Drs. Pope, Kehl, Barnes and Durso
Midwives of Macon
1062 Forsyth St, Suite 3B, Macon, Ga 31201
(478) 743-3454 www.pkbdobgyn.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Race: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Last Flu Vaccine (Mo/Yr): _____

Pharmacy Name & Location: _____ Primary Care Physician: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Policy Holder Same As Patient ☐

Policy Holder Name: _____ Date of Birth: _____ Social Security #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Carrier: _____ Policy Holder Same As Patient ☐

Policy Holder Name: _____ Date of Birth: _____ Social Security #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Emergency Contact Name: _____ Relationship: _____

Phone #: _____ Alternate Phone #: _____

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship: _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Please Complete Reverse Side ⇨

Drs. Pope, Kehl, Barnes & Durso
Midwives of Macon

AUTHORIZATIONS

- Θ I hereby authorize and request medical treatment necessary for the care of the above named patient as determined by the Physician, including checking my external prescription history.
- Θ I authorize the release of all medical records and appeals to the referring physicians, family physicians, and to my insurance company, if applicable. I allow the fax transmittal of my records if necessary. I also acknowledge that my doctors office will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange.
- Θ I acknowledge full responsibility for any services rendered by Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon. I understand that any co-payment I have with my insurance company is due at the time of service. I understand that I am financially responsible for payment of any co-insurance, un-met deductible, or non-covered services, as deemed by my insurance company, within a timely manner.
- Θ I further authorize and request that insurance payments be made directly to Drs. Pope, Kehl, Barnes, Durso, & Midwives of Macon for all services rendered.

LAB WAIVER

Certain lab specimens are sent to outside labs for processing. We will send the specimen to the laboratory that participates with your insurance carrier, to the best of our knowledge**. If your specimen is sent to the wrong lab, Drs. Pope, Kehl, Barnes, Durso, and Midwives of Macon will not be responsible for any fees incurred for processing**. I understand that it is my responsibility to know which laboratory my insurance authorizes, and to notify Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon's staff of this information.

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following individuals the right to obtain any information; including: lab results, appointment information, or any other diagnostic testing performed by Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

ACKNOWLEDGEMENT OF PRIVACY NOTICES (HIPAA) AND DISCLOSURE OF HEALTH INFORMATION

I understand that the patient's health information is private and confidential. I understand that Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it

Drs. Pope, Kehl, Barnes, Durso, & Midwives of Macon have a detailed document called the "Notice of Privacy Practices" in which contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this agreement.

My signature below indicates that I have been given the opportunity to review a current copy of Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon "Notice of Privacy Practices", and that I agree to allow Drs. Pope, Kehl, Barnes, Durso & Midwives of Macon to use and disclose the patient's health information to carry out treatment, payment from insurance companies, and all healthcare operations.

_____ _____

Patient and/or Guardian Signature Date

Patient Name: _____

Today's Date: _____

Medication List

Prescription and over the counter	Strength	Frequency

Drug Allergies

Surgical History Since Last Visit

Date	Type of Surgery