Harper & Associates Family Medicine, PC

5910 Hillandale Drive Suite 301
Lithonia, Georgia 30058
Phone: 678-418-2120 Fax: 678-418-2936

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
First MI Last

Sex: Male_____Female_____ Patient Date of Birth: _____/_____/_____Marital Status: _____
Single/Married/Divorced/Widowed/ Other

Social Security Number: _____-_____-_____ Drivers License # _____State Issued_____

New patient: Y / N Military or Student Status: Active duty_____ Full-time_____ Part-time_____Other _____

Name of Parent/Guardian If patient is under 18**:**_____

Does Patient live w/above named: Y N If NO, List other contact: _____

Patient Address: _____
City, State: _____**Zip:**_____ Home Number: _____

Employer's Name: _____ Occupation: _____

Address: _____ City, State, Zip _____

Work Number: ( ) _____ Cell/Other Number: ( ) _____

How were you referred to us? □ Family/Friend □ Newspaper/Magazine □ Other _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative (other than spouse) or friend ***not living with you***: _____
Relationship: _____ Address: _____ Phone #: ( ) _____-_____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance: _____**

Policy # _____ Group # _____ **Policy # _____ Group # _____**

Are you the Policyholder? □ **Yes** ***(If "yes" skip to Consent for Treatment)*** □ **If "No" (complete shaded area)**

*****Policyholder's Name: _____ □ Male □ Female SSN: _____-_____-_____

Relationship to patient: _____ Date of Birth_____/_____/_____

Address: _____

Telephone No.:_____ Work No.:_____

CONSENT FOR TREATMENT

I, the undersigned, hereby voluntarily consent to my treatment at Harper & Associates Family Medicine, P.C., the medical practice of Kenneth W. Harper, M.D. and Paula Pollard-Thomas, MD., and authorize such treatments, examinations, medications, and diagnostic procedures (including but not limited to radiographic and laboratory studies) ordered by my attending physician. I also authorize the release of any medical or other information necessary to process this claim, including information related to AIDS, mental health, and substance abuse. I also request payment of government benefits whether to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for all services rendered. **I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.**

_____ _____
Patient or Parent if Minor/Responsible Party Signature Date

Welcome to our office. We are anxious to make your visit as pleasant and convenient as possible. To provide you with excellent service and for our office to run successfully, we must emphasize several important factors. After reviewing these factors, please sign on the appropriate space provided below.

I THE UNDERSIGNED CERTIFY THAT I HAVE READ THE FOLLOWING, UNDERSTAND ITS CONTENT AND AGREE TO ALL TERMS AND CONDITIONS SET FORTH BELOW.

Patient Name (Please Print)	Parent/Guardian if patient is a minor (Print)
Patient/Guardian or responsible party (Signature)	Today's date

- **PROTOCOL**
  1. **If a patient is under age 18, a parent or legal guardian must be present for treatment. The parent/guardian or responsible party is responsible for authorizing and signing all necessary forms including but not limited to medical fees, insurance benefits, and registration and privacy policies.**

  2. **Time permitting; referrals are generated on day of service. Otherwise, referral requests are processed in 5 business days. Patients are required to schedule their own appointment only with the physician for whom the referral was generated or the referral is void.**

- **APPOINTMENTS**
  1. **If you arrive more than 15 minutes late for an appointment, we may have to reschedule your appointment. If time permits, you may wait and be *worked in* to another time slot with the first available provider.**

  2. **Please consider scheduled appointments carefully; appointment reminders are a courtesy extended to you by our office and is not a guarantee. You are ultimately responsible for maintaining your appointment.**

  3. **If you are unable to keep an appointment, kindly give 24-hour notice. Otherwise we reserve the right to charge a $25 fee for broken or missed (no-show) appointments without 24-hour advance notice.**

- **FINANCIAL & INSURANCE**
  1. **Payment is expected at the time service is rendered. We accept cash, checks (no counter checks), Visa, MasterCard, and Discover. All deductibles and fee amounts not covered by insurance are due at the time of service.**
  2. **Checks presented for insufficient funds, closed accounts or stop payments are charged a $30.00 fee for processing or the maximum amount allowed by law. Checks are processed by CERTEGY Check Services or National Check Trust.**
  3. **Insurance benefits are estimates only and not a guarantee of coverage. If your insurance company does not pay, you are financially responsible for payment of all fees and charges. Please acquaint yourself with what is covered by your insurance plan.**
  4. **Final billing is sent after determining all charges incurred less insurance payments. If any payments were actually received. An interest rate of 1.5% monthly (18% annually) will be assessed on all past due account balances.**
  5. **We reserve the right to charge for forms submitted for completion on/after your date of service, see preparation fee list posted at the front desk.**

We are excited to welcome you to our medical practice. We are dedicated to providing excellent patient care and courteous customer service. Any suggestions to enhance our success are greatly appreciated.