GEORGIA OBSTETRICS & GYNECOLOGY

A division of Atlanta Women's Health Group, P.C.

Patient Information Sheet

(Have Picture ID and Insurance Card with you)

Legal Name:_____ , _____ _____
(Last) (First) (Initial)

Date of Birth (mm/dd/yyyy): _____ **Marital Status**: _____

Address: _____

_____
City State Zip

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

Email:_____ **SSN XXX-XX-**_____

Primary Care Physician: _____ **Phone**: _____

Pharmacy Phone:_____

Emergency Contact: _____ _____
(Name) (Phone)

_____
(Relationship to You)

Primary Insurance Company: _____
(Name) (Plan Type)

Policy Holder: _____**DOB**:_____ **SSN**:_____

ID#:_____ **Group#**:_____

Claims Address: _____

Secondary Insurance Company: _____
(Name) (Plan Type)

Policy Holder: _____**DOB**:_____ **SSN**:_____

ID#:_____ **Group#**:_____

Claims Address: _____

Authorization and Consent: I authorize the release of Medical Information necessary to process my insurance claim. I authorize payment to Atlanta Women's Health Group, P.C. for any surgical and/or medical benefits. I understand that I'm financially responsible for any charges not covered or paid by insurance. I understand that payment is expected at the time of service. I authorize the physicians of Atlanta Women's Health Group, P.C. to treat me. I consent to medical evaluation and treatment for office based procedures necessary for my healthcare and understand that this consent shall not expire. IT IS MY RESPONSIBILITY TO INFORM ATLANTA WOMEN'S HEALTH GROUP IF I HAVE MEDICARE.

_____ _____
SIGNATURE DATE

Georgia Obstetrics and Gynecology

Financial Policies

Welcome and thank you for choosing Atlanta Women's Health Group for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. WE are pleased to discuss with you any questions you may have concerning a bill.

Payment is due in full at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard and American Express.

We also provide our patients with the ability to pay for their accounts online at www.awhg.org or over the phone at 404-303-7520.

Things to bring with you to EACH appointment:

- Health Insurance Card
- Drivers License
- Method of Payment

Appointments:

- Please arrive for your appointment 15 minutes early.
- If you are more than 15 minutes late for your appointment, you may be marked as NO SHOW and may need to reschedule your appointment.
- All co-pays are due at the time of service. Any co-pay not received at the time of service may result in a $25.00 processing fee.
- There will be a fee of $25.00 for any returned checks to our office.
- All balances are due prior to any further service provided by our office.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your appointment.
- Please inform the receptionist of any demographic changes such as name, phone number, address etc. Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for payment of any services not covered by your carrier.

Missed or Cancelled Appointments

- If you are more than 15 minutes late for an appointment, you may be marked as a NO SHOW. Failure to arrive on time may result in a $25 fee.

- 24 hour notice is required to cancel and/or reschedule all appointments.

"In Network" vs. "Out of Network"

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.

- We are contracted with multiple insurers to accept assignment of benefits.

- If you have insurance coverage under a plan with which we do not have a contract, you may be treated a *self-pay* patient.

- We offer a reasonable discount for our self-paying patients (those not using insurance). We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service.

- We are required to file with your primary insurance carrier only. As a courtesy we will file remaining charges to your secondary carrier. It is your responsibility to file charges with any further carriers for reimbursement.

Payment in full is due at the time services are rendered:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled.

- If you receive more than one type of service on the same day, you may be responsible for more than one co-payment.

- Any amount covered by the insured/patient's insurance is due within 30 days of the time of service.

- Failure to pay balances may result in discharge from the practice.

Additional Paperwork Fees:

- Patient paperwork completed by the practice will result in administrative fees.

- We offer an optional Administrative Service Fee of $15 annually for gynecological patients or a $75 fee for obstetrical patients. This fee, if elected will be effective for a 12 month period from the date you signed. This fee is intended to cover the cost of certain administrative services we provide that are NOT covered by your insurance. You are not required to pay the administrative fee. However, if you choose not to pay the optional fee and require patient paperwork to be completed by the practice, you will be charged for those fees accordingly.

- Please CHOOSE ONE of the following options below:

( ) I accept the Financial Policy, but do NOT want to pay the Administrative fee.

( ) GYN patient: I accept the fee at the cost of $15.

( ) OB patient: I accept the fee at the cost of $75 payable before the 7th month of pregnancy.

Minor Patients

- The parents or guardians accompanying a minor are responsible for providing current insurance information on the minor as well as the payment in full for services provided.
- Minors between the ages of 16-18 must have a Pre-Authorization for Medical Treatment form signed by the parents or guardians on file if they arrive unaccompanied for an appointment.
- Minors under under the age of 16 must have an Authorization for Agent of Proxy to Consent for Medical treatment signed by the parent or guardian for each visit.
- In compliance with HIPPA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient, unless otherwise documented.
- Both parent/legal guardian(s) are responsible for payment for services rendered to a minor patient.

Lab/Hospital Charges:

- Any service(s) provided by a lab or hospital is a contract between you and the lab or hospital. Any dispute with a lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits from your insurance carrier.
- Atlanta Women's Health Group utilizes Phytest as their lab billing company.
- Phytest is contracted with our practice to bill and collect lab balances due to our physicians, all correspondence from Phystest are processed under the name Atlanta Women's Health Group.

Collections and Outstanding Balances:

- The provider reserves the right to add a $10.00 monthly statement processing fee on any account that has an unpaid balance.
- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of 25% which will be added to the total balance due at the time an account is deemed delinquent.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from the practice.

Payment Plans:

- Our practice will be happy to work with your in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan.
- Please allow 5 mail days prior to each due date for each payment to be received by our practice.

Refunds:

- Refunds are issued to the appropriate party and will be processed approximately 30-60 days from the date of established credit.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds less than $50.00 will not be issued, unless requested, and will be credited to your account at our practice.

- We contract with Phytest to bill patients for our physicians' lab fees, if a patient has a credit with Atlanta Women's Health Group, but a balance with Phytest (or Atlanta Women's Health Group 2LLC), the patient's credit will be utilized to satisfy the lab balance due. Any remaining balance will be refunded to the patient.

By signing this document, I have fully read and understand the financial policy of Atlanta Women's Health Group. I hereby consent to allow your practice to reach via: (check all that apply)

_____Home Phone: (_____) _____-_____

_____Cell Phone: (_____) _____-_____

_____Work Phone (_____) _____-_____

_____Fax: (_____) _____-_____

_____Text: (_____) _____-_____

_____Email: _____@_____

I will cooperate with the billing department of Atlanta Women's Health Group to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial Policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to patient herein.

_____
Printed Name of patient/parent/guardian

_____ _____
Signature of patient/parent/guardian Date

Atlanta Women's Health Group

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____Date of Birth_____

- I understand that I can request restriction on how my health information is used or disclosed to carry out treatment or health care operation. However, there may be a time when Atlanta Women's Health Group, P.C., is not able to honor my requested restrictions. For example, they may need to release my medical information to get paid from an insurance company or to treat me.

- I consent to the disclosure of my protected health information for the purpose of medical diagnosis, providing treatment, obtaining payment, or to conduct necessary health care operation, and authorize direct payment of medical insurance benefits to Atlanta Women's Health Group, P.C., for service performed. I also understand and agree that I am responsible for payment of all valid charge not paid by my medical insurance.

- I accept that there is no guarantee of protection of my medical record from a court order release. In the event of legal proceedings involving patient care, I understand the contents of my file must be made available to legal counsel representing the practice and professional employee.

- I have received a copy of Atlanta Women's Health Group's Notice of Privacy Practices on the date listed below, and have been advised that I will be notified of any changes at future office visits. I may obtain a current copy by visiting the Web site www.awhg.org/privacy-policy-and-hipaa

- I acknowledge that I have had the opportunity to review a copy of Atlanta Women's Health Group, P.C. Notice of Privacy Practices. I understand that I am responsible to read this Notice and notify AWHG in writing of any request for restrictions in the use or disclosure of my protected health information (PHI). I understand AWHG has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www. awhg.org. AWHG will provide me with a copy of its most recent Notice upon my request.

Name(s) of others authorized to discuss or receive my PHI:

_____

_____

Patient Signature: _____

Authorization to Obtain Medication History

Patient Name: _____

DOB: _____

Address: _____

_____

By signing below, I hereby authorize Atlanta Women's Health Group to obtain Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

_____
Print Name

_____
Signature

I understand this authorization is revocable upon written notice to the office, where the original authorization is retained, except to the extent that action has already been take on this authorization. Atlanta Women's Health Group may not condition the provision of treatment, payment, or enrollment in the health plan, or eligibility for the benefits on the provision of this authorization.