ELIZABETH GEORGE, M.D., P.C.

207 RIVER PARK NORTH DRIVE
WOODSTOCK, GA 30188
OFFICE (678) 388-2184

Patient Information Sheet

Date____/____/_____

NAME: LAST______________________________FIRST ____________ MIDDLE INITIAL ____

ADDRESS ____

CITY ______________________________ STATE ____________ ZIP_______________

HOME PHONE (______) ______ - ________ CELL PHONE (______) ______ - ________

WORK PHONE (______) ______ - ________ EXT. ________ Email ________________________________

PRIMARY CARE DOCTOR ____

REFERRING PHYSICIAN ____

DATE OF BIRTH ____/____/_____ SEX ☐ F ☐ M SOCIAL SECURITY # _____ / _____ / ______

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ PARTNER
☐ MARRIED (SPOUSE NAME ____________) ☐ WIDOWED ☐ UNKNOWN

EMPLOYER NAME ____________________________________ ADDRESS ____________________

EMPLOYMENT STATUS: ☐ FULL TIME ☐ NOT EMPLOYED ☐ RETIRED
☐ PART TIME ☐ SELF EMPLOYED ☐ ACTIVE MILITARY

STUDENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ NOT A STUDENT
RESPONSIBLE PARTY: ☐ SELF ☐ GUARANTOR RELATIONSHIP______________

NAME______________________________ ADDRESS ________________________________

CITY_________________________ STATE _______ ZIP______________ DOB____/____/_____

EMERGENCY CONTACT:
NAME LAST__________________________ FIRST ____________ RELATIONSHIP________________

ADDRESS___________________________ CITY __________________ STATE _____ ZIP _________

HOME PHONE (______) ______ - ________ WORK PHONE (______) ______ - ________ EXT. ______

PERMISSION TO LEAVE MESSAGE: HOME ☐YES ☐NO WORK ☐YES ☐NO

AUTHORIZATION TO RELEASE INFORMATION TO: NAME ____________________ RELATIONSHIP _______
PHONE (______) ______ - __________

PHARMACY:
NAME ____________________________ LOCATION ______________________

PHONE (______) ______ - __________ FAX (______) ______ - __________

PRIMARY INSURANCE ____________________ POLICY HOLDER NAME______________________________

POLICY HOLDER SEX ☐ F ☐ M POLICY HOLDER DOB____/____/_____

POLICY HOLDER SSN # ______ - ______ - _______ POLICY HOLDER RELATIONSHIP TO PATIENT ___________

ID#_____________________________________ GROUP #____________________________________

SECONDARY INSURANCE ____________________ POLICY HOLDER NAME______________________________

POLICY HOLDER SEX ☐ F ☐ M POLICY HOLDER DOB____/____/_____

POLICY HOLDER SSN # ______ - ______ - _______ POLICY HOLDER RELATIONSHIP TO PATIENT ___________

ID#_____________________________________ GROUP #____________________________________

____
PATIENT, PLEASE SIGN FOR PERMISSION TO TREAT

____
IF PATIENT IS A MINOR, PARENTS SIGN HERE FOR PERMISSION TO TREAT IN YOUIR ABSENCE

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ________________________________, have been informed a copy of ELIZABETH GEORGE, M.D., P.C., **Notice of Privacy Practices**, is posted in the waiting room. A copy of this **Notice** will be furnished to me upon my request.

Patient Signature________________________________ Date____/____/______

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to **not** release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.
If you would like to have information released to someone other than yourself, please complete the following

I authorize ELIZABETH GEORGE, M.D., P.C. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them when ever this information changes.

Home Telephone	☐ YES	☐ NO	Voice Mail	☐ YES	☐ NO
Answering Machine	☐ YES	☐ NO	Cell Phone/Voice Mail	☐ YES	☐ NO
Work Telephone	☐ YES	☐ NO	Pager	☐ YES	☐ NO

May we fax medical records for referrals? ☐ YES ☐ NO

Please list names of people we can discuss your medical care with:

Spouse Name ________________________________ ☐ YES ☐ NO
Parent Name ________________________________ ☐ YES ☐ NO
Other Name ________________________________
Relationship ________________________________ Phone (______) ______ - ________

________________________________ ______/______/________
Signature of Patient/Guardian Date

Elizabeth George, M.D., PC

<u>Financial Policy</u>

The following is a statement of our financial Policy which we require you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

ALL CO-PAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO BEING SEEN.

For your convenience, we only accept Cash, Credit Card or Debit
(Mastercard or Visa)

Insurance
We cannot accept assignment of your insurance visits unless all of your insurance information is given at the time of your visit. It is imperative that a copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 45 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim.

It is extremely important for you to educate yourself about your individual insurance benefits. If you are scheduled for a procedure that could be considered a screening, you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and your coverage.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read the Financial Policy, and I understand and agree to this Financial Policy.

Per our policy, appointments **<u>MUST</u>** be cancelled 12 hours prior to appointment date or there will be a $ 25.00 no show fee. **<u>NO</u>** appointments or prescriptions will be filled until the account is paid in full. Returned checks will be charged $25.00.

____________________________________ ____________________

Signature of Patient or Responsible Party **Date**