ACADEMIA
OF WOMEN'S HEALTH &
ENDOSCOPIC SURGERY

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

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 this goal, we need your assistance and your understanding of our financial policy.

1. Copayments for office services are required at the time of your office visit.
2. Returned checks are subject to a $25 fee. Post-dated checks are not accepted.
3. We will process and file your primary and secondary insurance claims for coverable services in the following fashion: after the service is rendered and documented, the documented visit undergoes coding by coding expert, followed by submission of claims to the insurance company, and then you are billed for services not covered by your insurance company. At that point we encourage you to contact our billing service with any questions that you may have. You have a 90-day period from the issuing of the bill to discuss and dispute the bill or to organize a payment plan when applicable. After that, if we do not hear from you and if no payment plan is initiated, the account may be sent to a collection agency. (Please see further details.)
4. 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.
5. For services that are **not** covered by your insurance plan, the practice requires payment of 100% of non-covered charges prior to service rendered.
6. **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 hospital based surgeries that are cancelled less than 10 days prior to the date of surgery. A cancellation fee of $150 will be applied for in office surgeries that are cancelled less than 10 days prior to the date of surgery.**
7. If you require disability paperwork, a $35 fee will be charged for completion of the forms.
8. If you request your medical 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.

_____ Initial

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 bills for these services. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings regarding fees that could be your responsibility. 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 payments on your account*** or that you may have questions regarding your account. If such problems do arise, we encourage you to immediately contact our billing office at **(888)451-4440** for assistance in the management of your account. You will be required to leave a message at the billing company, and they will call you back within 24 hours. Our billing 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. We will allow you up to 90 days to pay any balance remaining after billing statement has been issued. Your account may be sent to our outside collection agency for collection if payment arrangements have not been established and/or regular payments are not received.
4. **Academia utilizes in-house lab (PathGroup). Lab charges are billed separately and not associated with this office. It is the patient's responsibility to know if PathGroup is covered by her insurance. The patient may request another lab company, if desired. PathGroup may be reached at 1-877-456-6706.**

_____ Initial

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)

Preventive Services, Problem Visits, and Ultrasounds

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. **Most insurances other than Federal Plans cover for only one annual examination a year (all doctors collectively.)**

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 will be applied to your deductible or require a copay.** For patients with a deductible plan, a payment of $150 will be collected towards deductible before checkout. Once processed with patient's insurance, the patient will receive a bill/and or credit from Academia for remaining balance, determined by the patient's insurance plan. 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 **ultrasounds performed at the time of annual visits are not covered under your preventive benefits unless performed for a known problem**. 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. The charge will not be sent to your insurance company as it is considered non-coverable.** ***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_____

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERTIONS

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the patient is a minor under state law.

Name: _____
Date of Birth: _____

I hereby authorize *Academia of Endoscopic Surgery & Women's Health* to release the following personal health information for (check all that apply):

____ Medical services claims information

____ Prescription, diagnostic, treatment, and/or care management services

____ Reviews required by HHS or HIPAA-compliant healthcare operations

The above information may be release by: ____Phone ____ Fax ____ Mail ____ Friend or relative _____
This consent is effective _____ (today's date)
I want this consent to continue: _____ Indefinitely; OR _____ Effective only until _____ (date)

COMMUNICATIONS WITH YOU

Note: Secure and private communication cannot be guaranteed fully with the use of non-secure technology such as cell/smart phones, regular email, or via our website. It is your right to decide whether using this type of non-secure technology may be permitted and under what circumstances. Should you choose to contact *Academia of Endoscopic Surgery & Women's Health* or your provider using any type of non-secure technology, it will be considered implied consent (with your permission) that we respond and return messages in the same non-secure manner. In the event that you choose not to allow non-secure modes of communication, we will only be able to contact you on a "home" (land-line phone, wire-to-wire fax, or US Postal Service mail). **Please also note:** We do not accept social media friend requests from former or current patients to protect your privacy and maintain a professional boundary in the therapeutic relationship.

How may we communicate with you?
□ Cell Phone #_____ Okay to leave voicemail? □ Yes □ No
□ Home Phone #_____
□ Mail (address): _____
□ Email (address): _____
Is there anyone with whom you specifically do not want us to share any information about your care? If so, please list their name(s) and relationship to you: _____

I understand that I have the right to revoke this authorization and consent in writing at any time. I request that my confidential information be handled in the herein authorized manner. Any other release of information will require a signed authorization for Release of Medical Information or Release of Psychotherapy Notes. I assume all risk and responsibility for updating the Practice with any changes in the above-provided information. I understand why I have been asked to disclose this information and I am aware that my patient rights are identified in the practice's Notice of Privacy Practices.
I have received a copy of Patient Notification Protocol (Next Page): Please initial: _____

Printed Name of Patient: _____ Date _____

_____ _____
Signature of Patient /Legal Guardian (Relationship to Patient)

ACADEMIA
OF WOMEN'S HEALTH &
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Results Notification Protocol

Dear Academia Patients, please note the following:

Pap smears and vaginal swabs: Normal results will be published on your patient's portal. Otherwise you will hear from our office in 2 weeks. If you do not hear from us in 2 weeks and your results are not available on patient's portal, please call our office to make sure that your result was received.

Problem-based Labs, CT, MRI and other imaging: At the time of current office visit, please schedule a follow up appointment in 1-2 weeks to discuss your findings and plan of care with Dr. Stepanian.

Mammograms: The imaging center contacts the patients with the results.
If you do not hear from imaging center within 2 weeks or if you have any questions about your results, please call our office.

When scheduling Hysteroscopy, Biopsies, Colposcopies, Urodynamic tests, and NS based surgeries, please schedule a follow up visit in 2 weeks to ensure discussion of the results and generation of further plan of care.

Bone Density Screening: Our office will notify you of the results that require any additional management within 2 weeks of your test. Normal or stable results are not reported routinely.

STD testing and Urine Culture and Sensitivity: we will call with all results and either state that "your results are normal" or we will ask to call us back to initiate treatment and make an appointment to discuss the findings. Please call us back with any questions.

It is a pleasure to be a part of your healthcare journey.

If after 2 weeks you do not receive information regarding your test, please call the office at 404-549-3224.

Dr. Assia Stepanian

755 Mount Vernon Highway NE, Suite 240 Atlanta, GA 30328 • Ph. 404-549-3224 • Fax. 404-459-0995

Notice of Privacy Practices Receipt

Our Notice of Privacy Practice (NPP) provides information on how our practice may use and/or disclose protected health information about you for treatment, payment, and health care operations. A copy of our NPP can be found in our lobby and upon request.

I acknowledge that I have received a copy of Academia of Endoscopic Surgery & Women's Health's, Notice of Privacy Practices.

Patient Name: _____

Patient's Legal Representative (*if patient is under 18*): _____

Patient's / Legal Representative Signature's: _____

Today's Date: _____

Patient's Date of Birth: _____

RECORDING OFFICE VISITS

Academia of Endoscopic Surgery & Women's Health

With the proliferation of smart phones, tablets, micro recorders, and other video and audio recording devices which capture and store video and audio files (collectively, "Recorders"), we wanted to make you aware of our office policy on the use of these Recorders within our practice and during your visit with a provider (our "Recording Policy"). Please ask the provider or any staff member if you ever have any questions about our Recording Policy.

Please understand that the genesis of our Recording Policy is to protect your personal health information, and that of other patients, from being accessed by non-authorized parties. As a medical provider, we are subject to certain state and federal privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which require us to take reasonable measures to prevent the unauthorized access of our patients' protected health information (PHI). Recorders used during an office visit may result in the unauthorized recording of another patient's PHI, intentionally or inadvertently, or you may misplace or lose your Recorder once you leave the office, providing others with access to your PHI and potentially subjecting us to fines and penalties.

Therefore, we have developed the following Recording Policy, and we ask that you carefully read and sign where indicated to signify your (i) understanding of the Recording Policy, and (ii) agreement to adhere to same.

1. **While in the office lobby, administration areas, receptionist area, billing office, hallways, and other common areas (collectively, the "Common Areas"):**

   The use of all Recorders is **strictly prohibited** in the Common Areas unless (1) the Recorder is needed for communication purposes in accordance with the Americans with Disabilities Act (ADA), OR (2) the Recorder is needed to help the patient remember what a staff member told him/her about billing questions, follow up instructions, future appointments, etc. If the latter, we ask that the patient first ask the staff member for permission to record the interaction. Under no circumstances, however, is a patient permitted to video record in the Common Areas unless ADA required.

2. **While in a patient room communicating with a provider (the "Patient Room"):**

   The use of all Recorders is **strictly prohibited** in the Patient Room unless (1) the Recorder is needed for communication purposes in accordance with the Americans with Disabilities Act (ADA), OR (2) the Recorder is needed to help the patient remember what the provider told him/her at the time of the visit. If the latter, we ask that the patient first ask the provider for permission to record the interaction. Under no circumstances, however, is a patient permitted to video record a provider visit unless ADA required.

If a provider or staff member has a reasonable belief that a patient has used a Recorder in violation of this Recording Policy, the patient will be (i) asked to turn the Recorder off, (ii) reminded of the Recording Policy, (iii) asked to delete any audio/video recordings taken within the Common Areas or Patient Room, and (iv) potentially, terminated from the practice.

By signing below, I am confirming that I have been able to ask questions about the Recording Policy, that all of my questions (if any) have been answered, and I agree to abide by the Recording Policy.

_____

Patient Name & DOB

_____ _____

Patient Signature Date