



# South Atlanta Neurology & Spine Clinic with **OPEN MRI**

518 Eagles Landing Parkway Stockbridge GA, 30281  
Phone- (770) 507-7359 Fax- (770) 507-8390

## CONFIDENTIAL PATIENT INFORMATION SHEET (PLEASE PRINT AND SIGN EVERY PAGE)

DATE: \_\_\_\_\_

PRIMARY/REFERRING DOCTOR: \_\_\_\_\_ PHONE #: \_\_\_\_\_

IS YOUR VISIT RELATED TO AN INJURY OR ACCIDENT? \_\_\_\_ YES \_\_\_\_ NO

IF YES, WHAT KIND OF ACCIDENT OR INJURY? \_\_\_\_\_ AUTO \_\_\_\_\_ WORKER'S COMPENSATION

HAVE YOU SEEN A NEUROLOGIST OR PAIN MANAGEMENT DR. IN THE PAST YEAR? YES NO

DO YOU HAVE YOUR MEDICAL RECORDS, MRI, CT, ANY TEST? YES / NO

### PATIENT INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

RESPONSIBLE PARTY (IF A MINOR): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE#: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: ( ) M ( ) F SOCIAL SECURITY #: \_\_\_\_\_

( ) SINGLE ( ) MARRIED ( ) WIDOW ( ) SEPARATED ( ) DIVORCED ( ) OTHER \_\_\_\_\_

### Race (check all that applies)

American Indian or Alaska Native

Pacific Island

Asian

White

Black or African American

Other

Native Hawaiian or Other

### Ethnic Group (check one)

Declined

Hispanic or Latino

Not Hispanic or Latino

**EMPLOYER INFORMATION**

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_

RELATIONSHIP TO INSURED: ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

**SECONDARY INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_

RELATIONSHIP TO INSURED: ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

**EMERGENCY CONTACT:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE & ZIP:** \_\_\_\_\_

**HOME & WORK PHONE #:** \_\_\_\_\_

**PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED:**

**RELEASE AND ASSIGNMENT**

I, the undersigned hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by the Physicians and Staff of South Atlanta Neurology and Spine Clinic and/or Open MRI of S.A.N.S.C on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes S.A.N.S.C to submit claims for benefits for any service rendered without obtaining my signature on each and every claim form and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

I, the undersigned, have coverage with the insurance companies as listed on the other side of this Patient Information Form and assign directly to Dr. Brice B. Choi all claims benefits, if any, otherwise payable to me for services rendered. **I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician, whether or not paid by the insurance company.**

**I hereby acknowledge and understand that I am financially and fully responsible for all co-pays, deductibles, co-insurance and elective charges incurred from the services rendered by my physician.**

**If any portion of my account balance is not reimbursed by my insurance company, for any reason, I agree to cooperate and arrange prompt payment to clear my bill. I understand that payment is due upon receipt of my monthly statement.**

This Release and Assignment will expire upon written notice.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

**Fees and Insurance**

Payment is expected at the time of service for all office visits and office procedures. All estimated payments, deductible, co-payments, and co-insurances are collected before services are rendered. If payment is not received from the insurance company within 60 days of the filing date, payment responsibility will be transferred to the patient. **It is the responsibility of the patient to ensure that we have all of the correct billing information and any referrals and/or authorizations required by your insurance company if applicable.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

**Release of Information**

I hereby authorize South Atlanta Neurology and Spine Clinic to release any information concerning my treatment to any insurance company for the purpose of determining eligibility for payment of insurance benefits. This included information regarding treatment for substance abuse or HIV.

I authorize South Atlanta Neurology and Spine Clinic to disclose protected health information (PHI) about me to the following person/people:

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_

This authorization will permit South Atlanta Neurology and Spine Clinic to release any and all information pertaining to my health and well-being. **This authorization will expire on :** \_\_\_\_\_.  
(There must be a date of expiration/event, whether it is 10-100 years, divorce, death, etc.)

I understand that when my PHI is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: South Atlanta Neurology and Spine Clinic, 518 Eagles Landing Parkway, Stockbridge, GA 30281.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Office Policies**

I have received a copy of the office policies of South Atlanta Neurology and Spine Clinic. I will read these policies and abide by them as long as I am a patient of South Atlanta Neurology and Spine Clinic. If I have any questions regarding any policy of South Atlanta Neurology and Spine Clinic, I understand that I can contact the office at 770-507-7359.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Receipt of Notice of Privacy Practices Written Acknowledgment**

I have received Notice of Privacy Practices and I have been provided the opportunity to review it.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**Office Policies**

I, understand and agree that if Dr. Choi orders me to follow up within a certain time frame it should be considered medically necessary that the follow up appointment is mandatory unless Dr. Choi has given PRN (as needed basis) orders. I understand and agree it is my sole responsibility to manage my appointments that Dr. Choi orders for me. I agree that I will follow all recommended follow up visits, test etc.

I, understand and agree that in the event I choose to seek legal representation or become involved in litigation against Dr. Choi my case must be supported by a board certified physician in the same specialty as Dr. Choi, Neurology or Pain Management.

\_\_\_\_\_  
Signature of Patient of Legal Guardian

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# **SOUTH ATLANTA NEUROLOGY AND SPINE CLINIC**

## **OFFICE POLICIES**

### **Patient Cancellation and No Show Policy**

South Atlanta Neurology and Spine Clinic requires a 24-hour notice of any appointment cancellation or reschedule. Offenders will be charged. **ALL CHARGES WILL BE PAID BEFORE BEING SEEN AGAIN!!!!**

- **1<sup>st</sup>** Offense- The patient is charged a \$30.00 no show fee for not giving 24 hours notice of cancellation or rescheduling.
- **2<sup>nd</sup>** Offense- The patient is charged a \$30.00 no show fee and they receive a dismissal warning stating that if they fail to give this office proper notice of any appointment changes again that they will be dismissed from this practice.
- **3<sup>rd</sup>** Offense- the patient is charged a \$30.00 no show fee and is dismissed from this practice. The patient will have to find another doctor.
- **MRI** Offense- the patient is charged a \$100.00 no show fee.
- **Procedures** that are no showed will be charged a \$50.00 fee.

### **Payment & Fees**

All co-pays, deductibles, and co-insurances are collected in full at time of service. We welcome cash check, MasterCard, and visa. **\$35.00 IS CHARGED FOR ALL RETURNED CHECKS.**

### **Insurance**

It is the responsibility of the patient to make sure that all authorizations and referrals are obtained. It is the responsibility of the patient to notify our office of any insurance change prior to your appointment

### **Disability and Medical Forms**

Forms are completed at the discretion of Dr. Brice Choi. It should be discussed at your visit and if he agrees to complete the forms, the following fee schedule will apply.

Simple Form Fees: \$ 20.00                      Detailed Form Fees: \$35.00                      Complex Form Fees: \$45.00

### **Medical Records**

We will gladly send your medical records to another physician free of charge. If the patient wants a copy or any insurance company or lawyer's office requests them there will be a charge.

### **Children**

Either a parent or a legal guardian should accompany all minors. Children are not to be left unsupervised in the waiting room. Please bring another adult with you to supervise your children while you visit with the doctor. Children below the age of 5 are not allowed in clinical rooms.

### **Late Policy**

If you are more than 15 minutes late for your appointment, you will have to reschedule. Please remember that traffic is not an excuse.

### **Scheduling of Appointments**

New patients that call to make there appointment must provide all requested information in order to schedule their appointment. (i.e. social security numbers, insurance information, PCP doctor, and/or referring doctor.)

**I have read and agree to the office policies of South Atlanta Neurology and Spine Clinic.**

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**Signature**

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**Date**