MEDICAL REGISTRATION AND HISTORY FORM

Name of Primary Care Physician (PCP) _____ PCP Phone # _____

• Atlanta, GA 30309

Name of Referring Physician? _____ Phone # of Referring MD _____

Reason for your visit? □ bleeding □ colonoscopy □ constipation □ hemorrhoids □ itching □ pain - anal □ pain - abdominal □ warts

□ other _____

PATIENT INFORMATION

Social Security # (All digits required for scheduling) ---------- _____

Patient Name:

_____

Last First Middle Initial

Address _____

City _____ State _____ Zip _____

E-mail _____

Sex: □ M □ F Age _____ Birthdate _____

Ethnicity: □ Asian □ African Am. □ Hispanic/Latino □ White Other _____

□ Married/Partnered □ Widowed □ Single □ Separated/Divorced

Spouse/Partner name _____

Spouse/Partner Birthdate _____

Patient Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

PHONE NUMBERS

Home (____) _____ Cell (____) _____

Best time and place to reach you _____

May we leave detailed messages? □ No □ Yes (□ at home □ on cell)

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home (____) _____ Work (____) _____

INSURANCE

Who is responsible for this account _____

Relationship to Patient _____

Primary Insurance Co _____

Group # _____ ID # _____

Is patient covered by additional (secondary) insurance? □ Yes □ No

Subscriber's Name _____

Birthdate _____ SS# _____

Insurance Co _____

Group # _____ ID # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

name of insurance company(ies)

and assign directly to ATL Colorectal Surgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

signature of beneficiary, guardian or personal representative date

_____

please print name of beneficiary, guardian or personal representative relationship to beneficiary

MEDICARE/MEDIGAP AUTHORIZATION ONLY □ NOT APPLICABLE

I request that payment of authorized Medicare benefits and , if applicable, Medigap benefits, be made either to me or on my behalf to

_____

name of doctor or clinic

for any services furnished to me by that provider.

To the extent permitted by law. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____

signature print name

FAMILY HISTORY	Age(s)	Alive Y/N	Cancer Y/N (specify)	Colon Polyps Y/N	Cause of Death
MOTHER					
FATHER					
SIBLINGS					
CHILDREN					

HEALTH HISTORY - Please check (v') symptoms you currently have or have had in the past.

HEMATOLOGY:
- □ coumadin use
- □ aspirin use
- □ hypercoagulable state
- □ DVT/blood clots
- □ bleeding gums
- □ easy bleeding
- □ easy bruising
- □ anemia
- □ varicose veins

CONSTITUTIONAL:
- □ chills
- □ fever
- □ weakness
- □ fatigue
- □ weight change: loss/gain
- □ loss of appetite
- □ cancer (location _____)

DERMATOLOGY:
- □ itching
- □ psoriasis
- □ rashes
- □ moles - requiring removal
- □ eczema
- □ hives
- □ keloid formation
- □ skin cancer

MUSCULOSKELETAL:
- □ back pain
- □ muscle aches
- □ osteoarthritis
- □ rheumatoid arthritis
- □ muscle weakness
- □ joint pain/swelling
- □ sciatica
- □ osteopenia
- □ broken bones requiring surgery
- □ carpal tunnel syndrome

ENDOCRINOLOGY:
- □ thyroid disease
- □ diabetes
- □ polyuria (excessive urination)
- □ weight loss

NEUROLOGY:
- □ strokes
- □ migraines
- □ vertigo
- □ headache
- □ tingling/numbness
- □ seizures
- □ insomnia
- □ memory loss
- □ dizziness

OPHTHALMOLOGY:
- □ cataracts
- □ glaucoma
- □ nearsighted
- □ farsighted
- □ wear glasses
- □ wear contacts
- □ loss of vision

ENT/RESPIRATORY:
- □ shortness of breath
- □ pneumonia
- □ asthma
- □ emphysema
- □ tuberculosis exposure
- □ COPD
- □ hay fever
- □ cough
- □ bloody noses
- □ sore throat

CARDIOLOGY:
- □ chest pain
- □ hypercholesterolemia
- □ irregular heartbeat
- □ high blood pressure
- □ low blood pressure
- □ atrial fibrillation
- □ poor circulation
- □ murmurs
- □ palpitations
- □ dizziness
- □ mitral valve prolapse
- □ heart attack _____ (dates)
- □ stents placed _____ (date)
- □ aspirin use

GASTROENTEROLOGY:
- □ incontinence of stools
- □ peptic ulcer disease
- □ hiatal hernia
- □ incontinence of gas
- □ changes in stool size or texture
- □ bloating
- □ rectal bleeding
- □ anal fissure
- □ hemorrhoids
- □ excessive gas
- □ nausea
- □ heartburn or reflux
- □ vomiting
- □ difficulty swallowing
- □ irritable bowel syndrome
- □ abdominal pain
- □ diarrhea
- □ constipation
- □ change in bowel habits
- □ blood in stool
- □ colon polyps
- □ diverticulosis
- □ last colonoscopy date: _____

PSYCHOLOGY:
- □ depression
- □ tension/stress
- □ ADHD
- □ anxiety

GENITOURINARY MALE:
- □ abnormal anal PAP smear
- □ erectile dysfunction
- □ benign prostatic hypertrophy
- □ prostate cancer
- □ history of radiation
- □ urinary incontinence
- □ kidney stones
- □ difficulty urinating
- □ increased urinary frequency
- □ hernias
- □ kidney disease
- □ renal failure

GENITOURINARY FEMALE:
- □ urinary incontinence
- □ # of vaginal childbirths _____
- □ # of episiotomies/ vaginal tears____
- □ # of vacuum/ forceps deliveries ____
- □ renal failure
- □ kidney disease
- □ kidney stones
- □ fibroid uterus
- □ ovarian cyst
- □ endometriosis
- □ rectocele
- □ increased urinary frequency
- □ pelvic pain
- □ abnormal PAP smear
- □ last mammogram date: _____

INFECTIOUS DISEASE:
- □ chlamydia
- □ genital warts
- □ herpes
- □ HIV
- □ HPV (Human Papilloma Virus)
- □ syphilis
- □ gonorrhea

Height ___' ___" Weight _____ lb.

List prior surgeries & year performed:

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS / ALLERGIES

Current medications with dosages you are taking:

_____

_____

_____

List allergies to medications or substances:

_____

Pharmacy Name _____ Phone (____) _____

HEALTH HABITS

check (v') which you use and how much:

□ Caffeine _____

□ Street Drugs _____

Current Tobacco Use:
□ cigarettes □ cigars □ pipe □ chew

packs per day _____ # of years _____

Former smoker, year quit _____

SIGNATURES

I have received both the ATL Colorectal Surgery P.C. Policy & Procedures statement and the Policy for Access & Denial of Patient Request for Protected Health Information. I have been provided an opportunity to review them. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or insurance status.

Signature of beneficiary, guardian or personal representative Date

Please print name of beneficiary, guardian or personal representative Relationship to beneficiary

ATL Colorectal Surgery, P.C. welcomes you to its family of physicians and healthcare providers. We are pleased you have selected ATL Colorectal Surgery, P.C. to provide you medical care. Our goal is to provide consistent high-quality colon and rectal health care. This Policy and Procedures statement is intended to address questions you may have with regard to services rendered at our facilities or in the hospital setting by members of the clinic. Your questions and comments are welcomed. We look forward to a longstanding relationship with you consistent with these policies and procedures. We require all of our patients to read and sign the acknowledgment set forth below which we will maintain in your medical file. Failure to adhere to these policies may result in your dismissal from the practice. However, we look forward to a long and healthy relationship with you as our patient.

Business Hours/After-Hours/Weekends: Our office is open Monday through Friday from 8:30 a.m. to 5:00 p.m. After hours urgent or emergency messages can be left with the answering service by calling our usual telephone number, 404-574-5820. In order to receive a call from the on-call physician, you must disable your caller ID.

Appointments for Minors: Patients under the age of 18 who are not married or emancipated and who seek medical treatment for problems must have written consent of a parent, guardian or custodian and may require a co-signor in order to receive medical treatment.

Cancellations/Missed Appointments/Re-Scheduled Appointments: ATL Colorectal Surgery, P.C. endeavors to provide services to our patients at their scheduled appointment time. Your office appointment has been scheduled at your request and the allotted time has been reserved especially for you and your needs. We have reserved examination space, medical personnel, medical equipment and medical supplies for your visit. Therefore, a 48-hour advance notice is required for re-scheduling and/or for cancellations of office appointments. Failure to notify our office more than 48 hours in advance will result in a charge of $100.00, which is not covered by your insurance and is your responsibility to pay. If you arrive late for your appointment and this affects the next appointment, you may need to be rescheduled. If you are scheduled for surgery or colonoscopy, and fail to cancel more than five (5) business days before the procedure date, you will be charged $200.00, which is not covered by your insurance. Excessive abuse of scheduled appointments may result in discharge from the clinic. Cancellation fees must be paid in advance of rescheduling a missed appointment, an in-office and surgical procedure. To cancel any appointment made with the office, you must contact the office at 404-574-5820 to speak with a representative. Please note that we do not accept cancellations via email and/or patient portal (Healow). You may leave a voicemail message regarding the cancellation, but only with the following cancellation window of Forty-eight (48) hours for office appointment and in-office procedures and five (5) business days for surgical procedures.

Treatment Plan and Termination: Patients of ATL Colorectal Surgery, P.C. may establish a specific plan of treatment under the care and advice of their physician and with that physician's consultation. Your refusal to comply with your recommended treatment plan or the existence of a less-than-optimal physician-patient relationship or relationship with members of the medical staff may result in discharge from the clinic. However, we will never terminate our relationship during an emergency medical care situation, due solely to a diagnosis of any disease or condition, or merely because insurance coverage has been dropped.

Prescription refill requests: Prescription refills are done during normal business hours. Please do not wait until you are out of your medication. Refill requests will not be filled if you are overdue for an appointment or owe a significant balance on your account unless satisfactory arrangements are made with the Office Manager in advance. Please be sure to have the name and dosage of your medication as well as the pharmacy telephone number. Please check with the pharmacy to see if your prescription has been filled. All Colorectal Surgery, P.C. reserves the right to dismiss a patient making repeated demands for habit-forming drugs.

Copies of Medical Records: Medical records remain in the custody and control of the physician. Upon written consent, copies can be made and supplied to you or to whom you designate. You authorize us to include all information including your billing and payment history. Our office charges for copying medical records according to Georgia State Law guidelines. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all information included in your file.

Payment for Services: For your convenience, we accept cash, VISA, MasterCard, Discover, American Express, and personal checks with valid picture ID. If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered. Unless other arrangements are approved by our practice in writing, the balance on your statement is due and payable when the statement is issued, is past due if not paid within thirty days, and is subject to finance charges. If it is necessary for you to make payment arrangements at any time, please contact our business office at (404) 574-5820. It is specifically not our intent to ever have finances prevent you from getting the very best of medical care. If payment of our fees ever presents a problem, please discuss the matter with the Office Manager.

Initials_____ Date_____

Self-Pay Patients: All Colorectal Surgery, P.C. welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the Office Manager in advance of your visit to determine if a reasonable payment arrangement can be established between us.

Your medical insurance coverage: In order to accommodate the needs of our patients we have enrolled in numerous managed care insurance programs. Although we endeavor to maintain a current understanding of the insurance coverage provided by each insurance company, you are always in a better position than we are to ascertain the terms, conditions and limitations of your own insurance policy. Your insurance policy is a contract between you and your insurance company. We are **NOT** a party to that contract. We have no control over the terms of your insurance contract, and questions regarding your coverage should be addressed to your employer, insurance agent and/or your insurance company. You agree to pay any portion of the charges not covered by your insurance.

Prior to your initial visit with your physician, please confirm that he or she participates in and is a member of your personal insurance network by reviewing the insurance literature provided with your policy of medical insurance or by contacting your insurance agent, employer or insurance company. If the physician does not participate with your insurance plan, you may be responsible for payment of out-of-network charges, or all charges at the time of your visit. You will be provided a completed superbill listing all the pertinent information you will need to submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information: If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurance, or services that are not covered by your plan. For *ATL Colorectal Surgery, P.C*. to file your insurance claim, we must have the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. Please bring your insurance card to each visit so that we can confirm your coverage. A current copy of your card must be kept on file in order for us to file insurance claims on your behalf. If your submitted demographics are incomplete or incorrect at the time of registration and this leads to a denial of payment, you may be responsible for full payment of your bill. You may be asked to verify your current insurance coverage, sign a release of information, an assignment of benefits, and present your insurance cards at each visit. If you arrive without your current insurance card, we will be happy to reschedule your appointment. If you wish to be seen without your insurance card, you will be required to pay for the visit in full that day; you will not receive any insurance discounts or adjustments. You can request reimbursement directly from your insurance company, but you will not receive the entire amount that you paid us.

You are financially responsible for certain charges at the time of **EACH** office visit. You may be responsible for any, or all, of the following items:

1. **Co-Pay:** This is a set dollar amount (usually between $5 - $50) or a percentage (usually 10 -25% of total charges) that you are REQUIRED to pay at **EACH** office visit. Under your contract, your plan has required that you pay a portion of the discounted amount they pay us at the time services are rendered to you. This amount is called your co-payment. Your co-payment is not paid in addition to, but instead is subtracted from the fee your insurance company pays to us. Therefore, it has become necessary for us to adopt a policy to collect your co-payment at the time services are rendered. We are unable to bill you for your co-payment, as this further increases our expenses and is also in violation with your managed care plan requirements.

2. **Deductible:** Some plans require that you pay a certain dollar amount (a "deductible") before your insurance company will cover any medical expense.

3. **Co-Insurance:** This is the percentage of charges that you pay in addition to any deductible. For example, if insurance pays 80%, then you pay 20%. This amount will be collected at your visit.

Patient Payment Responsibility for Non-Covered Services: In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. For this reason, we can provide you a form letter to complete by contacting your insurance plan and verifying the specific coverage you have prior to your preventive health visit We may request payment for any known, non-covered services at the time of your visit: otherwise, they will be billed to you at a later date.

Managed Care: If you are enrolled in a managed care insurance plan (i.e., HMO), you must obtain any necessary referrals for our office before seeing the physician. You are responsible for obtaining any referral and/or preauthorization for services should your insurance company require them. Failure to obtain the referral and/or pre-authorization may result in a denial of payment from your insurance company. If your insurance company requires a referral and/or pre-authorization and you do not have one, you may not be seen for your scheduled appointment, or you will be responsible for full payment of your bill at the time of service.

Initials_____ Date_____

Medicare Patients: Your physician accepts Medicare assignment on covered Medicare charges. Payment for the 20% Medicare coinsurance amount, deductible, or any non-covered charges is expected at the time of service, unless you have supplemental insurance. Insurance will be filed with your supplemental carrier; however, any unpaid balances are expected to be paid by you within 60 days of filing the claim if the supplemental policy does not pay the clinic.

Surgery/Procedure Charges: If a procedure or surgery is scheduled, we will file your insurance claim and accept assignment on your behalf. However, you will be responsible for payment of any deductible, coinsurance and non-covered charges **PRIOR TO** entering the hospital. If the determined deductible or coinsurance is not paid within 7 calendar days prior to your surgery/procedure, the surgery/procedure may be cancelled or rescheduled

A period of 60 days will be allowed for your insurance company to pay your claim. After that time, we will look to you for payment. We therefore ask that you contact your insurance company 45 days after your surgery to assist in obtaining payment on your behalf. After we receive payment from your insurance company, we will notify you of any remaining charges not covered by your plan. Payment in full will be due within 30 days of receiving this notification. Any credit due to you will be promptly refunded.

Finance Charge: A finance charge will be imposed on each item of your account that has not been paid within thirty (30) days of the time the item or service was added to the account The FINANCE CHARGE will be computed at the rate of two percent (2%} per month or an ANNUAL PERCENTAGE RATE of twenty-four percent (24%}. The finance charge on your account is computed by applying the periodic rate {2%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $0.50.

Returned Checks: There is a fee [currently thirty dollars {$30}] for any checks returned by the bank. If your check is returned by the bank, we will no longer accept checks from you for payment. We will accept Cash, Visa, Discover, Mastercard, and American Express cards.

Refunds: **O**verpayments are refunded after all insurance claims are processed and the account is reconciled. Refunds are issued to the original payer once no balance remains and claims are finalized". Patients are encouraged to contact billing team for refund/overpayment concerns.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred and may include charges up to 50% of the bill. If we have to refer collection of the balance to a lawyer, you agree to pay all attorney fees that we incur including all court costs. If we have to refer your account to a collection agency, you will automatically be dismissed from our practice and have emergency services available to you for thirty days.

Waiver of Confidentiality: You understand that if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if the past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

We appreciate the confidence you have placed in choosing our practice for your colon and rectal care. During our association if you have any suggestions, questions, criticisms, or comments, or if you just want to thank us, please let us know. Please feel free to report to us any complaint that you have about our office. We will do our best to correct it. Above all, we are here to serve you with the finest medical care possible. Please help us to help you.

I have read and understand the ATL Colo rectal Surgery, P.C. Policy and Procedures. I agree to assign insurance benefits to ATL Colorectal Surgery, P.C. whenever necessary.

Signature of patient or responsible party	Print Name of patient or responsible party	Date