Southeast Georgia Physician Associates
Patient Information and Authorization Form

Date: ____________________

Patient Information

Last Name:______________________________First Name: ____________________ MI.: __________

Date of Birth: ____/____/_____ Age: _________ SSN: ____________________

In accordance with CFR §170.207(n) & 82 FR 42819, Southeast Georgia Physician Associates request the following information.

*Legal Sex: Male or Female *Sex assigned at Birth: Male or Female

*Race – Black or African American / American Indian or Alaska Native / Asian / Caucasian / Hispanic / Pacific Island/Hawaiian / Refused

Mailing Address: ______________________________ City/State:________________ Zip Code:__________

Primary Phone Number: ____________________Alternate Phone Number: ________________________

Alternate Address: ____________________________ City/State:________________ Zip Code:__________

Email Address:____

Marital Status- Single / Married / Divorced / Widowed / Life Partner Primary Language: ______________

Employment Status – Full Time / Part Time / Student / Self Employed / Unemployed / Active duty / Disabled / Medical Leave / Unknown / Retired – If Retired, Date of Retirement: ____________________

Patient's Employer/ (if student, name of school) ____

Employer Address ____

Employer Phone #: ____

Family Physician: ____

Spouse or Parent/Guardian

Relationship to patient: ________________ Name of Spouse or Guardian:________________________

Date of Birth ______/_______/_______SSN: ____________________ Phone number: ________________

Address: ____

Employer: ____

Employer Phone #:____

Employer Address: ____

WITHOUT THE FOLLOWING INFORMATION, WE CAN NOT FILE A CLAIM AND YOU WILL BE RESPONSIBLE FOR THE BILL ON THE DAY OF SERVICE

Primary Insurance Information

Name of Insurance ____

Card Holder Name ______________________________ Relationship of Card Holder to patient: ____________________

Card Holder social security #______________________ Date of birth of Card Holder_______/______/______

Policy Number __________________________________ Group Number _______________________________________

Employer ____

Secondary Insurance Information

Name of Insurance ____

Card Holder Name ______________________________ Relationship of Card Holder to patient: _____________________

Card Holder social security # ______________________ Date of birth of Card Holder_______/______/______

Policy Number __________________________________ Group Number _______________________________________

Employer ____

HIPAA Contacts

Name of person(s) you wish to receive any test results, medical or billing information on your behalf:

Name: _______________________________ Relationship to you: ___________________________________

Date of Birth: _________________________ Primary Phone #: ____

Name: _______________________________ Relationship to you: ___________________________________

Date of Birth: _________________________ Primary Phone #: ____

☐ Check box if you would like yourself to be your **only** HIPPA contact.

I acknowledge that this HIPAA authorization remains in effect until I give written notification to discontinue.

___________________________________ ___________________________________ ______/______/_______

Print Name (PARENT OR GUARDIAN IF PATIENT IS UNDER 18) Signature Date

Patient Portal

Southeast Georgia Physician Associates and Southeast Georgia Health System have a patient portal, where you can access your medical information online, anytime.

Would you like to sign up for the Patient Portal? ☐Yes ☐No ☐ Already Signed Up

If yes, we will email you an invitation to the email address provided above to set up your personal, secure account and you can access important health information at your convenience. You may also access your patient portal via the ***Healthelife*** app, or an ***Application Programming Interface (API)*** of your choice, from the App Store or Google Play store.

SOUTHEAST GEORGIA PHYSICIAN ASSOCIATES

AUTHORIZATION AND AGREEMENT FOR TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKNOWLEDGEMENTS AND AGREEMENTS REGARDING THE TREATMENT TO BE PROVIDED THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that such medical care, treatment, and procedures will be performed by employees of Southeast Georgia Physician Associates. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made to the results which may be obtained.

AGREEMENT TO PAY SERVICES: For and in consideration of the care and treatment provided to the patient, I promise to pay all co-insurance and non-covered charge amounts for services rendered at the time of service. I also agree that I will be personally liable for legal fees incurred in collection attempts against any debts I accrue with Southeast Georgia Physician Associates.

EXPRESS CONSENT FOR COMMUNICATION: I expressly consent and authorize Southeast Georgia Physician Associates and its affiliates or agents, including any collection agency or debt collector hired by them, to communicate with me for any reason related to the services provided by Southeast Georgia Physician Associates including collection of amounts owed for said services. This communication may be made using an automatic telephone system, an artificial or prerecorded voice at the telephone number(s) I have provided including cell phones, mobile radio or paging service. In addition, I further expressly consent and authorize Southeast Georgia Physician Associates and its affiliates and agents, including any collection agency or debt collector hired by them, to communicate with me at any phone number, email address, other unique electronic identifier or mode that I provided to said hospitals, their affiliates or agents at any time, or any phone number or email address or other unique electronic identifier or mode that Southeast Georgia Physician Associates or its affiliates or agents finds or may obtain on their own, which is not provided by me.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Southeast Georgia Physician Associates to release my medical information in connection with these services for health insurance purposes or to the patient's personal physician or to a referral physician. I authorize by my signature below direct payment of all benefits to Southeast Georgia Physician Associates and authorize submission of insurance forms with this signature on file. I also understand that my records may be shared within Southeast Georgia Health System when necessary for coordination of my care; and that results of laboratory and/or other diagnostic tests may be mailed directly to me.

STUDENT, MANUFACTURING OR COMPANY REPRESENTATIVE OBSERVATION OR ASSISTANCE: I consent that students, including fellows, residents, Physician Assistants students, Medical Students, interns, Physician Assistants, clinical nursing or technical students, and manufacturing or company representatives, may observe or assist in the care which will be undertaken at Southeast Georgia Physician Associates.

PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT: I acknowledge that I have been provided with an opportunity to receive the Notice of Privacy Practices for Southeast Georgia Health System/Southeast Georgia Physician Associates. In reviewing the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

I HAVE READ THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS AND FULLY UNDERSTAND THE SAME.

Patient Signature________________________________ Print Name______________________________________
(PARENT OR GUARDIAN IF PATIENT IS UNDER 18) (PARENT OR GUARDIAN IF PATIENT IS UNDER 18)

Date: ________________________________

Telephone Treatment Permission Granted By: __________________Witness: ____________________

2nd Witness: ___________________

Southeast Georgia Physician Associates
Statement of Financial Responsibility

Thank you for choosing **Southeast Georgia Physician Associates** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding to our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. **Payment is due at the time of service unless prior financial arrangements have been made. We accept cash, personal checks, VISA, MasterCard, Discover, and AmEx.**
- **Copayments are due at check-in before services are rendered.**
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of coinsurance, deductibles and all other procedures for treatment not covered by their insurance plan.
- Patients may incur, and are responsible for payment of additional charges, if applicable.
  - These charges may include:
    - Charges for returned checks- $30.00
- Not all insurance plans cover certain services. In the event your plan determines a service to be "non-covered," you will be responsible to the complete charge. Payment is due upon receipt of a statement from our office.
- It may be necessary to send some specimens to a reference laboratory for testing, as we provide only basic laboratory services. If such services are provided, you will receive a separate bill from the reference laboratory. In addition, you will receive separate bills for services associated with hospital stays, anesthesia, pathology, and radiology. All billing questions and inquiries should be directed to the facility from which you have received a bill.

By my signature below, I hereby authorize assignment of financial benefits directly to **Southeast Georgia Physician Associates** and any associated healthcare entities for services rendered on by behalf. I understand that I am responsible for any balance due.

I have read, understand, and agree to provisions of this Patient Financial Responsibility Form:

____
Patient's Full Name Date of Birth

X ____
Signature of Patient or Legal Guardian Date

Southeast Georgia Physician Associates
Cancellation/No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have implemented an appointment/cancellation policy. If you are unable to keep your appointment, please call at least 24 hours in advance to reschedule.
Appropriate cancellation of an appointment is calling the office and speaking with the front office staff or leaving a message on the General Voicemail box by 10:00 a.m., one (1) working day in advance of the schedule appointment time. If a patient fails to give appropriate notice three times in a 12 month period, they may be subject to dismissal from the practice.

I have read and understand the information and I agree to the terms described:

X ____

Signature of Patient or Legal Guardian   Date