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 #: _____

HAVE YOU EVER BEEN IN A WORK INJURY OR AUTO ACCIDENT IN YOUR LIFETIME? _____ 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:_____

RESPONISIBLE 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

__ Asian

__ Black or African American

__ Native Hawaiian or Other

__ Pacific Island

__ White

__ 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 #: _____

Are you in a Nursing Home, Skilled Nurse Facility, or receiving Skilled Nurse Care?

YES ☐ **NO** ☐

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:_____ **Name:**_____
Relationship:_____ **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 should I initiate any legal action against Dr. Choi any and all experts used to support my claim, whether by affidavit or testimony, from the inception of the action to its conclusion, must be board certified physicians in the same specialty as Dr. Choi, Neurology. Failure to abide by this policy will result in dismissal of my claim.

_____ _____/_____/_____
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 for follow up appointments and a 48-hour notice for any MRI or Procedure appointments for cancellation or rescheduling. Offenders will be charged. **ALL CHARGES WILL BE PAID BEFORE BEING SEEN AGAIN!!!!!**

- **1st** Offense (Follow-Up)- The patient is charged a **$30.00** no show fee for not giving 24 hours notice of cancellation or rescheduling.
- **2nd** Offense (Follow-Up)- 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.
- **3rd** Offense (Follow-Up) - 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 for not giving 48 hours notice of cancellation or rescheduling.
- **Procedures** that are no showed will be charged a **$50.00** fee.
- **CANCELLING OF APPOINTMENTS MUST BE DONE WITH OUR OFFICE DURING NORMAL BUSINESS HOURS. CANCELLING CAN NOT BE DONE THROUGH OUR ANSWERING SERVICE AFTER HOURS.**

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. For patients, there will be a fee of $1.00 per page for medical records. If the patient request the records on a disc, the charge will be $15.00. For an MRI image disc, the charge is $5.00.

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 their 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.

Patient Signature:_____ Date: _____

ADVANCE BENEFICIARY NOTICE (ABN)

In some cases the physician may order specific tests to determine a diagnosis, or detect pre-symptomatic diseases or treatments. In the case that insurance is not billed, you are responsible for the balance. Be aware that no services will be rendered without your consent.

Acupuncture	$50 - $80
**MRI / MRA	$350- $450
**Medicine	$5 - $15
**Injection	$30 - $950
**Nerve Conduction Study (NCV/EMG)	$380- $480
**EEG	$440

**These prices are subject to change depending upon services rendered and / or units of medication administered.

I have been notified that in my case, my insurance may deny payment of these services listed above due to frequency, type of test performed, medical necessity or documentation. If my insurance denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Patient / Guardian Signature Date

_____ _____

Office Staff Signature Date