

**Drs. Kehl, Barnes, Durso, & Ekeledo**  
**Physicians and Midwives of Macon**  
1062 Forsyth St, Suite 3B, Macon GA 31201  
(478) 743-3454 [www.physiciansandmidwivesofmacon.com](http://www.physiciansandmidwivesofmacon.com)

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**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Cell (if different): \_\_\_\_\_ Work Phone: \_\_\_\_\_

Pharmacy Name & Location: \_\_\_\_\_

Mail Order Pharmacy, if applicable: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

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**INSURANCE INFORMATION**

\*\*\*\*\**(IF NEW PATIENT OR IF IT HAS CHANGED SINCE LAST VISIT)*\*\*\*\*\*

**Primary Insurance Carrier:** \_\_\_\_\_ Policy Holder Same as Patient ☐

Policy Holder Name (if not patient): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_ Policy Holder Same as Patient ☐

Policy Holder Name (if not patient): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer Name: \_\_\_\_\_

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**EMERGENCY INFORMATION**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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**SIGNATURE** \_\_\_\_\_ **Date:** \_\_\_\_\_

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

PLEASE COMPLETE REVERSE SIDE



# Drs. Kehl, Barnes, Durso, & Ekeledo Physicians and Midwives of Macon

## AUTHORIZATIONS

- I hereby authorize and request medical treatment necessary for my care as determined by the Physician, including checking my external prescription history.
- I authorize the release of all medical records and appeals to the referring physicians, family physicians, and to my insurance company, if applicable. I allow the fax transmittal of my records if necessary. I also acknowledge that my doctor's office will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.
- I acknowledge full responsibility for any services rendered by Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon. I understand that any co-payment I have with my insurance company is due at the time of service. I understand that I am financially responsible for payment of any co-insurance, un-met deductible, or non-covered services, as deemed by my insurance company, within a timely manner.
- I further authorize and request that insurance payments be made directly to Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon for all services rendered.

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## LAB WAIVER

Certain lab specimens are sent to outside labs for processing. We will send the specimen to the laboratory that participates with your insurance carrier, to the best of our knowledge. If your specimen is sent to the wrong lab, Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon will not be responsible for any fees incurred for processing. I understand that it is my responsibility to know which laboratory my insurance authorizes, and to notify Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon staff of this information.

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## AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following **\*individuals\*** the right to obtain any information; including lab results, appointment information, or any other diagnostic testing performed by Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon: *(leave blank if you don't want anyone to obtain your information. Your emergency contact is NOT automatically on this list.)*

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

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## ACKNOWLEDGEMENT OF PRIVACY NOTICES (HIPAA) AND DISCLOSURE OF HEALTH INFORMATION

I understand that the patient's health information is private and confidential. I understand that Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it.

Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon have a detailed document called the "Notice of Privacy Practices" which contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

My signature below indicates that I have been given the opportunity to review a current copy of the "Notice of Privacy Practices", and that I agree to allow Drs. Kehl, Barnes, Durso, & Ekeledo, and Physicians and Midwives of Macon to use and disclose the patient's health information to carry out treatment, payment from insurance companies, and all healthcare operations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_