Georgia Rheumatology Clinic, P.C.
101 McWilliams Dr. Suite B,
Peachtree City GA 30269
Telephone: (678) 889-7900 Fax: (770) 683-3349

Thank you for choosing Georgia Rheumatology Clinic, P.C.

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/INSURANCE AUTHORIZATIN, 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, coinsurance, or deductible. We accept cash, check, Visa, MasterCard, American Express and Discover.
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*.
4. 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 documents:

   Valid Insurance Card
   Photo Identification (e.g. valid Driver's license)
   Referral/Insurance Authorization, if required by your Health Plan
   Medical records (labs/imaging results) related to Rheumatology

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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 4:00 PM and Friday 8:00 AM to 2:00 PM. If you have any medical concerns after office hours, or if you feel you have a life-threatening emergency, please call 911 or proceed to the nearest emergency room.

WE DO NOT HAVE AFTER HOURS OR WEEKEND COVERAGE.
WE ALSO DO NOT EVALUATE FOR OR FILL OUT PAPERWORK FOR WORKER'S/WORKMAN'S COMPENSATION.
DR. KHASNIS DOES NOT FILL OUT SHORT-TERM/LONG-TERM DISABILITY PAPERWORK.

RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize Georgia Rheumatology Clinic, P.C. to share my PHI with the following people:

Name	Phone number	Relationship
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Signature:_____ Date:_____

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FINANCIAL POLICIES

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

And agree that all information that I have given is true to the best of my knowledge. I authorize and assign directly to GEORGIA RHEUMATOLOGY CLINIC P.C. and 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. This responsibility applies to copay, deductible, co-insurance, full payment if uninsured. 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.

Check Policy: If your check is dishonored or returned for any reason, we will debit your account for the check plus a processing fee of $30.00.

Collection Policy: We employ an outside collection agency for delinquent accounts. Fees will be incurred for their services.

Appointment No-Show Policy: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance, you may be charged a $25.00 fee. This fee will not be covered by your insurance company.

Waiver of medical necessity: Your insurance is a contract between you and your insurance company. Coverage benefits will vary based on your personal policy. Please contact them directly with any questions about your specific coverage.

We have a laboratory located in this facility for your convenience. However, the lab is not part of our practice and all questions, concerns regarding lab services including billing should be directly communicated with them.

RESPONSIBLE PARTY RELATIONSHIP DATE

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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_____

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

SEX: M____F____ AGE: _____ SINGLE, MARRIED, SEPARATED, DIVORCED, WIDOWED

***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 at 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

PATIENT NAME:_____ DATE: _____

PREFERRED PHARMACY:_____

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