

Peachtree Spine Physicians

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
City:	Sex:
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:
Email Address:	

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

ADDITIONAL INFORMATION

Primary Care Physician:	Pharmacy Name:
Phone:	Phone:
Fax:	Fax:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
<i>Complete information below, if applicable:</i>	
Attorney Name:	Adjuster Name:
Phone:	Phone:
Address:	Fax:
City/State/Zip:	Date of Injury:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or Peachtree Spine Physicians when they accept assignment.

Authorization To Release Medical Information. I hereby authorize Peachtree Spine Physicians to release any information necessary for my course of treatment.

Signed (patient or parent if minor)

Date



COMPANY POLICIES

CANCELLATION & NO SHOW POLICY:

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. In return, ***it is your responsibility to make every effort to keep your scheduled appointments and to arrive promptly at the time instructed.***

However, we realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least ***24 hours before your scheduled office appointment and 48 hours before your scheduled procedure*** to avoid paying a \$35.00 fee. This fee is **not** covered by your medical insurance or Worker's Compensation benefits. In an effort to see patients promptly at the scheduled time, this office does not double-book appointments; therefore, this notification of 24 or 48 hours is necessary so that we may schedule other patients needing immediate appointments.

The cancellation/rescheduling fee must be paid on or before your next scheduled appointment. Thank you for your attention to this matter.

Workers' Compensation patients, please note, we will need to notify your adjustor and/or Nurse Case Manager in the event that you cancel within 48 hours of your scheduled procedure. Also, please be aware that we do not back-date work excuse letters. If you are unable to go to work due to a work-related injury that we are treating you for you must see the doctor that day to receive a work excuse.

ADDITIONAL CHARGES POLICY:

The following services may be subject to additional fees:

Phone Consultations with our healthcare providers that are medically necessary to manage and coordinate patient care may incur a fee of \$25.00 when 5-10 minutes in length, \$50.00 when 11-20 minutes in length, and \$75 when 21-30 minutes in length.

Forms Completion for reasons such as FMLA, Disability Insurance, etc. may incur a fee of \$25 per page.

I hereby acknowledge that I have read and understand the above policies and I agree to abide by these guidelines.

Patient Signature

Date



MEDICATION AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help both you and your physician to comply with the law regarding pain-control medications.

I understand that this Agreement is essential to the trust and confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this Agreement.

I understand that if I breach this Agreement my physician will be forced to stop prescribing these pain-control medications.

I will communicate fully with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will safeguard my medication from loss or theft. **Lost or stolen medications cannot be replaced.**

I agree that only one physician may prescribe pain medications. If pain medications are received from other physician practices, our clinic will be unable to prescribe pain medications thereafter.

I agree that refills of my prescriptions for pain medication will be made only at the time of an office visit or during regular office hours.

Refills for pain medications will not be prescribed over the phone. You must come into the office and be evaluated by a staff member. No refills will be available during evenings or on weekends. It is very important to take the medication as prescribed so as to not run out of medications.

I authorize my physician and my pharmacy to cooperate fully with any city, state or federal law enforcement agency including this state's Board of Pharmacy in the investigation of any possible misuse, sale or other diversion of my medications. I authorize my physician to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to this Agreement and the medications presented for pain management.

I agree that I will use my medication as prescribed and that use of my medication at a greater rate will result in my being without medication for a period of time.

I agree to follow these procedures that have been fully explained to me. All of my questions and concerns regarding my medications have been adequately answered. A copy of this Agreement has been given to me.

Nothing herein shall be deemed to alter the discretion of my physician to use his best judgment in recommending treatment and medication options.

This Agreement is entered into on this _____ day of _____, _____.

Patient signature: _____

Witnessed by: _____

Physician signature: _____



Authorization For Use and Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Patient Address:	SSN:

By signing below, you hereby authorize us to use or disclose information about yourself(or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

Information may be disclosed to the following party/parties: _____

Information to be used or disclosed(must be identified in a specific and meaningful fashion); and purpose of the use and disclosure:

Clinical Notes, diagnostic reports, medications prescribed _____

Information that *may not be used or disclosed*:

The name or other specific identification of the person(s):
Peachtree Spine Physicians, Inc.

Expiration Date or an expiration event(must relate to the individual or the purpose of the use of the disclosure):

This information about you is to be protected under federal law, and you may have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign authorization.

Patient Signature or Personal Representative Date
As a personal representative, I have authority to act for the individual because I am: _____

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

Peachtree Spine Physicians would like to assure you of your rights and responsibilities as a patient.

You have the right to:

- Considerate, respectful & dignified care provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Personal & informal privacy, within the law.
- Information presented in a manner and form that you understand. You or an individual designated by you or a legally authorized person, have the right to be informed about your condition and the recommended procedures to be performed so that you can make the decision whether or not to undergo the procedure knowing the risks, benefits and alternatives. You also have the right to ask questions.
- Request information on formulating an advance directive.
- Appropriate assessment & management of pain.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns of your health.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Be able to participate or refuse to participate in any research without risk of compromising your right to access care, treatment and/or services.
- Know the identity & professional status of individuals providing service.
- Request a change in providers of care if other qualified providers are available.
- Request information on the financial aspects of provided services and after hour care provisions.
- Request a consultation at your own expense.

PATIENT COMPLAINT OR GRIEVANCE

Peachtree Spine Physicians will promptly review, investigate & resolve any patient grievances or complaints in a timely manner. If you feel you may have an issue, please contact the surgery center directly and ask to speak with the Office Administrator, Kerry Hobbs, at 404-843-3323.

Office of Regulatory Services
Department of Healthcare Resources
2 Peachtree Street, Suite 33.250
Atlanta, GA 30303-3142
404-657-6487

<http://ors.dhr.georgia.gov/prortal/site/DHR-ORS/>

Medicare Ombudsman
1-800-633-4227

www.medicare.gov

www.cms.hhs.gov/center/ombudsman.asp

PATIENT RESPONSIBILITIES

You are responsible for:

- Providing accurate complete information regarding your present health status (including past & present medications), past medical history.
- Inform the healthcare provider about any advance directive at (living will) at that might affect your care.
- Following the treatment plan recommended by the physician and discharge instructions provided by the nurse.
- Following the rules & regulations of the facility affecting patient care & conduct.
- Notifying the facility if unable to keep an appointment.
- Being considerate & respectful of the rights of other patients & facility personnel.
- Providing a responsible adult to transport you home after surgery & an adult to be responsible for you at home for the first 24 hours after surgery/anesthesia.
- Indicating whether you clearly understand a contemplated course of action & what is expected of you.
- Your actions if you refuse treatment leave the facility against the advice of the practitioner and/or do not follow the practitioner's instructions relating to care.
- Assuring financial obligations of your health care are fulfilled as expediently as possible.

ADVANCED DIRECTIVE

Peachtree Spine Physicians is not an acute care facility; therefore regardless of the contents of any advanced directive or instructions from a healthcare surrogate, if an adverse event occurs during your treatment, we will initiate resuscitative or any other stabilizing measures & transfer you to an acute care setting for further evaluation. Any information regarding current health care directives of health care power of attorney will be shared with the facility where you are transferred.

PHYSICIAN INVESTMENT

Peachtree Spine Physicians complies with federal HIPAA(Health Insurance Portability & Accountability Act) regulations to maintain the privacy of your health information.

ACKNOWLEDGEMENT

By signing this form I acknowledge written receipt of the Patient Bill of Rights prior to the day of the scheduled procedure and had an opportunity to ask questions.

Signature: _____

Date: _____