Judson G. Black, M.D.

Mount Vernon Medical Center
755 Mount Vernon Highway
Sandy Springs, Georgia 30328-4279
Phone: 404-303-9945
Fax: 404-303-8257

New Patient Information Form

PATIENT INFORMATION

Patient's Name: ____ Age: _____ Date of Birth: ___/___/___

Spouse's Name: ____ Age: _____ Date of Birth: ___/___/___

Circle Sex: M F Circle Marital Status: Single Married Widowed Divorced Separated

Home Address:____

City:____State:______________________Zip:________________________

Phone: _________________________Work Phone: _______________________ SSN #: ___________________________

Patient's Employer: ________________________________ Patient's Occupation: _________________________________

Address: ____City: _______________ State: ________ Zip: _____________

Primary Care Physician: ________________________________ Referring Physician: ______________________________

Emergency Contact: ___________________________________ Phone: ____

RESPONSIBLE PARTY IF OTHER THAN PATIENT

Responsible Party Name: ____ Age: _____ Date of Birth: ___/___/___

Relationship to Patient: ____________________________ Responsible Party SSN #: ______________________________

Responsible Party Home Address: ____

City: _______________________________State: ___________ Zip: ____________ Phone: _________________________

Responsible Party Employer:___________________________________ Occupation: ______________________________

Address: ___________________________________City: ___________________ State: __________ Zip: _______________

Responsible Party Work Phone: ____________________

INSURANCE INFORMATION

Company Name: ___________________________________ Plan #: ________________Group #: __________________

Subscriber Name: __________________________________ Subscriber Insurance ID#: __________________________

Subscriber Birth Date: ______/______/______ Subscriber Sex: M F

Effective Date (From): ______________________________ Effective Date (To): _________________________________

Deductible Amount: __________________ Deductible Met? Y N Co-Payment Amount:__________

Co-Insurance % (Patient Responsibility) ______________

Does Your Current Insurance Plan Have A Pre-Existing Clause? Y N

How Long Have You Had Coverage Under This Specific Insurance Plan? ______________________________________

Secondary Coverage (If Applicable)

Company Name: ___________________________________ Plan #: ________________Group #: __________________

Subscriber Name: __________________________________ Subscriber Insurance ID#: __________________________

Subscriber Birth Date: ______/______/______ Subscriber Sex: M F

Effective Date (From):______________________________ Effective Date (To): _________________________________

Deductible Amount: __________________ Deductible Met? Y N Co-Payment Amount:__________

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Co-Insurance % (Patient Responsibility) _____________

Patient Payment/Assignment of Benefits Agreement

Thank you for allowing us to serve you. We are committed to providing to our patients the best possible medical care in addition to prompt and courteous service. Our services are based on medical necessity. As a courtesy to our patients, we will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. However, some insurance carriers do not reimburse for certain procedures and/or diagnosis. **Judson G. Black, M.D., L.L.C.** will have you sign a *Notice of Likelihood of Medicare Denial* if we believe Medicare will deny any services we provide you. In the event a claim is filed and denied for charges not covered, you are ultimately responsible for all denied charges.

We ask that you sign this agreement for all services rendered

I *(print name)* ___________________________________, have received instructions that certain procedures and diagnosis may not be covered by my insurance carrier. I further agree to reimburse **Judson G. Black, M.D., L.L.C.** Inc. for all charges related to services rendered.

Insurance claims are filed as a courtesy to our patients. Patient co-payments and/or patient responsibilities are due at the time service is rendered

We ask that you sign this agreement so we may file your insurance

I, the undersigned realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s), including Medicare, to pay directly to **Judson G. Black, M.D., L.L.C.** any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I authorize my physician to release to my insurance company any medical information necessary to process my claims.

Authorized Signature: _____________________________________ Date: ____/____/____

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Dear Patient:

We appreciate your selection of this office to serve the medical needs of your family. We will do all we can to provide you with the very best care. In order to do so, please read the following information. We look forward to serving you and having a most happy and healthy relationship.

OFFICE POLICIES

Appointments will be taken Monday through Friday, 8:30 A.M. to 3:45 P.M. Please call our office telephone in case of emergency at any time. In the event that you can not keep your scheduled appointment, please call our office 24 hours in advance. **ALL PATIENTS THAT FAIL TO KEEP THEIR SCHEDULED APPOINTMENTS WILL BE CHARGED A NO SHOW FEE. THE NO SHOW FEE FOR INITIAL VISITS IS $250 DOLLARS AND FOR ESTABLISHED PATIENT VISITS IT IS $50.**

Medical emergencies will be given immediate attention. Please note, however, that under normal circumstances our office will give priority to all patients with scheduled appointments. Those patients who call the office or visit without an appointment will be assisted as time permits during the course of the day or following days.

For LAB ONLY OR INJECTION PATIENTS: Please notify our office by telephone 24 hours in advance of the time that you will be coming in. This will allow us to have your chart ready and minimize your time waiting.

Please call your pharmacist for prescription refills. Your pharmacist will fill the prescription or call the office for authorization if necessary. We will **not** authorize refills after our usual office hours, on weekends, or for other doctor's prescriptions. Please keep in mind that many medications require routine follow-up visits.

Effective immediately, we will no longer bill patients for co-payments or known co-insurance amounts. All co-payments and co-insurance are due **PRIOR** to seeing the physician. All other balances will be billed monthly and payable upon receipt. In addition, all patients with deductibles should plan to pay for their visit in full during the first three months of each calendar year. If there are financial problems, we will be happy to review your account and set up a payment plan to accommodate your budget constraints.

NEW LAB POLICIES

For all new patients, you will be required to have a face-to-face follow-up visit with Dr. Black to discuss your initial test results. Dr. Black will not provide your lab results to other providers nor will he fax any results directly to you until you discuss those lab results with Dr. Black face-to-face. We will schedule you for a follow-up appointment 14 business days from the date of your initial visit.

For our established patients we will send your lab results to you directly upon receipt and review. Because of the complex nature of many of the lab tests we order, your lab tests are often forwarded to a specialty Endocrinology lab in California. As a result, it might take as long as 14 business days to receive your lab results and additional time to review the results prior to mailing them to your home. Once you receive your lab results in the mail make sure to review the form carefully as Dr. Black will make specific recommendations directly to you on the lab form.

If you have additional questions regarding your lab tests or any other aspects of your condition, please call our office to schedule a follow-up visit. This will enable Dr. Black to devote adequate attention to your concerns.

Please sign below to indicate that you have read and understand the above and agree to abide by the policies printed. Again, thank you for choosing this office for your medical care. Feel free to offer comments and suggestions on how we can continue to provide the highest quality of care to our valued patients.

____________________________	____________________
Patient Signature	Date

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Patient Acknowledgment of Understanding of Judson G. Black, M.D., L.L.C.'s Notice of Privacy Practices.

Patient's name: ____ Date of birth: __________

SSN: ______________________ Previous name: ____

I understand that the patient's health information is private and confidential. I understand the providers at Judson G. Black, M.D., L.L.C. work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Judson G. Black, M.D., L.L.C. 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 health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Judson G. Black, M.D., L.L.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Judson G. Black, M.D., L.L.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Judson G. Black, M.D., L.L.C. will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative location.

Judson G. Black, M.D., L.L.C. has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Judson G. Black, M.D., L.L.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Judson G. Black, M.D., L.L.C.'s "Notice of Privacy Practices".

____ __________ ______________
Patient or legally authorized individual signature Date Time

____
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Name(s) of individuals we may release relevant information to regarding your care: ____________________

____

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LAB RELEASE POLICY

We estimate it costs us an average of $25 per patient per year to copy, fax, and mail lab results.

Because of continued cuts in physician reimbursements by both the government and private insurance companies, we are now forced to begin charging our patients that $25 dollars per year to release their lab results.

If you are one of our patients who request that we "fax" or "mail" your lab results, effective February 1, 2006, you will be charged an annual "lab release fee."

No labs will be mailed to you until the $25 dollars is paid in full to the practice. If you wish you may pay that fee today.

An additional change for 2006 is that we will now only be able to mail the lab results to *you* the patient. We will no longer fax or mail results to another provider, hospital, etc., as we did in the past.

NEW LETTER/FORMS AND CHART COPY POLICY

Effective February 1, 2006, all letters and forms done by Dr. Black, that you the patient request, will have to be paid in full prior to the letters being mailed.

In addition, all chart copy requests – after your 1st free copy – will also have to be paid in full prior to the medical records being forwarded.

__________________________________ __________________
Patient's Signature Date