Georgia Clinic PC

Patient Name: _____ DOB: _____
Appointment Date: _____ MR #: _____
Location: _____ Provider: _____

AUTHORIZATION FOR MEDICAL TREATMENT

Georgia Clinic, PC and its medical staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consider or refuse consent to any proposed procedure or therapeutic course absent emergency or extraordinary circumstances. I understand that emergency medical services shall be provided by a specifically requested private physician or by another member of the Georgia Clinic, PC medical staff as available.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Georgia Clinic, PC, and are accessible to Practice personnel and medical staff. Practice personnel and physicians in attendance may use and disclose medical information for Practice operations and functions and to any other phyician or health care personnel involved in the cintinuum of care for my treatment. Safeguards are in place to discourage improper access. Georgia Clinic, PC, and its medical staff are authorized to disclose all or part of my medical records to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of Georgia Clinic, PC, charges and to any health care provider who is or may become involved with my care. The information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits for Georgia Clinic, PC, provider charges payable to the insured are to be made payable to Georgia Clinic, PC, and that physician benefits otherwise payable to the insured are to be made payable to Georgia Clinic, PC. Any payments received for services rendered to me by Georgia Clinic, PC, may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRE-CERTIFICATION POLICY

I understand that Georgia Clinic, PC, will assist with insurance pre-certification requirements which are the responsibility of the policyholder, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment.

FINANICIAL RESPONSIBILITY

As consideration for the services provied me, payment is guaranteed for any amount due for such services provided by Georgia Clinic, PC, and my physician, regardless of insurance status. Charges for services and goods shall be at Practice's billed charges rate unless otherwise agreed to in writing by Practice. I acknowledge that I am fully responsible for all non-covered services, deductibles and co-payments. Charges not paid within 90 days by insurance will become my responsibility. I further agree, in the event of default due to non-payment, to be responsible for collection fees, court cost, and/or legal fees, and there will be a $35.00 for all returned checks.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete discription of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is included in your New Patient packet (after 4/14/2003) and is posted in physicians offices throughout the Practice.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me in my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of the Patient Agreement. A photocopy of this document has the same effect as an orginal.
I have received a copy of Georgia Clinic, PC, Notice of Privacy Practice.

_____ _____ _____

Patient or Responsible Party Representative Date Signed Witness

Basis for refusal, if refused: _____

THIS PATIENT AGREEMENT TO REMAIN IN EFFECT UNTIL RESCINDED BY PATIENT.