Georgia Rheumatology Clinic, P.C.
184B Jefferson Parkway,
Newnan GA 30263
Telephone: (678) 889-7900 Fax: (770) 683-3349

Thank you for choosing Georgia Rheumatology Clinic.

We would like to give you some information about our practice.

We work by appointments only. We give each patient the care needed and sometimes, due to emergencies and other medical needs, we may fall behind the schedule, but know that you will receive the same care when we see you. We attempt to remind you of your appointment 24-48 hours in advance. Please be sure we have the most updated as well as alternative phone numbers. Should you change or cancel your appointment, we request that you give us at least 24 hours notice. Phone: 678-889-7900. **If you do not give us 24 hours notice or do not show up for your scheduled appointment, you may be charged a no show fee of $50.00 for new patients and $25.00 for existing patients.**

We understand that delays can happen, however, we must try to keep the other patients and provider on schedule. When you are late for your appointment, we will try our best to accommodate you, but may have to ask you to reschedule. We do make every attempt to stay on schedule and do not wish to delay those patients who are on time.

We appreciate and thank you for your cooperation and understanding.

****PLEASE BRING COMPLETED FORMS IN THIS PACKAGE WITH YOU TO YOUR APPOINTMENT!**

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, YOU MUST HAVE IT IN HAND BEFORE YOU CAN BE SEEN.

Please check with your insurance company prior to appointment to verify we are an in-network provider and to verify if you need a referral for your visit.

When you arrive for your visit, we will:

1. Collect any co-pay that is due. We accept cash, check, Visa, MasterCard, American Express and Discover. We also accept Visa and MasterCard DEBIT CARDS.
2. Review your medication. Be sure you have a complete list of medications including the strength of each medication and how often you take them.
3. If blood work or imaging (X-rays, CT, MRI, Bone Density Test) are needed, you will be provided with a lab or imaging request letter to take to the appropriate facility to have the respective tests done. If your insurance requires a special lab, *please let us know so we can mark your file appropriately*.

Before you leave, we may also give you prescriptions (30-day or 90-day supply), and make your follow up appointment.

You may reach us by phone Monday through Thursday 8:00 AM to 4:30 PM and Friday 8:00 AM to 3.30 PM. If you have an emergency after hours, or if you feel you have a life-threatening emergency, please note that you should call 911 or proceed to the nearest emergency room.

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WE DO NOT HAVE AFTER HOURS OR WEEKEND COVERAGE. WE ALSO DO NOT PROVIDE EVALUATION FOR WORKER'S COMPENSATION. DR. KHASNIS DOES NOT FILL OUT DISABILITY PAPERWORK, BUT WE CAN PROVIDE A LETTER STATING AND EXPLAINING YOUR DIAGNOSIS AND COURSE OF TREATMENT.

Signature:______________________________ Date:__________________________________

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REQUIRED DOCUMENTS

For your first time visit or, if you have not been seen in this office for 3 years or longer, please bring with you the following;

- Valid Insurance card of official policy or document.
- Photo Identification (e.g. valid Driver's License).
- Referral, if required by your Health Plan.
- Current address and phone number.
- Business card from referring Physician (optional).

ASSIGNMENT AND RELEASE

I, the undersigned certify that I have insurance coverage with______________________________
Insurance Company Name

And assign directly to GEORGIA RHEUMATOLOGY CLINIC P.C., DR. ATUL KHASNIS, M.D. all insurance benefits, in any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize GEORGIA RHEUMATOLOGY CLINIC, P.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance company submissions.

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RESPONSIBLE PARTY RELATIONSHIP DATE

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Georgia Rheumatology Clinic, P.C.

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

I, ________________________________, understand that as part of my healthcare, Georgia Rheumatology Clinic, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination & test results, diagnoses, and treatment plans for future care of 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 health care professionals.

I understand and have been with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand **Georgia Rheumatology Clinic, P.C.** 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 organization has already taken actions in reliance thereon. I also understand that by refusing to sign this consent or revoke this consent, this organization may refuse to treat me as permitted by *Section 164.506 of the Code of Federal Regulations*.

I further understand that **Georgia Rheumatology Clinic, P.C.** reserves the right to change their notice and practices and prior to implementation, in accordance with *Section 164.520 of the Code of Federal Regulation.* Should **Georgia Rheumatology Clinic, P.C.** change their notice, they will send a copy of any revised notice to the address I have provided (whether US Mail or, if I agree to Email.)

I agree that I will submit to blood or urine tests if requested to starting treatment in monitor therapy or determine toxicity of some of my medications.

I wish to have the following restrictions to the use of disclosure of my health information:

____

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____

I understand that a part of this organization's treatment, payment, or healthcare operations may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **Accept** or **Decline** the terms of this consent.

Patient's Name: ______________________________________ Date: ____________________

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For Office Use:

Consent Received By: ______________________________
Consent Refused by Patient and Treatment Refused as Permitted: __________
Consent Added to the Patient's Medical Record on: ____________________
Revised December 26, 2017

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PATIENT INFORMATION

NAME: ____ SS#: ________-________-__________

ADDRESS: ____ HOME PHONE: ______-________-________

____ CELL PHONE: ________-________-________

DOB: _____-_______-________

MAY WE REMIND OF YOUR APPOINTMENTS BY TEXT MESSAGING: YES/NO______ MOBILE CARRIER? ______________________

E-MAIL ADDRESS (FOR NOTIFICATION OF APPOINTMENTS):________________________________

SEX: M____F____ AGE: _______ SINGLE, MARRIED, SEPARATED, DIVORCED, WIDOWDED

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED: _______________Phone:____________________

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR BILL: SELF___ SPOUSE___ OTHER___ IF NOT YOU, GIVE US THE
NAME: ____ DOB:______-_________-_____________
ADDRESS IF DIFFERENT FROM YOU____ SS#:
________-__________-________________

EMPLOYER: ________________________________ OCCUPATION: ____________________________
EMPLOYER ADDRESS:____
EMPLOYER PHONE: ________-_________-___________INSURANCE COMPANY:_________________________
GROUP#:________________ ID#: ________________________ SUBSCR1BER#: ___________________

SECONDARY INSURANCE

PERSON RESPONSIBLE FOR BILL: SELF___ SPOUSE___ OTHER___ IF NOT YOU, GIVE US THE
NAME: ____ DOB:______-_________-_____________
ADDRESS IF DIFFERENT FROM YOU____ SS#:
________-__________-________________

EMPLOYER: ________________________________ OCCUPATION: ____________________________
EMPLOYER ADDRESS:____
EMPLOYER PHONE: ________-_________-___________INSURANCE COMPANY:_________________________
GROUP#:________________ ID#: ________________________ SUBSCR1BER#: ___________________

EMPLOYER: ____ OCCUPATION: ________________________
EMPLOYER ADDRESS: ____
EMPLOYER PHONE: _________/_________/___________X _______

PRIMARY CARE DOCTOR: ___________________________________ PHONE #: _______/_________/_________

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MEDICAL RECORDS RELEASE FORM

I, ____________________________ hereby request that you release my medical records, including all clinical information and other data related to my medical treatment while under the care of Dr. Atul Khasnis @ Georgia Rheumatology Clinic, P.C.

RECORDS REQUESTED FROM (NAME OF PROVIDER/PRACTICE):

____

____

____

Please fax the requested information to (770) 683-3349.

What are you requesting?

Please check one: ☐ Clinical Information ☐ Labs ☐ Radiology Reports ☐ Full Medical File

What time Frame?

Please check one: ☐ Past Year ☐ Past 5 years ☐ Specific Date/s: ________

Patient's Name: ______________________________ Patient's Date of Birth: ___________

Patient's Signature: ___________________________ Today's Date: __________________

*** **In compliance with HIPPA Regulations, these medical records release forms are to be used only for patient's care.**

(Fill out BELOW ONLY if you want records to GO to another provider or practice)

PLEASE SEND RECORDS TO: ____

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MEDICATION LIST

DATE: ____________________

Please list your medications including over the counter (OTC) medications and Prescription medications.
E.g.: Aspirin, Tylenol (OTC) or Celebrex, Codeine, Prednisone (Prescription)

Medication	Dose	Used for what condition?	How do you take this medication?	Prescriber/OTC	Started/Stopped