GWINNETT CLINIC

PLEASE PRINT

NEW PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	MARITAL STATUS ☐M ☐S ☐W	HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -
ADDRESS			CITY	STATE	ZIP CODE	
			SEX	AGE	DATE OF BIRTH / /	
EMPLOYED BY	YEARS	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE ( ) -

REFFERED BY - ☐ CHECK HERE IF REFERRED BY DOCTOR

LAST NAME	FIRST	M.I.	ADDRESS	TELEPHONE ( ) -

IN CASE OF EMERGENCY NOTIFY

LAST NAME	FIRST	M.I.	ADDRESS	TELEPHONE ( ) -

RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST	M.I.	MARITAL STATUS ☐M ☐S ☐W	HOME PHONE ( ) -	WORK PHONE ( ) -	CELL PHONE ( ) -
ADDRESS			CITY		STATE	ZIP CODE
SOCIAL SECURITY NO.		SEX	AGE	DATE OF BIRTH / /	HAS RESPONSIBLE PARTY BEEN A PATIENT? ☐ YES ☐ NO	
EMPLOYED BY	YEARS	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE ( ) -

INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	GROUP NO.	NAME OF SECONDARY INSURANCE COMPANY	GROUP NO.
ADDRESS		ADDRESS	
CITY / STATE / ZIP CODE / TELEPHONE ( ) -		CITY / STATE / ZIP CODE / TELEPHONE ( ) -	
NAME OF INSURED IF THE RESPONISBLE PARTY IS NOT THE INSURED			

REASON FOR TODAY'S VISIT - OR - CHIEF COMPLAINT:

I AUTHORIZE GWINNETT CLINIC LTD. & THEIR PHYSICIANS TO EXAMINE, EVALUATE AND TREAT_____(NAME OF PATIENT) FOR PRESENT AND ANY FUTURE PROBLEMS FOR WHICH SAME PATIENT COMES BACK FOR EXAMINATION, EVALUATION AND TREATMENT.
I UNDERSTAND THAT THE OFFICE DOES NOT BILL FOR ROUTINE OFFICE CHARGES AND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHERWISE APPROVED BY OFFICE STAFF. I ALSO AUTHORIZE RELEASING INFORMATION TO MY REFERRING PHYSICIAN/CLINIC AND MY EMPLOYER (IF WORKMAN'S COMPENSATION INJURY).

PAYMENT AGREEMENT

I UNDERSTAND THAT, AS A COURTESY GWINNETT CLINIC LTD. MAY FILE MY CLAIMS TO THE APPROPRIATE INSURANCE COMPANY. HOWEVER, ALTHOUGH INSURANCE FORMS WILL BE SUBMITTED, ALL CHARGES ARE PRIMARILY MY RESPONSIBILITY.

IF MY INSURANCE PAYMENT IS NOT RECEIVED WITHIN 60 DAYS FROM THE DATE OF SERVICE/TREATMENT, I AGREE TO PAY THE ENTIRE AMOUNT OF THE BALANCE DUE, UNLESS MY INSURANCE COMPANY HAS A CONTRACTUAL AGREEMENT WITH GWINNETT CLINIC LTD. & THEIR PHYSICIANS.

I ALSO AGREE TO PAY INTEREST AT THE RATE OF 1.5% PER MONTH IF MY BILL IS NOT PAID WITHIN 90 DAYS OF DATE OF SERVICE/TREATMENT.

DUE TO DEFAULT, I ALSO AGREE TO PAY ALL COST OF COLLECTION, INCLUDING, BUT NOT LIMITED TO, COURT COSTS, COLLECTION AGENCY FEES, ATTORNEY FEES, ETC.

DATE _____ AUTHORIZED PERSON'S SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

PAYMENT OF BENEFITS

I AUTHORIZE PAYMENT OF BENEFITS, AS DETERMINED BY THE COMPANY, DIRECTLY TO:

GWINNETT CLINIC LTD.

I ALSO UNDERSTAND THAT I MAY STILL BE RESPONSIBLE FOR ANY AMOUNTS NOT PAID BY MY INSURANCE COMPANY

X _____ DATE / /

MEDICAL RELEASE AUTHORIZATION

INSURED PARTY MUST SIGN FOR ALL CLAIMS. DEPENDENT PATIENT MUST ALSO SIGN IF NOT A MINOR. I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, DENTIST, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO PROCESSING MY CLAIM. I CERTIFY THAT THE INFORMATION I FURNISH IS TRUE AND CORRECT.
I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

X _____ DATE / /

X _____ DATE / /

Updated April 2017

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

- *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)*

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.

Name of Patient

Signature of Patient or Legal Representative

Date

Printed Name of Patient's Legal Representative

Relationship to the Patient

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.

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name of Patient Print Name of Representative

Please describe the Representative's authority to act on behalf of 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.

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 Appointments	☐ Yes	☐ No
Remind you of any medications (if Applicable)	☐ Yes	☐ No
Speak to household members concerning your care (listed below)	☐ Yes	☐ No

_____

Name Relationship Telephone Number

_____

Name Relationship Telephone Number

_____

Name Relationship Telephone Number

FOR GWINNETT CLINIC STAFF USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

_____

GWINNETT CLINIC

Updated February 2018

GWINNETT CLINIC

EMAIL & 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.

CONDITIONS FOR THE USE OF EMAIL & DIGITAL COMMUNICATION

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

- *Email 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 encrypte
- In short, it is your responsibility to maintain the security of all email and digital communication.

RISK OF USING EMAIL & 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.

_____ (initials) **YES**, I authorize the use of email and digital communication with Gwinnett Clinic!	_____ (initials) **NO**, I do not authorize the use of email and digital communication with Gwinnett Clinic.
MY E-MAIL ADDRESS:	
MY CELL PHONE #:	

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient or Legal Representative _____ Relationship to the Patient (if applicable) _____

GWINNETT CLINIC

Orthopedics

Name: _____ _____ _____

(Last) (First) (MI)

DOB: _____ / _____ / _____

Email Address: _____

Pharmacy Name: _____

Address: _____

Pharmacy Phone Number: _____

Would you like a copy of your office note? Y/N

**If yes, office notes will be available to pick up 2-3 days after the date of service. **

Patient Signature: _____ Date: _____

GWINNETT CLINIC

Orthopedic Medical Health History Form

PLEASE COMPLETE ALL PARTS OF THIS FORM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS

Name:_____ Age:_____ Date of Birth:_____ Sex: Male/Female

Regular Family or Medical Doctor if different than referring doctor information (Name, Address and Phone Number):

_____

_____

PAST MEDICAL HISTORY: Please circle if you have or have ever had, any of the following conditions –

High blood pressure	sleep apnea	seizure disorder	stomach problems	rheumatoid arthritis	bleeding disorder
Irregular heart beat	emphysema	depression	esophageal reflux	osteoarthritis	blood clots
Heart disease	lung disease	anxiety	ulcer disease	thyroid disorder	HIV/AIDS
Heart attack	pneumonia	stroke	liver disease	cancer – if yes, what type_____	
Heart failure	asthma	mental illness	hepatitis	adult diabetes – if yes, do you use insulin Yes/No	
Irregular heart beat	any prior problems with anesthesia		kidney disease	childhood diabetes – if yes, do you use insulin Yes/No	

List any medical conditions not listed above: _____

_____

PAST SURGICAL HISTORY: Please list ALL surgeries you have had with year and any complications –

_____ _____ _____

_____ _____ _____

MEDICATIONS: Please list ALL current medications you are taking, including dose take and how often –

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: Please list any allergies to medications that you have, with the type of reaction caused by the medication

_____

_____

SOCIAL HISTORY: Marital Status: _____ Education(years/degree):_____

Alcohol Use (type, amount):_____ Tobacco Use (amount, years used):_____

EMPLOYMENT: Occupation: _____ Date last worked it out of work: _____

PLEASE CONTINUE AND COMPLETE THE SECOND PAGE OF THIS FORM *PAGE 1*

PLEASE COMPLETE THIS PAGE AND SIGN THE FORM, IT IS VERY IMPORTANT TO PROVIDE DETAILED AND ACCURATE ANSWERS TO ALL OF THE QUESTIONS

FAMILY HISTORY: Please list age and health of parents, (if deceased, how), and any medical problems that run in your family –

Mother: _____ Father: _____

Family Health Problems: _____

REVIEW OF SYMPTOMS: Please circle if you have any of the following symptoms, and give a brief description –

Constitutional: fever, recent weight gain/loss, appetite problems_____

Eyes: double vision, blurring, difficulty seeing_____

ENT: deafness, sinusitis, hoarseness, dizziness_____

Cardiovascular: chest pain, palpitations, murmur, extra beats_____

Respiratory: shortness of breath, wheezing, cough, bloody cough_____

Digestive: abdominal pain, constipation, diarrhea, rectal bleeding_____

Urologic: pain with urinating, hesitant urination, bleeding, incontinence_____

Gynecologic: breast masses, pain, discharge_____

Are you sexually active? **Yes/No** Birth Control used if any? _____

Skin: persistent rashes or lesions, changes in moles_____

Neurologic: seizures, loss of balance/coordination, weakness, memory loss_____

Psychiatric: depression, anxiety, hallucinations, sleep disturbances_____

Endocrine: excessive thirst, excessive urination, heat/cold intolerance_____

Blood and Lymph: anemia, bleeding tendencies, swollen nodes_____

Allergic and Immunologic: hives, eczema, persistent itching_____

Musculoskeletal: (ONLY DESCRIBE PROBLEMS OTHER THAN THE PROBLEM YOU ARE BEING SEEN FOR TODAY)

Stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arms or legs, numbness/tingling_____

_____

Other problems not covered above:_____

PLEASE SIGN FORM HERE: Patient:_____ Date:_____

Physician:_____ Date:_____

PAGE TWO