Patient's Full Name (Please Print)	SS#	Marital Status S M W D Sep	Sex M F	Date of Birth	Indicate if Student Part-time Full-time
Mailing Address (If a PO Box include street address)	City and State			Zip Code	Home Phone #
Patient's Employer	Business Phone #		Cell Phone #		
Spouse's Full Name	SS#	Date of Birth	Employer		Business Phone Ext.
Nearest Relative to Notify in Case of Emergency	Relationship		Phone #		
If Patient is a Child: Father's Full Name	SS#	Date of Birth	Employer		Business Phone Ext.
If Patient is a Child: Mother's Full Name	SS#	Date of Birth	Employer		Business Phone Ext
If Patient is a Child: Other Guardian's Full Name	SS#	Date of Birth	Employer		Business Phone Ext
Email Address of Guarantor					

Deductibles, co-payments, and co-insurance amounts are due AT THE TIME OF SERVICE.
Additional billing fees will apply for balances not paid at the time of service.
PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD(S).

PAYMENT POLICY

Stephens County Hospital Physicians Group files your insurance as a courtesy. It is your responsibility to verify that Stephens County Hospital Physicians Group participates with your particular insurance company and that your claim is paid. You are responsible for deductibles, co-pay, co-insurance and non-covered services. We accept cash, check and credit cards.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance company(s) be made to Stephens County Hospital Physicians Group for any services furnished to me. Regulations pertaining to Medicare Assignment of benefits apply.

I authorize any hold of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original.

I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)
I have read the above and understand my obligation regarding the payment policy and insurance authorization and assignment.

Signature ______________________________ Date:

Financial Policy

Thank you for choosing Stephens County Hospital Physicians Group as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, we are available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the new patient information forms prior to seeing the physician. As the responsible party, please understand:

1. Fees for services are due at the time of service. This may include prior fees, unpaid balances, deductibles, co-insurance amounts and co-pays. If you are not covered by insurance, then you will be offered a 25 percent discount if you pay in full at the time of service. We accept cash, check, VISA and MasterCard.

2. As a courtesy to you, it is the policy of Stephens County Hospital Physicians Group to bill your insurance carrier. However, your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance and their determination of "usual and customary" charges. As your medical provider, our relationships with the insurance companies are as independent contractors, which require us to supply factual information to facilitate claims processing.

3. All charges are your responsibility. Unless we are obligated by our contract with the payer to adjust our charge then the non-reimbursed amount will be due in full from you. If a payment is made directly to you for services billed by Stephens County Hospital Physicians Group, you recognize the obligation to promptly remit payment to Stephens County Hospital Physicians Group.

4. With your signature below, you understand and agree that if you fail to make any of the payments for which you are responsible, in a timely manner; after such default and upon referral to a collection agency or attorney by Stephens County Hospital Physicians Group, you will be responsible for all costs of collecting monies owed, collection agency fees, and attorney fees.

5. Workers' compensation claims are guaranteed by your employer. However, as a workers' compensation patient you may be held responsible for charges in the event that your claim is overturned or denied by your employer.

6. Motor vehicular accident claims will be established as cash accounts until complete and active insurance claim can be established. Customer service representatives will be responsible for the management and the thirty day administrative review of these claims. Should your med/pay benefits be exhausted and/or if the claim is filed past its timely filing requirement for your health insurance then you will be held responsible for these claims.

At Stephens County Hospital Physicians Group, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problem to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (706) 282-4200 and ask to speak to someone in our Business Office.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW:

Printed Name of Patient: $[[FN]]　　　　Account #: $[[PID]]

Signature of Patient or the Responsible Party　　　　Date

Patient Consent Form

Patient Consent for Use/Disclosure of Health Care Information

Patient's Name: **$[[FN]]** Date of Birth: **$[[DOB]]**

SSN: ______________________ Previous Name: ______________________

I understand that the patient's health information is private and confidential. I understand that Stephens County Hospital Physicians Group works very hard to protect the patient's personal health information.

I understand that Stephens County Hospital Physicians Group may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

Stephens County Hospital Physicians Group has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Stephens County Hospital Physicians Group may update this "Notice of Privacy Practices". If I ask, Stephens County Hospital Physicians Group will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Stephens County Hospital Physicians Group to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Stephens County Hospital Physicians Group does not have to agree to my request. If Stephens County Hospital Physicians Group does agree to my request, I understand that Stephens County Hospital Physicians Group would follow the agreed limits.

I give permission to Stephens County Hospital Physicians Group to contact me by e-mail, phone and leave phone messages on my answering machine or voice mail. These phone calls and/or messages may be in regard to my appointments, status of health or financial standing, but are not limited to these topics.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Stephens County Hospital Physicians Group can give me called "Revocation of Consent for Use and Disclosure of Health Care Information", or

2. Writing, signing, and dating a letter to Stephens County Hospital Physicians Group. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Stephens County Hospital Physicians Group does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Stephens County Hospital Physicians Group's "Notice of Privacy Practices". My signature means that I agree to allow Stephens County Hospital Physicians Group to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

____

Patient or legally authorized individual signature **Date** **Time**

____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

North Georgia Orthopaedics
58 Big A Road
Toccoa, GA 30577

CONSENT FOR DISCLOSURE TO FAMILY MEMBER(S) AND/OR PERSONAL REPRESENTATIVE

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission to Stephens County Hospital Physician's Group, the physicians and staff, to disclose my personal medical information to the following individual(s):

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Name: ______________________________ Relationship to Patient: ____________________

Conditions for Disclosure **(Please check item(s)** that apply:

____ The practice may disclose my personal health information and account balance to the individual(s) above, only in my presence.

____ The practice may disclose my medical information and account balance to the individual(s) listed above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: ____

Date of Signature: ____

** North Georgia Orthopaedics is an affiliate of Stephens County Hospital Physicians Group