ATHENS ASSOCIATES IN FAMILY PRACTICE

FAMILY

Patient Information

Last Name _____ First name_____ MI ____

Address _____

mailing address city state zip code

If mailing address is P.O. Box, what is your physical address?

_____ _____

address city state zip code

Email Address (AAFP internal usage only) _____

Preferred Primary phone _____(Circle One: cell / home) 2nd phone _____(Circle One: cell / home)

Employer Name _____ Work Phone _____ Ext _____

Marital status: ☐ Single ☐ Married ☐ Other Sex: ☐ Male ☐ Female

Date of Birth _____ Social Security Number _____

Insurance Coverage Information (Please present your insurance card to the front desk)

Primary Insurance _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

Secondary Insurance _____

Name of Insured _____
(if self, please put "self)

Insured Date of Birth _____

Insured ID # _____

Group # _____

Group Name _____

How did you hear about us?

- ❑ Family\ Friends
- ❑ Internet
- ❑ Insurance Listing
- ❑ Doctor\ Referral

**I understand that Physician Assistants (PAs) that have been approved by the Georgia State Board of Medical Examiners are used in our office. I am in agreement with being treated by a PA who is acting under the supervision of the Medical Director. I understand that I have the right to request to see a doctor when I am prescribed medicine by a PA in the office. I authorize AAFP to obtain a history of my medication use from outsourced databases*.

I authorize the release of my medical and billing information to the following:

Emergency Contact / Telephone number

_____ _____
Name Date

_____
Relationship to patient

_____ _____
Name Date

_____
Relationship to patient

I have read and understand the financial policy. I hereby authorize payment of medical benefits for all covered services to be paid directly to Athens Associates In Family Practice. I accept financial responsibility for any service(s) provided to me not covered by my insurance policy and understand that these services are due to be paid on the date that they are rendered. If the Practice does not participate with my insurance, I also accept responsibility for fees that exceed the payment made by my insurance company. I understand that all co-payments will be due when I check in for my appointment. All other out of pocket amounts such as coinsurance or deductibles will be due before I leave on my date of service. This practice accepts cash, checks, money orders, VISA, MC and Discover. **Privacy Release: I have been given notice of the Privacy Policy of AAFP.**

_____ _____
Signature (***If patient is a minor, parent signature is required***) Date

Financial Policy

Athens Associates in Family Practice is committed to providing you and your family with the highest level of quality medical care and personal service. In our practice, we do everything possible to make our patients our first priority including working to hold down the costs of healthcare. We feel that it is the patient or guardian's responsibility to meet the financial obligations that you have made with both your insurance company and our practice. The following is a summary of our financial policies.

1. Each new patient must complete a registration form prior to or at the time of his or her appointment. Registration forms are updated annually.
2. Proof of insurance and identity must be provided on the date of service, otherwise the patient will be expected to pay in full for all services when services are rendered. If we are unable to verify insurance benefits, the patient will be expected to pay at the time services are rendered.
3. Out of pocket amounts are due on the date of service. Patient prescriptions, referrals, or any other services to be rendered by our practice may be held until all outstanding balances are paid in full by the patient
4. Payments for services may be made by Cash, Check, Money Order, VISA/MC, or Discover Card.
5. If we are filing a claim for you, your contracted exam co-payments, coinsurance and deductible amounts will be collected at the time of service.
6. Patients with outstanding balances must make payment arrangements before their next appointment with the doctor.

Insurance

7. It is each patient's responsibility to understand his or her insurance coverage. As your health care provider, our relationship is with you, not with your insurance company. While filing of insurance is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.
8. Verification of your benefits is not a guarantee of payment. All payments are subject to the terms and allowances of your plan when services are rendered and claims are received and processed by your insurance company.
9. If we have not received a payment or a denial from your insurance company within 45-days of submission, we reserve the right to bill you directly for the services.
10. Statements will be generated when your claims are internally processed or the balance exceeds the 45-day maximum allowance for outstanding balances. A statement may not be generated for balances due under $15, however these amounts will remain on your account and will be due on the next service date or can be paid via the patient portal. ***Statement balance amounts will be due within 30-days of statement date.*** If you find an error on your statement or have any questions, please contact us immediately to clear up any confusion or concerns.
11. If your plan requires it, you must contact them prior to your appointment with us to assign us as your Primary Care Physician. If enrolled in a HMO plan, you must receive a referral from our office before seeing a specialist. You must have been seen by your PCP within 12-months of your requested referral to a specialist, otherwise you will be required to come in for an office visit.

Credits & Overpayments / Returned Checks

12. Credits will remain on your account to be used for future visits unless you request those amounts be refunded to you. Overpayments will be refunded within 30-days upon written request to our practice. **Credits under $5 can be refunded to the original credit card used only.
13. Returned checks will incur a $30.00 service charge. Payment for return checks and services are due upon the notice of the returned check and are payable by cash, money order, VISA/MC or Discover ONLY. Athens Associates in Family Practice reserves the right to refuse payment by check if a history of returned checks is established.
14. ***Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24-hours prior to your appointment time or a $30 cancellation fee will be applied to your account.***

I have read, understand and agree to comply with the Financial Policy as stated above. I agree to allow Athens Associates in Family Practice to file claims on my behalf and receive payment for those services as governed by contract. I acknowledge that all previous balances owed as well as current amounts due will be paid prior to my receipt of services.

_____

Patient Name (Print)

_____ _____

Patient Signature *Date*

All accounts not paid within 60-days of the due date may subject to dismissal from the practice and may be turned over to our contracted collections agency and documented on your credit report. Accounts reported to the credit bureau are subject to a collection fee with a maximum of $20 that will be added to your total balance due and will be your responsibility. Past due balances of over $200.00 may be taken to small claims court.