GWINNETT CLINIC

NEW PATIENT REGISTRATION

PLEASE CAPITALIZE ALL PRINT AND FILL OUT ALL NUMBERED FIELDS

1 Patient Information

LAST NAME	FIRST	M.I.	SEX ☐M ☐F ☐OTHER
DATE OF BIRTH / /	EMAIL		MARITAL STATUS ☐M ☐S ☐W ☐D
ADDRESS	CITY	STATE	ZIP CODE
CELL PHONE	HOME PHONE	EMPLOYED BY	

2 Emergency Contacts

PRIMARY	LAST NAME	FIRST	PHONE	RELATIONSHIP
SECONDARY	LAST NAME	FIRST	PHONE	RELATIONSHIP

3 Financial Responsible Party (If patient not guarantor)

LAST NAME	FIRST	M.I.	DATE OF BIRTH / /
ADDRESS	CITY	STATE	ZIP CODE
CELL PHONE	HOME PHONE	EMAIL	

4 Insurance Information

NAME OF GUARANTOR/PRIMARY POLICY HOLDER			NAME OF GUARANTOR/PRIMARY POLICY HOLDER		
PRIMARY INSURANCE COMPANY			SECONDARY INSURANCE COMPANY		
GROUP NO.	PHONE		GROUP NO.	PHONE	
ADDRESS (ON BACK OF INSURNACE CARD)			ADDRESS (ON BACK OF INSURNACE CARD)		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

5 Referred By ☐ Check here if referred by doctor

LAST NAME	FIRST	M.I.	CELL PHONE
ADDRESS	CITY	STATE	ZIP CODE

IF NOT REFERRED BY DOCTOR, HOW DID YOU HEAR ABOUT US?
☐INSURANCE ☐WEBSITE ☐ONLINE AD ☐OTHER (Please specify):

6 Reason for Today's Visit or Chief Complaint

7 Authorization & Payment Agreement

Printed name of patient or legal representative _____

SIGNATURE _____

DATE _____

Relationship to the patient (if applicable) _____

I authorize Gwinnett Clinic and its physicians/nurse practitioners to examine, evaluate, and treat the patient listed above for current and all future problems for which the same patient returns for examination, evaluation, and treatment. I understand that payment, in full, is due at the time of service unless approved by office staff. I also authorize releasing my health information to my referring physician/clinic, employer (if workman's compensation injury), auto insurance company (if motor vehicle accident), and/or health insurance company. I understand that, as a courtesy, Gwinnett Clinic may file my claims to the appropriate insurance company. However, although insurance claims will be submitted, all charges are primarily and ultimately my full responsibility. If my insurance payment is not received within 60 days from the date of service, I agree to pay the entire balance due, unless my insurance company has an overriding contractual agreement with Gwinnett Clinic and its physicians/nurse practitioners. I also agree to pay interest at the rate of 1.5% per month if my bill is not paid within 90 days from the date of service. Due to default, I also agree to pay all cost of collection, including but not limited to, court costs, collection agency charges, attorney fees, etc.

8 Payment of Benefits

I authorize payment of benefits, as determined by the insurance company, directly to:

Gwinnett Clinic

I also understand I may still be responsible for any amounts not paid by my insurance company.

SIGNATURE _____ DATE _____

9 Medical Release Authorization

Insured party/guarantor must sign for all claims; dependent patient must also sign if not a minor. I authorize any insurance company, health care organization, employer, hospital, physician/office, dentist, pharmacist, or other relevant entity/institution/clinic to release any information requested with regard to processing my claim. I certify that the information I furnished is true and correct.

I know it is a crime to fill out this form with facts that I know are false or to omit facts that I know are relevant.

SIGNATURE _____ DATE _____

GWINNETT CLINIC

HIPAA/PROTECTED HEALTH INFORMATION

10 Acknowledgement of Receipt of Notice of Privacy Practices

I have been given a copy of ***Gwinnett Clinic's*** Notice of Privacy Practices, version effective September 2013.
I consent to the uses and disclosures of my health information as outlined in the Notice.
I understand that I can access the Notice of Privacy Practices at any time on the Gwinnett Clinic website.

PRINT NAME OF PATIENT _____ DATE _____

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ PRINT NAME OF REPRESENTATIVE (IF APPLICABLE) _____

If Representative signing on behalf of patient, please describe the Representative's authority to act on behalf of the patient (**initial one**):

_____ The representative is the parent of the patient, who is a minor.

_____ The representative is the guardian of the patient, who has been adjudicated incompetent.

_____ The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to Gwinnett Clinic personnel.

11 Communicating About Your Care

Necessary medical care at Gwinnett Clinic:
- I understand these communication methods are essential to receiving the best quality care.
- I understand Gwinnett Clinic will respect and maintain my privacy to the best of its ability.
- Automated phone, automated text, personalized text, and patient portal utilization are necessary for my care.

What number do you prefer we use to contact you? _____

Do we have your permission to:

Leave a message on your answering machine?	☐Yes	☐No
Confirm appoinments?	☐Yes	☐No
Remind you of any medications (if applicable)?	☐Yes	☐No

If we cannot reach you, who can we speak to about your care?

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

GWINNETT CLINIC

FINANCIAL POLICY

WE HOPE TO MAKE YOUR VISIT IN OUR OFFICE AS THOROUGH AND PLEASANT AS POSSIBLE. WE ALSO WANT YOU TO HAVE A FULL UNDERSTANDING OF YOUR INSURANCE PLAN AS WELL AS OUR FINANCIAL POLICIES AND EXPECTATIONS FOR PAYMENT. PLEASE READ THIS DOCUMENT CLOSELY.

INSURED PATIENTS

Payment is due at the time services are rendered. This includes outstanding balances, deductibles, co-payments, co-insurances, other fees for services not covered by your insurance company, and expected charges for services rendered during your visit.

- Your payment at check-in is a deposit for the visit. Charges may also be collected at check-out for services rendered. This applies to all insurance plan types. You will subsequently receive an explanation of benefits from your insurance company, and, if needed, statements from your insurance company and Gwinnett Clinic to collect any outstanding balance.
- If you are not sure what your insurance covers, PLEASE CALL YOUR INSURANCE COMPANY DIRECTLY! As the insured member, you are in the best position to get accurate information. As there are hundreds of insurance plans, we are only to provide general cost estimates. In addition, the information given to us comes with a disclaimer that it may be inaccurate.
- As a courtesy, we assist with filing insurance claims, completing insurance forms, and requesting insurance pre-certifications.
- In short, the ULTIMATE RESPONSIBILITY for filing, processing, and paying claims remains with you. If your insurance has not paid their portion within ninety (90) days of being billed, we encourage you to continue contacting them. (Please note that insurance carriers may provide false or inaccurate information at time of initial benefits verification.)
- You will receive regular statements requesting payment of any unpaid balance. After two (2) statements, your balance will be forwarded to a third-party collection agency.

PRIVATE PAY (NO INSURANCE)

Gwinnett Clinic will collect full payment at the time of your visit for services rendered during the visit.

- Prior to your visit (at check-in), an office visit fee – along with payment for all previously unpaid balances – is collected.
- After seeing the physician / nurse practitioner (at check-out), there may be additional charges depending on the level of service that was provided by the physician or nurse practitioner and the additional services (labs, imaging, etc.) that may have been ordered / rendered during the visit.
- If additional tests are ordered that need to be completed after the visit, and you anticipate a problem paying for these – please let your health care team know before leaving the office.

ALL PATIENTS

Gwinnett Clinic will collect full payment at the time of your visit for services rendered during the visit.

- *NO-SHOWS: $25 (office visits not cancelled within 24 hours prior to appointment may result in a $25 charge; there may be significantly higher charges for missing scheduled tests, including stress tests and sleep studies)
- BOUNCED CHECKS: $35.00 (any checks returned by the bank)
- FORM FEES: $15 - $150 (applicable to each form completed your physician / NP beyond standard medical documentation)

*No show fees may be adjusted or waived at the discretion of the Medical Director.

Adoption Forms *minimum $150, must be completed by physician only*	**Handicap Parking Forms/ Parking Permits** *minimum $15*	**School Admission Forms** *minimum $15*
Employment Screening Forms *minimum $15*	**Health Screening/Biometric Exam/ Proof of Wellness Visit Forms** *no charge if 1 page only, otherwise minimum $15*	**Sports Physical** *minimum $20*
FMLA Forms *minimum $50*	**Immunization Forms** *minimum $15*	**Short Term Disability Forms** *case-by-case basis, minimum $20*

12 Financial Policy Acknowledgement

I have read in full and understand the above policies. I know that I will be charged a minimum of $15 for any form beyond standard clinical documentation. I understand that I may receive a copy of this form upon request. I understand that if I pay with debit/credit card, Gwinnett Clinic securely saves that information in my patient profile and may use it to charge unpaid balances on my account after 90 days.

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE _____ SIGNATURE _____

DATE _____ RELATIONSHIP TO THE PATIENT (IF APPLICABLE) _____

GWINNETT CLINIC

PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION CONSENT FORM

WE USE YOUR CELL PHONE NUMBER AND E-MAIL ADDRESS PRIMARILY FOR APPOINTMENT CONFIRMATIONS AND FEEDBACK. WE DO OUR UTMOST TO RESPECT AND MAINTAIN PRIVACY. WE WILL NEVER SEND SPAM E-MAIL / TEXTS OR SHARE YOUR CONTACT INFORMATION.

It is important to make you aware of the intent of electronic correspondence and potential risks involved with it. This consent concerns currently available and future communication methods between you and Gwinnett Clinic. Of note, digital communication includes, but is not limited to, email, patient portal, text messages/SMS, etc. Gwinnett Clinic only uses secure and encrypted software to communicate with you. However, Gwinnett Clinic is not responsible for a breach of information if your device is not secure.

CONDITIONS FOR THE USE OF PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION

Gwinnett Clinic cannot guarantee, but will reasonably strive, to maintain security and confidentiality. Please note:

- *Patient portal, phone or other digital communication is not appropriate for urgent or emergency situations.*
- You should never use email or other digital communication to discuss sensitive medical information.
- It is your responsibility to follow-up and/or schedule an appointment if warranted.
- If you opt in to participate in email and other digital communicaton with Gwinnett Clinic, it is understood that you are responsible for the security and privacy of the recipient email client, cell phone, tablet, etc.
- If you opt in to participate in email and other digital communication with Gwinnett Clinic, it is understood that most widely available software (e.g. email service providers, email clients, text message/SMS services, wireless communication providers, etc.) and hardware (e.g. cell phones and computers) are neither HIPAA-certified nor encrypted.
- In short, it is your responsibility to maintain the security of all email and digital communication.

RISK OF USING PATIENT PORTAL, PHONE & DIGITAL COMMUNICATION

Transmitting information by email & other digital means has a number of risks, including, but are not limited to:

- Email and other digital communication can be circulated, forwarded, stored, and broadcast.
- Email and other digital communication can mistakenly use the wrong email address, phone number, etc.
- Backup copies of email/other digital communication may exist even after deleted.
- Employers and online services may have a right to inspect email and all other digital communication.
- Email and other digital communication can be intercepted, changed, forwarded, etc. without authorization.
- Email and other digital communication can be used to introduce viruses into hardware.
- Email and all other digital communication can be used as evidence in court.
- Gwinnett Clinic's server and/or information technology infrastructure could go down and neither email nor any other digital communication would not be received until the server is back online.
- **I consent to receiving automated appointment reminders and other essential communication regarding my appointments and medical care by automated phone calls and text messages. I understand that Gwinnett Clinic will never sell my information to a third party.**

13 Communicating with Gwinnett Clinic Staff and Approved Contractors

Gwinnett Clinic may engage in staffing arrangements with contract workers both in and outside the United States. All are trained on US compliance standards and HIPAA privacy and security. Contract staff may be used for care provided in the office or for support services when you are communicating with the clinic before or after visits.

14 Permissions

_____ (initials) **YES**, I consent to Gwinnett Clinic's standard communication protocols. I understand that patient portal, phone, and digital communication are not appropriate for emergency situations.

EMAIL ADDRESS **(REQUIRED)** _____ CELL PHONE # _____

15 Patient Portal, Phone & Digital Communication Acknowledgement

I have read in full and understand the intent of electronic correspondence and potential risks involved with it. I understand that I may receive a copy of this form upon request.

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE _____ SIGNATURE _____

DATE _____ RELATIONSHIP TO THE PATIENT (IF APPLICABLE) _____

GWINNETT CLINIC

475 Philip Blvd, Suite 200, Lawrenceville, GA 30046
Office: (678) 226-6201
eFax: (678)707-8701 Fax: (678) 225-4037
www.gwinnettclinic.com

GWINNETT CLINIC NEUROLOGY & SLEEP MEDICINE POLICIES

Effective 01/02/2024

We are hoping to create a more streamlined experience for our patients and our staff. Beginning 01/02/2024, Gwinnett Clinic Neurology & Sleep Medicine will be instituting the following policies:

1. **PATIENT PORTAL**: To reduce delay in communication, we encourage you to use our patient portal rather than leaving a message on our voicemail. We will return voicemail messages within 24-48 hours.
    a. If you are **NOT** signed up for the Patient Portal please give us a call or visit our office and our front office staff will assist you.
2. **CANCELLATIONS AND RESCHEDULING:** If you need to cancel or reschedule our appointment, please leave us a message on the patient portal or voicemail at least 48 hours before your appointment. This way we can accommodate another patient waiting for your appointment.
3. FMLA paperwork will need to be filled out by the patient and will require a fee of $100. You must pick up the documents to provide to your employer.

PLEASE NOTE THAT THIS CLINIC WILL NOT FAX ANY PAPERWORK ON YOUR BEHALF.

4. We no longer complete paperwork for disability of any kind. You are welcome to request your clinical notes for disability purposes.
5. As of 01/02/2022, our clinic has suspended sleep apnea device compliance downloads for the purpose of DOT physicals.

If you are unable to abide by the above policies, please let our front office staff know and your appointment will be canceled and your copay or deductible will be refunded.

_____
Patient Signature Date

_____
Printed Name

NEUROLOGY CLINIC VISIT

Patient Name: _____
MRN: _____
DOV: _____

Name, Phone Number and Address of Your Pharmacy:

ROS	Circle	Normal
General:	fever, chills, weight change, appetite change	□
Eyes&Ears	difficulty seeing, double vision, light flashes, hearing loss, hearing buzzing or ringing	□
Heart:	chest pain, palpitations, fainting spells	□
Lungs:	shortness of breath, wheezing, cough	□
GI:	abdomen pain, nausea, vomiting, constipation, diarrhea	□
Psych:	worrying thoughts, crying, thoughts of suicide, depression, anxiety	□
MSK:	neck pain, back pain, joint pain, stiffness	□
GYN:	using oral contraceptives, pregnant	□
Neuro:	loss of balance, weakness, memory loss, headache, numbness	□
Blood:	bleeding or bruising tendency, using blood thinning medications, clotting problems	□
Sleep:	excessive daytime fatigue, snoring, pauses in breathing, difficulty falling or staying asleep, unusual nighttime behavior, excessive kicking in bed, early morning headaches	□

MEDICATIONS

Name	Dose	Times Per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY

□ High blood pressure
□ High cholesterol
□ Coronary artery disease
□ Congestive heart failure
□ Cardiac arrhythmias
□ Atrial fibrillation
□ Sleep Apnea
□ Hypothyroidism
□ Cancer (type): _____
□ Other: _____
□ Other: _____

□ Diabetes
□ Seizures
□ Stroke
□ Asthma
□ COPD
□ Depression
□ Anxiety
□ HIV/AIDS

ALLERGIES

_____
_____

PAST SURGICAL HISTORY

□ _____
□ _____
□ _____
□ _____
□ _____

FAMILY HISTORY

Mother:_____
Father:_____
Other:_____

SOCIAL HISTORY

Smoking: □ Never □ Former □ Current Smoker _____ packs per day
Occupation: _____ Alcohol: _____
Education: □_____ Grade □ Graduated High School
□ Graduated College □ Other: _____

Referring MD:		
CC:		
Weight:	Height:	
BP:	HR:	
SpO2:	Neck Circum:	
□ Corrected □ Uncorrected		
OU: 20/	OS: 20/	OD: 20/