Dalton:
1105 Burleyson RD
Dalton, GA 30720
Phone: 706-278-4640
Fax: 706-275-6599

Associates in Obstetrics & Gynecology

Calhoun:
105 JW Plaza DR SE Suite 1
Calhoun, GA 30701

Phone: 706-278-4640
Fax: 706-275-6599

Patient Information:

First	Middle Initial	Last

Name: **Birthdate:**

Social Security #	**Consent to text reminders: YES ( ) NO ( )**
Home Phone:	**Mailing Address** (If PO BOX include street address) **City, State, Zip Code**:
Cell Phone:	
Work Phone & Extension:	**Physical Address:** (If different from mailing)
Preferred Pharmacy:	**Email Address:**

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )	**Ethnicity**: African American ( ) Caucasian ( ) Hispanic/Latino ( ) Other ( )	**Language**: English ( ) Spanish ( ) Other ( )

Method of payment will you be using today: Cash ( ) Personal Check ( ) Debit/ Credit Card ( )

Primary Insurance:	**Secondary Insurance:**
Name of policy holder:	**Name of policy holder:**
Date of birth of policy holder:	**Date of birth of policy holder:**
Relationship to patient: Self ( ) Spouse ( ) Parent ( )	**Relationship to patient:** Self ( ) Spouse ( ) Parent ( )
Policy #:	**Policy #**
Financial Responsibility: SELF ( ) SPOUSE ( ) Parent ( ) : **If minor (under 18 years of age and unmarried): Full name and date of birth of parent or legal guardian:**	

ASSIGNEMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance.**
- **I authorize and give consent for my provider to bill me directly for recommended services performed that are no covered under the terms of my health plan.**
- **I authorize the physician to release and medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**

Patient Signature: _____ **Date:** _____

AOG Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment of services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician and you (the patient) and our contract is with you. We will not compromise your medical care to satisfy ANY insurance company. Bear in mind, insurance is meant to help defray the cost of medical care and is NOT intended to dictate your treatment.

Payment is due and expected in full at the time services are rendered unless other arrangements are made PRIOR to your appointment. This includes deductibles, copayments, coinsurance and non-covered services.

If you are scheduled for your annual gynecological exam, that is how your insurance carrier will be billed. If during your encounter with your provider additional problems and/or concerns are found, we can schedule another appointment to address your problems or we can treat those problems and/or concerns concurrently with your annual exam, however, there will be an additional charge for that service.

As a courtesy we are happy to assist you in the filing of most insurance claims, completing insurance forms, and insurance precertification. You will be responsible for any and all balances not covered by your insurance. If your insurance has not paid their portion within 60 days of being properly billed, the entire balance will be your responsibility. If you are unsure of any specific requirements of your insurance, PLEASE ASK THEM. We are unable to be completely familiar with every type of insurance and plan. As the insured client, you are in the best position to follow up and exert pressure on your insurance carrier to ensure payment is being processed. Due to stricter guidelines from insurance carriers and the Office of the Inspector General we are unable to change charges after they have been submitted to your insurance carrier.

In signing this form you, the patient, authorize payment to be made to Associates in Obstetrics & Gynecology, PC. You also authorize the release of any medical information, about yourself, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information to my insurance carrier and/or Centers for Medicare and Medicaid Services (CMS) and its agents and/or Medigap insurer that are necessary to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this authorization will be considered as effective and valid as the original.

You will receive a monthly statement requesting payment on any unpaid balance. If your account becomes past due, please contact our office to discuss payment arrangements and to avoid further collection efforts. We are committed to being sensitive to patient financial difficulties, but we are unable to assist you if you do not contact us to discuss your account. If payment is not made for our services, we may turn the account to an outside collection agency. In the event that your account is placed with an outside collection agency you will be responsible for the cost of collection, including but not limited to attorney fees, court costs, and applicable collection fees.

There is a fee (currently $35) for any check returned by the bank. Appointments not cancelled with at least 24 hour notice may incur a charge of $50 for time reserved. In an effort to utilize the time of our doctors and the operating room, your account will be charged a fee of $200.00 if you cancel your surgery or procedure within two weeks of the date of your surgery. FMLA or disability papers will incur a charge of $10 per form to be completed. This fee must be paid before the forms will be released.

I have read and understand the financial policy of AOG, I acknowledge it is my responsibility to ensure payment of fees for services provided by AOG and I agree to be bound by its terms.

Print Patient Name **Date** **Signature of Patient or Responsible Party**

ASSOCIATES IN OBSTETRICS AND GYNECOLOGY, PC

1105 Burleyson Road * Dalton, Georgia 30720

Patient Acknowledgment of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Associates in Obstetrics & Gynecology, PC on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Associates in Obstetrics & Gynecology, PC.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regards to this Notice of Privacy Practices, I may contact:

Associates in OB/GYN * Attn: Privacy Officer
1105 Burleyson Road * Dalton, Georgia 30720
706-278-4640 * 706-275-6599 FAX

_____ _____

Signature of Patient Print Name

_____

Date

THIS SPACE TO BE USED BY PRACTICE ONLY.

Date Acknowledgment denied by patient:
Reason Denied by Patient:
Name of person reviewing denial:
Date:

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MEDICATION HISTORY CONSENT FORM

Do not sign this form until you have read it and fully understand its contents.

By signing below, I give permission for AOG to access my medication history information from Surescripts through a secure electronic exchange. This will enable AOG to see the current medications that have been prescribed by other providers using Surescripts. Once you have given consent the medication history will be turned on and this information will automatically populate to your chart.

I have read and fully understand the information in this form and I give consent to AOG to access my medication history via Surescripts.

_____
Patient Name (Print)

_____
Patient Signature

_____
Date

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Patient Name: Date:

Mobile Phone:

The following individuals may have access to ANY and ALL of my medical records:

Name	Relationship to Patient	Phone Number

Patient Signature: _____ Date: _____

Emergency Contact:

Name:_____
Phone:_____
Relationship:_____