Please PRINT

MRN Date

PATIENT INFORMATION

Last Name First Name Middle Initial Nickname/AKA

Date of Birth Social Security Number Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other Language other than English

Race ☐ Native Hawaiian ☐ American Indian ☐ >1 Race ☐ Asian ☐ Pacific Islander ☐ Hispanic ☐ White ☐ Black/African American ☐ Prefer Not Reporting

Home Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

Email Address Employment Status ☐ Active Duty Military ☐ Child ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time ☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Other

Employer Employer Phone

PHYSICHIAN REFERRAL INFORMATION

Primary Care Physician Referring Physician

How did you hear about us? ☐ Employer ☐ Friend ☐ Magazine ☐ Physician ☐ Website ☐ Other ☐ Family Member ☐ Insurance ☐ News ☐ Yellow Pages

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Life Partner ☐ Other

Last Name First Name Middle Initial

Date of Birth Social Security Number

Home Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

Employer Employment Status ☐ Active Duty Military ☐ Child ☐ Disabled ☐ Employed Full-Time ☐ Employed Part-Time ☐ Homemaker ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Student Full-Time ☐ Student Part-Time ☐ Other

Employer Phone

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Last Name First Name Relationship to Patient

Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

OTHER CONTACT INFORMATION - NOT LIVINF WITH PARENT

Last Name First Name Relationship to Patient

Address Apt # City State Zip Code

Home Phone Work Phone Cell Phone

I hereby authorize payment of medical benefits directly to Infectious Disease Specialists of Atlanta, P.C, realizing I am responsible for all charges incurred. I authorize the release of any medical or other information necessary to process insurance claims.

Signature:_____ Date:_____

INSURANCE INFORMATION

Account No. _____ Date _____

Patient Name _____

Address _____

_____

_____

Date of Birth _____

Is this a work related injury? Yes ☐ No ☐

If YES, date of injury _____

Primary Insurance _____

Name of Insured _____

Insured's Date of Birth _____

Patient's Relationship to Insured _____

Insurance Address _____

_____

ID or Policy No. | Group No. | Primary Care Physician | Effective Date

Co-Payment $

Secondary Insurance _____

Name of Insured _____

Insured's Date of Birth _____

Patient's Relationship to Insured _____

Insurance Address _____

_____

ID or Policy No. | Group No. | Effective Date | Co-Payment/Ins.

Additional Insurance _____

Name of Insured _____

Insured's Date of Birth _____

Patient's Relationship to Insured _____

Insurance Address _____

_____

ID or Policy No. | Group No. | Effective Date | Co-Payment/Ins.

Financial Statement and Release of Information

I hereby authorize payment of medical benefits directly to Infectious Disease Specialists of Atlanta, P.C., realizing I am responsible for all charges incurred. I authorize the release of any medical or other information necessary to process insurance claims.

Signature: _____ Date: _____

Agreement of Financial Responsibility
&
Assignment of Benefits and Release of Information

Infectious Disease Specialists of Atlanta, PC

Responsibility for Payment:
I understand that I, personally, am financially responsible to Infectious Disease Specialists of Atlanta, 2665 North Decatur Road, Suite 330, Decatur, GA 30033 for charges not covered by the assignment of insurance benefits.

Assignment of Insurance Benefits:
I hereby authorize payment of medical benefits directly to the physician or supplier to cover the costs of the care and treatment rendered to myself or my dependent.

Medicare Benefits:
I certify that the information given by me in applying for payment under the Social Security Administration and the Centers for Medicare and Medicaid Services is correct. I authorize any holder of medical or other information about me to release any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Release of Information:
I hereby authorize and direct Infectious Disease Specialists of Atlanta, and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Collection of Fees:
I understand that in the event my account is placed in collection status, any additional fees incurred due to this will be added to my outstanding balance. I understand that these additional fees will be my personal responsibility.

_____ _____

Signature of Patient/Guardian **Date**

_____

Patient Name (please print)

INSURANCE, BILLING AND OFFICE POLICIES

Infectious Disease Specialists of Atlanta, PC

The physicians and staff of Infectious Disease Specialists of Atlanta, P.C. (IDSA) are committed to providing our patients with the best possible medical care. We also strive to minimize administrative and billing costs that would otherwise increase the cost of medical care to our patients. With these objectives in mind we developed insurance and billing policies that clearly outline the financial responsibilities of the medical provider and the patient. **We ask you to review these policies before treatment so that there will be no misunderstandings later.** The physicians and staff of IDSA firmly believe that a good physician-patient relationship is based upon clear communications and a mutual understanding of expectations.

We recognize that the process of filing medical insurance claims is complex, and we are ready and willing to help you with this process.

Insurance, Managed Care and Government programs:

- The physicians of IDSA contract with numerous insurance plans and managed health care programs, and our business staff take pride in their ability to respond to the challenges of working with so many constantly changing plans. As a courtesy to our patients, our business office submits claims directly to insurance companies for services rendered for patients who are members of these plans. However, we cannot provide this service unless the patient completes all necessary insurance information, including special forms, before leaving the office.

- If referrals are required by an insurance company before treatment can be provided, it is the ***PATIENT'S*** responsibility to obtain the necessary referral ***PRIOR*** to being treated. ***If a required referral is not obtained by the patient in advance of treatment, the insurance carrier may not pay the physician for the treatment. Therefore, the appointment may have to be rescheduled, or the patient may have to pay IDSA in full for the treatment received at the time of service and seek direct reimbursement from the insurance provider.***

- It is the patient's responsibility to pay any deductible, co-insurance or any portion of the charges as specified by the plan at the time of the visit. Co-payment must be made **before** the patient sees the physician or practitioner. Any medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of service.

- Insurance companies require us to ask the patient to present a photo ID and current insurance membership card at each visit. The federal HIPAA Privacy Rule also requires us to verify identity at each visit to protect the privacy of each patient's medical information.

- If IDSA is unable to verify the patient's eligibility for benefits under an insurance plan, payment in full will be expected at the time of service.

- The receptionist or billing representative may require documentation that a deductible has been met so that insurance will cover the cost of a visit. A recent "explanation of billing" from the insurance company verifying the deductible met or deductible remaining for the patient will usually be satisfactory as documentation.

- It is the patient's responsibility to provide us with current address and phone numbers as well as insurance information.

- It is the responsibility of IDSA business office representatives to answer patients' questions regarding how an insurance claim was filed. We are also responsible for providing additional information that an insurance carrier may need to process a claim. However, we are not able to explain specific coverage details for individual patients. This information can only be supplied by the insurance company's member services department. The telephone number for this department is listed on the insurance membership ID card.

- In an effort to save paper and our environment, a copy of your clinical summary will be saved in your electronic medical record. You will be provided a printed copy upon request.

Forms of Payment

- Co-payments and private payment for professional services can be made with cash, check, MasterCard, Visa or Discover.

- Patients who do not have insurance are expected to pay for treatment at the time of service unless prior arrangements have been made with us.

- In the event a patient is unable to pay the full amount due at the time of service, under certain circumstances IDSA will allow the patient/guarantor to complete a promissory note for payment. This note is a legal agreement to make payment within a maximum period of 12 months from the date of service. The minimum payment per month is $30.00. Failure to complete payment will be considered a breach of a legal agreement and will result in the account being turned over to a collection agency.

Please confirm that you have read and agree to these insurance and billing policies by signing here:

_____ _____

Signature of Patient/Guardian **Date**