Academia of Women's Health & Endoscopic Surgery
(404) 549-3224

Patient Registration Form

ACADEMIA
OF WOMEN'S HEALTH &
ENDOSCOPIC SURGERY

PLEASE PRINT | TODAY'S DATE: / /

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH

SOCIAL SECURITY #	MARITAL STATUS	RACE	E-MAIL
	Married ☐ Divorced ☐ Single ☐ Other ☐	Caucasian ☐ Black ☐ Hispanic ☐ Middle Eastern ☐ Asian ☐ Other ☐	

ADDRESS APT#	CITY STATE ZIP	HOME PHONE	CELL PHONE
		( ) -	( ) -

EMPLOYED	EMPLOYER/SCHOOL	EMPLOYER/SCHOOL ADDRESS	EMPLOYER PHONE
Part Time ☐ Full Time ☐ Not ☐ Retired ☐ Student ☐			( ) -

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS	CITY	STATE	ZIP	HOME PHONE	CELL PHONE
				( ) -	( ) -

IN CASE OF EMERGENCY CALL

NAME	RELATIONSHIP	PHONE NUMBER
#1		
#2		

PRIMARY CARE PHYSICIAN OR GROUP NAME

NAME	PHONE	FAX
	( ) -	( ) -

PRIMARY INSURANCE COMPANY INFORMATION

NAME	IDENTIFICATION NUMBER	GROUP NUMBER

SECONDARY INSURANCE COMPANY INFORMATION

NAME	IDENTIFICATION NUMBER	GROUP NUMBER

How Did You Hear about Us:

Google ☐ Website ☐ Friend/Relative ☐ Physician ☐ Other: _____

PHARMACY INFORMATION

NAME	ADDRESS/CROSS STREET	PHONE	FAX
		( ) -	( ) -

PREFERRED LAB

NAME	PHONE	FAX
#1	( ) -	( ) -
#2	( ) -	( ) -

PLEASE READ AND SIGN ON PAGE 2 OF THIS FORM AND PRESENT YOUR INSURANCE CARD AND ID

ACADEMIA OF WOMEN'S HEALTH & ENDOSCOPIC SURGERY, LLC
FINANCIAL POLICY

Patient Name: _____
(Please Print)

If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Copayments for office services are required at the time of your office visit.
- Returned checks are subject to a $25 fee. Post-dated checks are not accepted.
- We will process and file your primary and secondary insurance claims for covered services.
- For services that are covered by insurance, the practice requires payment of your coinsurance and/or copayment specified by your insurance at the time of your visit.
- For services that are **not** covered by your insurance plan, the practice requires payment of 100% of noncovered charges.
- **Patients who fail to keep or cancel a scheduled appointment within 24 hours of the scheduled appointment will be charged a $50 fee. A cancellation fee of $250 will be applied for scheduled inpatient, outpatient, or office surgeries that are cancelled less than five (5) business days prior to the date and time of surgery, unless cancellation is due to insurance denial, medical necessity, or uncontrollable circumstances**.
- If you require it, a $35 fee will be charged for completion of disability paperwork.
- If you request your Records Released to you, or another physician, pursuant to Georgia 31-33-3, we will charge a retrieval fee of $25.88, plus $0.97 per page for the first 20, $0.83 per page for pages 21 through 100, and $0.66 per page in excess of 100 pages.

Insurance and Patient Responsibilities:

1. ***Your insurance is a contract between you, your employer and/or the insurance company.*** While we may be a provider of services, we are not a party to your individual contract. We encourage you to contact your insurance carrier personally to remain informed of your benefits. Please contact their customer service department with any questions you may have after they have processed your claim.

2. ***Not all services are a covered benefit in all contracts.*** Some insurance companies select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment or payment of a specific amount from your insurance carrier.

3. ***We realize that temporary financial problems may affect your ability to make payment on your account***. If such problems do arise, we encourage you to contact our office immediately for assistance in the management of your account. We will allow you up to 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue an additional $10 fee for each month the balance remains unpaid. Our staff will arrange for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to contact us. Your account may be sent to our outside collection agency for collection if payment arrangements have not been established and regular payments are not received. In the event your account must be turned over to an outside collection agency, you will be billed and are responsible for all fees incurred in the collection process.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy.

My signature authorizes Academia of Endoscopic Surgery & Women's Health, LLC, to file insurance claims on my behalf to Medicare and/or other insurance plans and for payments of any benefits due under my insurance plan to be made directly to Academia of Endoscopic Surgery & Women's Health, when insurance is filed on my behalf.

Signature:_____ Date:_____
(Patient and/or Guarantor)

ACADEMIA OF WOMEN'S HEALTH & ENDOSCOPIC SURGERY, LLC (404) 549-3224

Patient Printed Name: _____ **DOB:** _____ **ACCT#:** _____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plan, providers, individual, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

I understand that I have read the "Notice of Information Practices" that provides a more complete description of information uses and disclosures, posted in the lobby reception room. I understand that upon request I will be provided a copy of such notice. It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. (Except appointment reminders, leaving date, time and doctor's name only) Whenever returning phone calls and the answering machine picks up, we will only leave our name and number if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself please complete the following:
I authorize Academia of Women's Health & Endoscopic Surgery, LLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

(PLEASE FILL THIS OUT COMPLETELY, IT TELLS US HOW TO CONTACT YOU.)

Home telephone # _____	Yes _____	No _____	Answering Machine	Yes _____	No _____
Work telephone # _____	Yes _____	No _____	Voice mail	Yes _____	No _____
Cell phone/Voice mail #_____	Yes _____	No _____	Postal Service	Yes _____	No _____

Please list names of people we can discuss your medical care with:

Spouse: _____ Yes _____ No _____ Phone #_____
Parent: _____ Yes _____ No _____ Phone #_____
Other: _____ Yes _____ No _____ Relationship: _____ Phone # _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Academia of Women's Health & Endoscopic Surgery, LLC originate and maintain health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A source for determining participation in/qualification for research studies

I understand that the *Notice of Information Practices* provides a more complete description of Information uses and disclosures and that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to use of my health information for director purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already acted in reliance thereon.

I would like to be provided with a copy of the Notice of Information Practices: (please mark one) □ **Yes** □ **No**

_____ _____
PATIENT/GUARDIAN/PERSONAL REPRESENTATIVE --RELATIONSHIP _____ **ORIGINAL DATE**

_____ _____
WITNESS SIGNATURE **UPDATED ON**

TELEPHONE AUTHORIZATION IN PATIENT'S ABSENCE **Employee Sign:** _____ **Date:** _____ **Witness Sign:** _____

Preventive Services, Problem Visits, and Ultrasounds

Dear Patient of Academia Women's Health and Endoscopic Surgery:

Please see below our financial policies related to preventive visits, problem visits, and ultrasound performance, practiced at Academia and consistent with American Medical Association (AMA) guidelines:

Preventive, Problem Visits, and Ultrasounds

According to the AMA, a ***periodic preventive medical visit*** is described as an encounter that includes an appropriate history, examination, counseling/anticipatory guidance, risk factor reduction, interventions, and ordering corresponding laboratory and diagnostic testing. Please note that the focus of this visit is preventive.

According to the same Association, if existing problems are voiced or discovered and addressed at the time of the Preventive Visit, it is appropriate to charge for both a Preventive Visit and for an additional evaluation and management service. **While these additional services are usually covered by your insurance carrier, they are not considered a part of your preventive benefits and they <u>may be applied to your deductible or require a copay</u>**. Should you not want your problems addressed at the time of your Preventive Visit, ***please let the physician or staff know*** and we will gladly schedule an appointment for you to return to address those problems or concerns.

Please also know that **<u>ultrasounds performed by us at the time of annual visits may not be covered under your preventive benefits</u>**. Our commitment during your annual examination is to detect any potential problem as early as possible. Performance of the transvaginal pelvic ultrasound substantially enhances our ability to do so. **As our commitment to your care, the charge for the ultrasound service (76830) has been reduced to $125 to make annual ultrasound more affordable, <u>if your insurer does not cover that service</u>**. ***To receive this reduced price, payment must be made on the date of service***. Otherwise, the regular price of $200 will be charged.

Commitment

Academia of Women's Health and Endoscopic Surgery ensures the most accurate processing of your claims. Still, should you have any questions, our billing department will be glad to answer them and will help with your claims as much as possible.

Patient Signature_____ Date_____