Southeastern
GERIATRIC HEALTHCARE GROUP

OUR POLICIES

Effective April 1, 2008, due to continued decreasing insurance reimbursements, we will begin strictly enforcing fees for certain tasks that we perform on behalf of our patients.

Phone calls to doctors and nurses on their cell phones to discuss anything *other than an emergency* will be $50.00. The physician will determine whether or not the call is an emergency.

Forms to be filled out such as Veterans Administration and disability benefits, Family and Medical Leave, and Social Security, etc. are each $10.00.

Prior Authorization for prescriptions is $10.00 for each authorization completed.

Releasing of medical records is $20.00 for the first 20 pages and $.20 for each additional page thereafter.

Cancellation of an appointment within 24 hours is $75.00.

****Invoices will be sent out on a monthly basis to Patient/Guarantor ****

I, _____ , (please print) have read and understand the policies which have been presented to me. I understand that I will be billed for the above services. I also understand that if I do not pay for these services, medical care may be stopped at any time.

Sign_____Date_____

Relationship to Patient_____

1301 Hightower Trail • Suite 150 • Atlanta, GA 30350 • Phone: 404-497-1830 • Fax: 404-497-1828
www.GeriatricHealthcare.com

Southeastern Geriatric Healthcare Group

1301 Hightower Trail Suite 150 Atlanta, GA 30350
Phone 404 497-1830 Fax 404 497-1828

Thank you for choosing Southeastern Geriatric Healthcare Group for your healthcare needs. We appreciate your trust and the opportunity to serve you.
Enclosed is a map to our office as well as a packet of information that will be used in preparation for your visit.

The following will be needed at time of your appointment:

1. The completed information packet. This is ***very important*** *please read our policy below.
2. Insurance cards. ***If you do not have cards, please be prepared to pay for your visit*** We accept cash, check, debit cards, Visa, American Express, or Mastercard. Please be advised that we **do not participate with any Non-Medicare replacement policies or HMO products** and so payment would be due at the time services are rendered. Payment would also be due if your policy does not have **mental health benefits.** It is the **responsibility of the policy holder** to know if we are in or out of network, or if you have mental health benefits.
3. The Power of Attorney will not be recognized or enforced unless a copy is in the chart. Please bring a copy if you wish it to be applicable.
4. A current list of medications or you may bring the medications.
5. Recent tests done within 90 days, by other doctors relating to the reason being seen. (CT scan, neurological exams, blood work, neuropsychological testing etc...)

Please arrive 15 minutes before your appointment time and call if you will be arriving later than your schedule appointment time. Office policy allows for a 15 minute window, by our clock (as this is the clock by which we run the schedules)to be late. *If your arrival time is beyond this window, please be prepared to reschedule your appointment.*
Please be advised that we will need 15 minutes to prepare a chart with paperwork you have completed.* ***If you choose to not have this paperwork completed upon arrival of your appointment and you have not allowed an hour to fill out the paperwork, you will be asked to reschedule.*

Appointment policies have been developed to respect the time of both our patient and providers.
If we can be of further assistance, please call 404 497-1830

Contact:_____ Patient Name:_____

Appt Date:_____ Time:_____ Provider:_____

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Pre Visit Form

Please complete this form, bring it with you to your appointment and give it to the receptionist when you sign in.

Date of first appointment _____

Last Name _____ First _____ MI ____

Date of Birth _____ Current Age _____

Who referred you to this office? Other_____
Doctor _____ Name_____

(required) Phone: _____ (required)Fax: _____

Primary Healthcare Physician (if different from above)

Ph _____ Fax _____

Height _____ Weight _____ Gender Male ❑ Female ❑

Marital Status:Married ❑ Single ❑ Widowed ❑ Divorced ❑

Spouse's name _____ Number of Children _____

Names_____ Phone_____

_____ _____

_____ _____

Where were you born and raised?
Where do you currently reside?_____

Education (highest level completed)_____Are you retired? **No** ❑ **Yes** ❑ Yr?_

Do you have special living situation needs? _____

Are you disabled? No ❑ Yes ❑ If yes, please describe nature of disability:

_____

_____

_____

Health History

Please describe reason for visit. _____

_____

_____

Do you have a memory problem? **No ❑ Yes**
❑
If yes, please explain:_____

Past Psychiatric History:_____

_____

_____

Has anyone in your family ever had memory or emotional problems? **Yes ❑ No ❑**
If **yes,** please indicate your relationship to the individual and their age when the illness occurred. _____

Past Medical History

Please check all that anolies

❑ Rheumatic Fever	❑ Hearing Aid
❑ Heart Attack	❑ Ulcers
❑ Congestive Heart Failure	❑ Anemia
❑ Rapid or irregular heart beat	❑ Urinary Tract Infections
❑ Dizziness	❑ Prostate problems
❑ Swelling of the ankles	❑ Cancer
❑ Shortness of breath	❑ Constipation
❑ Stroke	❑ Diarrhea
❑ TIAs	❑ Kidney Disease
❑ Head injury/loss of consciousness	❑ Asthma
❑ Diabetes	❑ Seasonal Allergies/ Hay Fever
❑ High Blood Pressure	❑ Thyroid Disease
❑ Cataracts	❑ Liver Disease
❑ Glasses	❑ Arthritis
❑ Seizures	❑ Other: please describe

Have you ever had surgery(s)? **No ❑ Yes ❑ If Yes,** please list type of surgery and date.

_____

_____

_____

Do you have any allergies to medications? If so, please list them.

_____

_____

Please list all medication and dosage:

_____

_____

_____

_____

Please list the year of most recent:

Tetanus Vaccine _____ **Rectal Exam** _____
Flu Vaccine _____ **Pneumonia Vaccine** _____
Cholesterol Check _____ **TB Test** _____

Have you ever smoked? **No ❑ Yes ❑ If yes,** how many packs a day? _____

If you are no longer smoking when did you quit? _____

Do you drink alcoholic beverages? **No ❑ Yes ❑ If yes,** how often? _____

Do you have a special diet? If so, please describe _____

Do you exercise regularly? _____

Do you have difficulty sleeping? **No ❑ Yes ❑ If yes,** please describe _____

Have you been hospitalized recently? **No ❑ Yes ❑ If yes,** please indicate the name of the facility and the date of hospitalization. _____

_____

_____

_____

.\/ Please check the column if any family member has or had the problems listed:

	Father	Mother	Children
Alcoholism			
Asthma			
Bleeding Disorder			
Diabetes			
Seizure			
Glaucoma			
Heart Disease			
Hypertension			
Kidney Disease			
Mental illness			
Migraine			
Osteoporosis			
Stroke			
Thyroid Disease			
Other			

Please use this space below to provide additional information you may want us to know:

_____

_____

_____

_____

This form must be completed prior to your visit. This information will give our physicians a preliminary overview and would allow more time for them to focus on your care during your first visit to our office.

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Name
Last _____ First _____ MI _____

Address (pt resides here)_____

City _____ State_____ Zip _____

Birth Date _____ Soc Sec#_____ (required if filing ins)

(Phone) Ho: _____ Cl_____ Wk_____

Name of employer (if applicable) _____

Retired _____ Disabled _____

Person to whom billing and correspondence should be mailed:
(if different from above)

Name _____ Relationship _____

Address_____ St ____Zip _____

(Phone) Ho: _____ Cl:_____Wk: _____

Emergency Contact: Name _____ Relationship _____

(Phone) Ho:_____ Cl:_____Wk: _____

Date_____

Service Payment and Insurance

Please understand that we are obligated to file your primary insurance *one time* for *each visit*. We file secondary insurance as a courtesy and the cost for doing so is incurred by the practice.

Having current insurance information is of the utmost importance to making sure that your insurance claims get paid.

If we are not notified of insurance changes prior to services then the patient will have to be billed when the claim denies. Please always call and notify the practice of changes in insurance *or* demographics.

***Hospitals and other facilities do not relay changes in information to us as a courtesy. It is the responsibility of the patient to do so.**

I, the undersigned have read the services, payment and insurance information and have provided the most current insurance filing information to file for the insurance benefits on my behalf.

Signed: (must be the patient/person on the insurance card), or we must have a copy of the legal document for a legal representative to sign for the patient.

X_____Relationship_____Date_____

Office Staff only below this point:

Is there a legal document in the chart? Yes____ No____ Int____

Type of document_____ Int_____

Primary Ins_____
Secondary Ins_____

Medical and Surgical Consent

The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions to such physician: the undersigned recognized that some physicians furnishing services to the patient including the radiologist, neurophysiologist, and the like, are independent contractors and are not the employees or agents of the hospital. The undersigned consents to X-Ray examination, laboratory procedures, and medical treatment or hospital services rendered to the patient under general and special instructions of the physician.

Authorization to release information

I hereby authorize Southeastern Geriatric Healthcare Group to release medical information to my referring physician any insurance company with whom I have medical or surgical benefits for the purpose of filing a medical or surgical claim.

Assignment of Benefits

I authorize my health insurance benefit plan to pay directly to Southeastern Geriatric Healthcare Group the medical/ surgical benefits otherwise payable to me.

Medical Lifetime Claim Authorization

I authorize any holder of medical or other information about me to release to the Social Security Administration and center for Medicare and Medicaid Services or its intermediaries or carriers of any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payment of the medical insurance benefits either to myself or to the party who accepts assignments. Regulation pertaining to Medicare Assignment of Benefits applies.

(Must be signed by the patient/person on the insurance card **or we must have a copy of the legal document for a legal representative to sign for the patient.** Legality can not be enforced without a copy of the legal document.)

Signed,

X _____ **Relationship** _____ **Date** _____

Office Staff only below this point:

Is there a Legal document in the chart? **Yes** _____ **No** _____

*The above signature authorizes Southeastern Geriatric Healthcare Group to file for insurance benefits. **If not signed, please be prepared to pay for your visit today and for future visits or charges.**