of statements, if you have not made payment arrangements, your account balance will be sent to CBA collection agency.

If you are scheduled for a procedure, ***PLEASE NOTE THE BILLING FOR THE PHYSICIAN AND FACILITY IS SEPARATE.***
The bill from the facility (such as a surgery center or hospital) includes the costs of the procedure room, medical supplies, and medications. The physician bills separately for his services.

Patient signature below authorizes The Physicians' Spine & Rehabilitation Specialists of Georgia, P.C. to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim.

I have read and understand the above Financial Policy. I authorize my insurance benefits to be paid directly to The Physicians' Spine & Rehabilitation Specialists of Georgia, P.C.

PATIENT SIGNATURE _____ **PRINTED NAME** _____ **DATE** _____

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

PLEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the Categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

. You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny J{)Request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a Certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact SHANNYN SERFOZO, Privacy Officer, 790 Church Street, Suite *550,* Marietta GA 30060.. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

[Practice Administrators: If you choose to have patients or their personal representatives sign this Notice, please use the lines below. Otherwise, the lines below should be removed.]

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient or Patient's Personal Representative Date

_____ Patient provided form, but refused to sign _____(name of witness)_____

Date

THE PHYSICIANS

PRIVACY NOTICE ACKNOWLEDGEMENT

PATIENT NAME: _____

I acknowledge that I have received a copy of the Privacy Notice for The Physicians' Spine & Rehabilitation Specialists of Georgia, P.C.

Privacy Notice Revision Date: April 14, 2003

_____ _____

Patient or Personal Representative Signature | Date

_____

Personal Representative's Relation to Patient

OFFICE USE ONLY

DOCUMENTATION OF GOOD FAITH EFFORT

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

☐ Patient refused to sign the Privacy Notice Acknowledgement

☐ Patient was unable to sign because:

_____

☐ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

☐ Other reason, described below:

_____

_____

_____ _____

Employee Name/Signature | Date

THE PHYSICIANS

PRACTICE POLICIES

In an effort to best meet the needs of all of our patients, we would like to remind everyone of the following office policies. Thank you.

1. APPOINTMENT CONFIRMATION / CANCELLATION POLICY

As a courtesy, you will receive a COMPUTER call 2 days prior to your appointment to remind you of the date and time. Please follow the computer prompts to confirm. If you would like to cancel, please contact our office at least 24 hours PRIOR to your appointment.

*Effective November 2008, there will be a patient charge of $25 for any appointment not cancelled with at least a 24 hour notice.

2. MEDICATION PRESCRIPTIONS

All medication prescriptions will be given to you during your scheduled appointment. These prescriptions will be for the amounts appropriate to control your pain until your next visit. Refills can not be given over the phone.

3. CLINICAL QUESTIONS

If you have questions, would like to leave a patient update or request information, and are internet active, we can be reached at our e-mail address: questions@thephysicians.com. You may also contact us via the WEB PORTAL. However, if the question requires extensive medical decision making, you will need to schedule an appointment.

4. FORMS AND ADDITIONAL REQUESTED SERVICES

There will be a processing fee for completing insurance and disability forms not directly associated to billing of your visits. The fee will be determined by the physician, depending on the extent required of the form. This fee also applies to the insurance medication prior approval process, which your insurance carrier does not include in your physician services. We appreciate your understanding with these policies. We unfortunately cannot control the additional work insurance companies are requesting from patients and providers each year that are not included in the medical services provided. We are doing our best to make sure that we remain focused on the services we provide – medical care – in order to treat our patients with the highest level of care possible.

5. MEDICAL RECORDS

Please note that any requests for medical record copies needs to be made in writing. We will fax records directly to your other treating providers, upon this written request, for no fee. Appropriate copying charges will apply for all others, to cover the time and resources required.

I have read and understand the above policies.

Patient or Personal Representative Signature

Date

The Physicians' Spine and Rehabilitation Specialists of Georgia, P.C.

PATIENT RIGHTS AND RESPONSIBILITY

YOU HAVE THE RIGHT:

TO be treated with respect, consideration and dignity at all times.

TO receive assistance in a responsible manner.

TO receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.

TO know 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 Office Manager, physician or staff.

YOU HAVE A RESPONSIBILITY:

TO review and understand your health insurance coverage and benefits.

TO learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay 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 provided if the patient, at the time of service, does not provide insurance information, or if the information provided is inaccurate.

TO treat all office personnel respectfully and courteously.

TO keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment (24 hours).

TO pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit unless prior arrangement have been made.

TO ask questions and seek clarifications until you fully understand the care you are receiving.

TO follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.

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 late 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 interests of our other patients.

I have read and understand the office policy as stated above and accept responsibility as described. I give my consent to obtain treatment from Physicians' Pain and Rehabilitation Specialists of Georgia, P.C.

Patient Name: _____

Patient Signature: _____ Date: _____