YOUR FAMILY
MEDICAL GROUP

Authorization to Treat

I authorize the physician and staff of Your Family Medical to treat myself, or the person for whom I have responsibility. I understand that this consent to treat includes my consent for medical test, procedures, drugs and other services and supplies as considered advisable; and may include, but is not necessarily limited to: radiology and other diagnostic services, as well as other special test and services as ordered by the physician responsible for my care during my visit to Your Family Medical. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment at Your Family Medical. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care. I understand I may request a copy of Your Family Medical's Notice of Privacy Practices to read and/or take home with me at anytime. I understand that if I want more information about these privacy practices or have questions or concerns, I may ask the Center's staff or contact Your Family Medical as indicated on the notice.

I authorize Your Family Medical, or its agents, to release medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers, as necessary to determine payment for these or related services. I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf to Your Family Medical for services provided by said group. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that I am required to notify Your Family Medical of any change in insurance Coverage.

I understand I am financially responsible for payments of services provided during the visit if I do not have insurance coverage. I also understand that if I have a co-payment for this service, it is payable today. **Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. Any specialty orthopedic products will be billed by DJO, LLC.** Some insurance companies require preauthorization for certain services. If I am required to obtain an authorization for todays visit and have not done so, I agree to assume all financial responsibility.

In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provisions apply equally to any individual for whom I am authorized to consent to treatment, or for whom I qualify as an authorized representative or authorized agent under any laws.

Skidaway Medical Group is responsible for the management of, and has a financial interest in Primary Care Savannah and Urgent Care of Berwick/Urgent Care of Sandfly. Our goal is to enhance access to quality health care services for our patients. Referrals to alternative providers and/or facilities will be made available to the patient upon request. Ongoing patient care is in no way contingent upon the patient accepting the recommended referral.

_____ **Date:** _____

Patient's Signature (If patient is a minor, have guardian or representative sign in their place)

_____**Patient's Date of Birth**: _____

Print Patient's Name Clearly

Address _____**City/Zip** _____

Home Phone #_____**Cell Phone #**_____**Work Phone #**_____

Reason For Today's Visit _____

YOUR FAMILY
MEDICAL GROUP

PATIENT INFORMATION

Today's Date: _____ Gender: _____ Date of Birth: _____/_____/_____ Age: _____

Last Name: _____ First Name: _____MI: _____

SSN# _____--_____--_____ E--mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: (_____) _____--_____ Work #: (_____) _____--_____ Cell # : (_____) _____--_____

Employer:_____

Race/Ethnicity _____ Preferred Language: _____

Marital Status: (Circle) Single Married Divorce Separated Partnered Widowed

Emergency Contact: _____ ***Relationship to Patient:*** _____

Emergency Contact Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN : _____--_____--_____

ID #: _____

Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN: _____--_____--_____

ID #: _____

Group #: _____

Reason for today's visit: _____

If Injured: Where you injured on the job? (Circle) Yes No Injury Date: _____

Signature of Responsible Party:_____ Date: _____/_____/_____

Please continue to the next page for your office visit details and sign the authorization to treat.

Berwick: 5730 Ogeechee Road, Suite 192 • Savannah. Georgia 31405 • 912.201.1140 (t) • 912.777.6449 (f)
Sandfly: 7360 Skidaway Road, Suite L2 • Savannah, Georgia 31406 • 912.201.1140 (t) • 912.999.6271 (f)
Primary Care: 310 Eisenhower Dr, Suite 12A • Savannah, Georgia 31406 • 912.201.1140 (t) • 912.417.4348 (f)

PRIMARY CARE
Wilmington Island

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this farm, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we contact you by phone to confirm appointments?	YES	NO
May we leave a message an your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

1) Name_____Number_____Relationship_____

2) Name_____Number_____Relationship_____

3) Name_____Number_____Relationship_____

This consent was signed by:_____

(PRINT NAME PLEASE)

Signature: _____Date: _____

Witness: _____Date: _____

PRIMARY CARE
Wilmington Island

Dear Patient:

Many Insurance companies are now specifying which commercial laboratory you may use for studies. It is your responsibility as the patient to be aware of this and to provide it to our office at the time of your visit. Please be aware that if your lab work is sent to a non-preferred lab, YOU WILL BE RESPONSIBLE FOR PAYMENT.

Our in-office lab can perform only limited studies, all other testing must be sent to a reference lab.

Please indicate below your insurance carrier's preferred lab. Inaccurate information will result in you being held responsible for all lab charges.

___ Lab Corporation of America

___ St. Joseph/Candler Lab

___ Quest Diagnostic

Signature: _____

Date: _____

If you are a new patient or have new insurance you should call your Insurance Company for the preferred lab prior to your appointment. If you do not then you will be asked to do so at the time of your appointment.

PRIMARY CARE
Wilmington Island

Authorization for Release of Medical Records

Patient: _____ SSN Last 4 Digits: _____

DOB: _____ Date of Service: _____

Requested By: ***Dr. Jeanne Hungerpiller Dr. Adrienne Fabrizio***

Release To: ***Dr. Jeanne Hungerpiller Dr. Adrienne Fabrizio***

_____

Release From: _____

Purpose or Need for the Information ***PCP Chart Update***

Please include all Office Notes, Radiology Reports (MRI, CT, US, Mammo, etc.) & Labs

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

1. Communications between patient and psychiatrist or psychologist
2. Medical information concerning alcohol and/or drug dependency
3. Medical information concerning alcohol and/or drug abuse
4. Medical information concerning mental retardation
5. Medical information concerning Acquired Immune Deficiency Syndrome(AIDS)HIV

THIS RELEASE IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE ORGANIZATION WHICH IS TO MAKE THE DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON IT. IF NOT PREVIOUSLEY REVOKED, THE RELEASE WILL TERMINATE AS INDICATED IN DATE APPEARING BELOW AS EXPIRES.

SIGNATURE: _____ ***DATE:*** _____

WITNESS: _____ ***DATE:*** _____

WITNESS RELATIONSHIP: ***Front Office Records & Referrals***

YOUR FAMILY
MEDICAL GROUP

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Adrienne Fabrizio, MD. When you schedule an appointment with ***Adrienne Fabrizio, MD we set aside enough time to provide you with the highest quality care. Should you need*** to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below.

- Effective October 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged **a $35.00 fee** for Routine visits/ **$50.00 fee** for Annual Wellness visits.
- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice a second time will be considered a No Show and charged **a $50.00 fee** Routine visits/ **$75.00 fee** for Annual Wellness visits.
- If a **third** No Show or cancellatlon/reschedule without **at least 24 hour notice** should occur the patient may be **dismissed** from our practice.
- Any new patient who fails to show for their Initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due prior to scheduling your next appointment.**
- As a courtesy, **when time allows**, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain In effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office. We may be able to waive the No Show fee. You may contact our office 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you should leave a message with the answering service.

Adrienne Fabrizio, MD **912-201-1140**

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ **Date:** _____

Signature

_____

Relationship to Patient (Parent/Legal Guardian)