

SOUTH ATLANTA NEUROLOGY & PAIN CLINIC

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

DATE: _____ PRIMARY OR REFERRING DOCTOR: _____

DOCTOR PHONE # _____

IS YOUR VISIT RELATED TO AN ACCIDENT? ____ YES ____ NO

IF YES, WHAT KIND OF ACCIDENT? _____ 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 () DOMESTIC PARTNER () SEPARATED () DIVORCED () OTHER

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 Pain Clinic on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes SANPC 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.**

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 is effective for the period of 2007-2017.

_____/_____/_____
Signature of Patient or Legal Guardian Date

If you have Medicare coverage, please read the following carefully and sign below:

MEDICARE AUTHORIZATION

I, the undersigned, request that payment of authorized Medicare benefits be made on behalf of Brice B. Choi, MD for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item #9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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

This Medicare Authorization is effective for the period of 2007-2017.

_____/_____/_____
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 insurance 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 insurance information and any referrals or authorizations required by your insurance company.

Signature of Patient or Legal Guardian

_____/_____/_____
Date

Release of Information

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

Name: _____
Relation: _____

Name: _____
Relation: _____

This authorization will permit South Atlanta Neurology and Pain 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 Pain Clinic, 1040 Eagles Landing Parkway, Ste 102, 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 Pain Clinic. I will read these policies and abide by them as long as I am a patient of South Atlanta Neurology and Pain Clinic. If I have any questions regarding any policy of South Atlanta Neurology and Pain 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 Acknowledgement

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 or Legal Gaurdian

_____/_____/_____
Date