PATIENT FINANCIAL POLICY AGREEMENT AND AUTHORIZATION/CONSENT FOR TREATMENT

Copays: The patient is expect to present an insurance card at each visit. All copayments and past due balances are due and payable at the time of service. **Initials_____** **Self Pay Accounts:** Self pay accounts are patients who are covered by insurance plans that Family Medical Center does not participate in, patients without an insurance card on file or at the time of service. It is expected that payment is required at time of service. **Initials_____** **Automobile Accident cases or Third Part Liability Claims:** The patient will treated as a self pay account. The patient is expected to pay for services in full at time of service. **Initials_____** **Divorce and/or Child Custody cases:** In the case of divorce, the individual who initiates care for the child, is responsible for payment of copays, coinsurance and non participating insurance balances at the time of service. We will not bill a divorced spouse for the patients care. The parent with primary custody is usually the parent with whom the child lives and who usually seeks medical treatment for child. The custodial parent is responsible for payment at time of service, whether the account is considered self pay, participating insurance or non participating insurance. Gore Medical Management does not get involved with divorce specifics, ex: one parent pays 80% and the other parent pays 20%. Again, the custodial parent or guardian or non custodial parent, whom signs this agreement, will be held responsible for any and all balances pertaining to the child's account, unless this agreement/authorization/consent is revoked or modified before services are initiated by another parent or guardian. **Initials_____** **Collection Services:** Gore Medical Management, LLC utilizes the services of a Credit Bureau Reporting Collection Agency to assist in the collections of delinquent accounts. Delinquent/Outstanding balances or accounts that payment arrangements have not been made on, will be referred for outside collection services, resulting in reporting to Equifax and TransUnion, possible court ordered garnishment of wages and possible formal discharge from Gore Medical Management, LLC for any future medical services. In the event of financial default, patient/guarantor agrees to be responsible for reasonable collection costs/attorney fees. **Initials_____**

Signature of Responsible Party:_____

Printed Name of Responsible Party:_____

Request for Confidential Communication of Protected Health Information
By completing the area below, you are authorizing confidential communication and/or release of protected health information to the following individual(s). **who our office can release information to or discuss your personal healthcare with**

Name of Designated Contact Person	Relationship to Patient	Phone Number of Designated Contact

At times, our office will need to contact you concerning appointments, test results, etc.
If you have a voicemail or answering machine, is it permissible to leave your protected health information on your voicemail or answering machine or communicate with you via email when feasible? Yes_____No_____

What is your email address?_____

For treatment for a minor child, I authorized the individual(s) listed below to initiate or seek medical treatment at Gore Medical Management, LLC, on my behalf.

Name of Authorized Individual	Relationship to minor child	Phone Number of Authorized Individual

Preventative/Wellness Services: If you are here for your Yearly Wellness Exam, we will file the claim to your insurance company. We have "routine" test that our providers consider part of a yearly physical but each insurance company has different benefits for these types of services. If available, please provide your provider with a copy of what your insurance will cover, otherwise, some of the testing we may do, may not be covered by your insurance company and you may be held responsible for those services. You have the right to decline testing.

ALL AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR OTHER PERSON, OR PERSONS AUTHORIZED TO GIVE THEIR CONSENT FOR MEDICAL TREATMENT PURSUANT TO AUTHORITY AS DESIGNATED BY THE GEORGIAL MEDICAL CONSENT LAW AS ENACTED BY THE GEORGIA GENERAL ASSEMBLY. IF AUTHORIZATION IS NOT SIGNED, GORE MEDICAL MANAGEMENT BY LAW, RESERVES THE RIGHT TO REFUSE TREATMENT. I, THE UNDERSIGNED, HEREBY ACKNOWLEGE THAT THIS SIGNED POLICY, AUTHORIZATION/CONSENT IS IN EFFECT AND IS AUTHORIZATION/CONSENT FOR ALL FUTURE SERVICES THAT I MAY SEEK FROM GORE MEDICAL MANAGEMENT, LLC. THIS AUTHORIZATION/CONSENT MAY BE REVOKED OR MODIFIED BY ME AT ANY TIME IN WRITING TO FAMILY MEDICAL CENTER.
I, the undersigned, hereby authorize/consent Family Medical Center physician(s) (etc.) (and whomever they may designate as his assistant(s) to administer such treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand that Gore Medical Management, LLC may participate with my insurance plan. I request that payment for this claim be made directly to the practice. A copy of this authorization may be used in lieu of the original. I recognize and accept personal responsibility for any balance remaining after payment of such benefits. NOTICE OF PRIVACY PRACTICES I am aware of Family Medical Center's Privacy Practices and have been offered a copy of such practices. I am also aware that a copy is kept on display at the practice.

_____ _____

Patient/Guardian Signature Date

INTERNAL MEDICAL CENTER PATIENT REGISTRATION

Date: **SS#**

First Name **MI** **Last Name**

Patient's Address

City **State** **Zip Code**

Mailing Address (if different)

Email Address: **Home#** **Cell#**

Preferred contact method: (circle one) **Home #** **Cell #** **Email**

Male or Female **DOB** **Single** **Married** **Divorced** **Widowed**

Race: **Caucasian** **Black** **Hispanic** **Asian** **Native American** **More than One Race**

Ethnicity: **LatinoHispanic** **Other** **Language:** **English** **Spanish**

Patient's Employer **Employer's Tel #**

Employer's Address

Emergency Contact **Phone #**

PRIMARY INSURANCE

Primary Insurance Carrier **Policy #** **Group#**

Policy Holder's Name **SS #** **DOB**

Address **City** **State** **Zip**

Relationship to Insured **Self** **Spouse** **Child** **Other**

SECONDARY INSURANCE

Secondary Insurance Carrier **Policy #** **Group#**

Policy Holder's Name **SS #** **DOB**

Address **City** **State** **Zip**

Relationship to Insured **Self** **Spouse** **Child** **Other**

PARENT/GUARDIAN/RESPONSIBLE PARTY/INSURED

Name (if other than patient) **SS#**

Mailing Address **City** **State** **Zip**

Home# **Cell#** **DOB**

Signature of Patient or Guarantor