By __ _____
Date_____

The Primary Care Group of West Georgia, PC
REGISTRATION AND CONSENT FORM

Check All That Apply: ◯ We are your Primary Care Doctor ◯ We are your Pulmonary Doctor ◯ I saw your advertisement ◯ I saw your web site

Today's Date:	Preferred Doctor(s):	Preferred Pharmacy And Location:

PATIENT INFORMATION - A PICTURE ID AND INSURANCE CARD IS REQUIRED OF ALL PATIENTS

Last name	First	Middle	Preferred Name	Maiden Name

Date of Birth: _____/_____/_____	Race:	Religion:	Marital Status:	Jr. Sr. I II III IV
Social Security #: _____/_____/_____	Language:	Male / Female		Name Suffix

Address: _____

City: _____ State _____ Zip Code _____

Home Phone:	Cell Phone:	Work Phone:
Can we leave a message here? ___Yes ___No	Can we leave a message here? ___Yes ___No	Can we leave a message here? ___Yes ___No
Which number do you prefer?	Can we send you a text? ___Yes ___No	**Email:**
Occupation:	Employer:	Employer Address:

Spouse:	Best Phone:	Can we leave a message here? ___Yes ___No

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:		Policy Holder's Social Sec. #	Relationship:
Name of Policy Holder:		Policy Holder's Date of Birth	Co Pay
Group #:	Policy #:	Member #:	Effective Date:
Secondary Insurance:		Policy Holder's Social Sec. #	Relationship:
Name of Policy Holder:		Policy Holder's Date of Birth	Co Pay
Group #:	Policy #:	Member #:	Effective Date:

PAYMENT RESPONSIBILITY - PATIENT, PARENT, GUARDIAN OR ADVOCATE

Name:	S.S. no.:	Birth date:	Address:
			Employer:

Relationship to Patient:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone no.:	Cell phone no.:

HIPAA - PROTECTED HEALTH INFORMATION (PHI) - YOUR COMPLETE NOTICE OF PRIVACY PRACTICES IS AVAILABLE AT THE FRONT DESK

In order to maintain continuity of care I give permission to Primary Care Group to release my medical records to any medical facility associated with my medical treatment. **We will not** release your PHI to a friend or family member unless you expressly authorize our office to hold such a discussion. You may revoke this authorization in writing. I hereby authorize the physician's and staff of The Primary Care Group of West Georgia to share my (PHI) with the following:

Name Of Authorized Person :	Relationship:
Name Of Authorized Person :	Relationship:
Patient/ Guardian Signature:	Date:

I hereby authorize the Primary Care Group of West Georgia to treat my medical needs as they find appropriate. I authorize my insurance benefits be paid directly to the physician. I also authorize The Primary Care Group to release any information required to process my claims.

Patient/ Guardian Signature:	Date:

FINANCIAL POLICY

We appreciate the opportunity to provide medical services to you. Our goal is to keep your financial arrangements as simple as possible by timely filing of claims and using the following guidelines:

Please initial each item

_____ You are ultimately responsible for payment of charges for services received at our office.

_____ I understand that (PCG) may use the services of an outside agency to collect on all insufficient checks and they will collect the maximum charges allowed under the law.

_____ It is your responsibility to provide us with your correct address, phone number and insurance information at each visit.

_____ It is your responsibility to confirm with your insurance company that our doctor is on your plan prior to your visit with our office. If you choose to see a provider who is not on your plan you will be responsible for payment in full.

_____ Co-pays and deductibles are to be paid at the time of your appointment. Failure to pay a co-pay will result in an additional $25 fee added to your account.

_____ A $25.00 no show fee will be charged to your account if you do not give 24 hour notice of cancellation.

_____ Laboratory services are provided by a contracted outside lab. Lab charges not covered by your insurance will be billed to you by an independent lab billing service.

_____ I understand there may be an administrative fee charged for completion of forms that I bring to the Dr. for completion. Those fees must be paid upfront and the charges range from $10 to $150. We will estimate the cost of any form completion upfront.

_____ I understand that if I do not pay for services rendered The Primary Care Group uses a collections company for collection efforts and they will potentially blemish my credit rating.

Responsible Party Signature _____ Date _____

PERSONAL HEALTH INFORMATION (PHI)

A complete Notice of Privacy Practices is available for you at the front desk. Below is a brief overview of our policy:

Your personal health information (PHI) will be used and disclosed for your treatment, payments, healthcare operations, law enforcement request and public health reporting. Your PHI is protected and only you can authorize its disclosure. You must understand that we will contact you about appointments and share your PHI with other providers to manage your medical condition.

- I authorize The Primary Care Group of West Georgia to furnish any information required to process all insurance claims. A copy of this authorization shall be as the original. This authorization shall be in effect until revoked in writing.
- I authorize PCG to obtain my medical records including prescribed medication history.
- I authorize PCG to distribute medical records they deem necessary to other providers to which I may be referred.

Patient/Guardian signature _____ Date _____