Patient Information Form

Thank you for choosing Bowers Family Medicine. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Have you previously been a patient of Dr. Bowers? Yes / No (Please Circle One)	Marital Status: Single / Married / Widowed (Please Circle One)
Patient's Legal Name	Social Security Number
Date of Birth	Address City State/Zip
Home phone	Work phone
Mobile phone and/or pager	Email address
Employer	Occupation
Primary Insurance Information (*see your insurance card*) Company___________________________________ ID/Member #______________________________ Group #____________________________________ Effective date_____________________	Secondary Insurance Information (*see your insurance card*) Company___________________________________ ID/Member #______________________________ Group #____________________________________ Effective date_____________________

If patient is a minor, please name responsible party:____

DOB:______________SSN:__________________Address:____

Is the patient covered under another person's policy? Yes / No

If yes, please describe the patient's relationship to the policyholder: Spouse / Child / Grandparent / Other:___________________

Policyholder's Name	Social Security Number
Date of Birth	Address
Home phone	Work phone
Mobile phone and/or pager	Email address
Employer	Occupation

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R. Edward (Ted) Bowers, II, M.D.
PO Box 606 · 3824 S. Hwy. 27
La Fayette, GA 30728
Phone: (706) 639-9055 · Fax: (706) 639-9057

Release of Medical Information and Insurance Assignment Form

Patient Name: ______________________________ Date of Birth: ______________

TO MY PHYSICIAN AND INSURANCE CARRIER(S) FOR INSURANCE AND SELF-PAY PROCESSING OF CLAIMS:

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits directly to my physician(s).
3. If I am a participant in a preferred provider arrangement or a member of a health management organization, I authorize the release of my medical information for utilization reviews and such other procedures as provided by the plan.
4. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
5. I agree that a photocopy of this form may be used in lieu of the original.
6. I understand that unless I am a participant in a preferred provider arrangement or health management organization, which may limit my liability, I am personally responsible for the payment of all charges that occur as a result of my medical treatment. I also understand that even if I am a participant in a preferred provider arrangement or health management organization, I still may be personally responsible for the payment of all charges that occur as a result of my medical treatment. Further, if it is determined through the Utilization Management review under such plan that any medical services that any medical services that I hereafter receive are not covered under the plan, I agree that I am personally responsible for the payment of the charges that occur of said medical services, and I agree to pay the charges for said services.
7. I authorize any holder to bill Medigap-covered services.

______________________________ ______________

Patient (or person authorized to sign for patient) Date

MEDICARE LIFETIME AUTHORIZATION (TO BE SIGNED BY MEDICARE RECIPIENTS):

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier and information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

______________________________ ______________

Patient (or person authorized to sign for patient) Date

CONSENT TO TREAT:

I (or my legal guardian or parent) authorize Bowers Family Medicine to provide care reasonable by today's standards.

______________________________ ______________

Patient (or person authorized to sign for patient) Date

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PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ____________________________________ Date of Birth: ____________

As required by the Privacy Standards of the Health Insurance Portability and Accountability act of 1996 (HIPPA) I have received a copy of the Notice of Privacy Practices of Bowers Family Medicine on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Bowers Family Medicine.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

PRIVACY COMPLIANCE OFFICER
PO BOX 606
3824 S. HWY 27
LAFAYETTE, GA 30728
PHONE: 706-639-9055 FAX: 706-639-9057

____ ________________________
Patient (or person authorized to sign for patient) Date

THIS SPACE TO BE USED BY PRACTICE PERSONNEL ONLY

Patient signed acknowledgment of Notice of Privacy Practices: Yes No (Circle)

If refused to sign, document reason in chart:____

Signed acknowledgment documented in computer: Yes No (Circle)

Name and initials of employee documenting same:____

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APPOINTMENT CANCELLATION AND NO-SHOW POLICY

Patient Name: ____Date of Birth: _____________

Bowers Family Medicine is always happy to work with you to address your health care needs. In order to provide timely scheduling for our patients, we respectfully request that you observe the following:

New & Established Patients:

- Please provide at least 24 hours notice prior to the cancellation of an appointment. **Failure to keep any scheduled appointment will result in a $30.00 no-show charge to your account.**

- If you are more than 15 minutes late for your appointment, you may need to be rescheduled to another day so that we may preserve the scheduled appointments of our other patients. In the event you are running late, please call our office as soon as possible to determine if an appointment is still available.

We greatly appreciate your compliance with our office policies and assistance accommodating our patient scheduling needs. Please sign below that you have read and acknowledge the above information provided to you. We are happy to provide copies of this and any other office policy upon your request.

____ _________________________
Patient (or person authorized to sign for patient) Date

____ _________________________
Witness Date

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FINANCIAL POLICY AGREEMENT

Your complete understanding of your financial responsibilities is essential. Teamwork, which includes patient participation, is required to succeed with insurance processing and reimbursement. If the insurance company fails to pay, it is the patient's responsibility to pay the balance.

When you receive healthcare services from us and we bill your insurance, it is the same as us extending you credit. You receive the service and we await payment from you and/or your insurance company. Due to high costs of rendering care and decreasing reimbursements by many insurers, including Medicare, we cannot carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency unless prior payment arrangements have been made.

Our practice policy requires all patients to sign the financial policy agreement prior to any services being rendered.

Co-pay and co-insurance:
We are obligated to collect your co-pay at the time of your visit. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy. If you receive two different types of services on the same day, you will be asked to pay two co-pay amounts, if required by your insurance plan.

All payments are due at the time of service.

Laboratory, radiology and other diagnostic service bills:
Please check with your insurance company to verify what your schedule of benefits allows for any laboratory, x-ray or other diagnostic studies (bone densitometry, mammogram, etc.) that may be ordered by the doctor during you visit. These services will be billed separately by the laboratory/diagnostic facility that does these tests and are not covered by the payments that you make at this office. Any insurance claims or problems associated with an off-site laboratory must be dealt with through that facility or their billing agent.

Outstanding balances/collections:
Prior to providing additional services to you, payment in full of total outstanding balances will be required. Outstanding balances that are not paid after a reasonable request will be referred to an outside collection agency.

Returned check:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to either: 1) $35.00 Service Charge or; 2) 5% of the face amount of the instrument, whichever is greater in accordance with O.C.G.A. 13-6-15. Once notice is

received of the returned check, Bowers Family Medicine will notify the Responsible Party by letter of the returned check. If a response is not made within 10 days from the letter date by the Patient or Responsible Party, Bowers Family Medicine may file a civil suit against the Patient for two times the amount of the check or instrument, but in no case more than $500.00, in addition to the payment of the check or instrument plus any court costs incurred by Bowers Family Medicine in taking the action.

Refunds:
Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full.

FMLA and other disability paperwork:
There is a charge of $25 per form, payable prior to these forms being completed. Please allow the office ten (10) business days in which to review your medical record for the information requested, complete the form, and mail, fax, or copy the form.

Collection fees:
Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the Patient's Responsible Party understands they are responsible for any and all costs of collection including, but not limited to, prejudgment interest in accordance with the law, court costs and reasonable attorney's fees calculated as 15% of the principal and interest owing at the time of collection in accordance with O.C.G.A 13-1-11. The patient further agrees to pay a liquidated collection fee in the amount of $50.00 in addition to the aforementioned costs and fees.

This agreement shall be governed exclusively by the laws of the state of Georgia.

I understand and agree to Bowers Family Medicine’s Financial Policy.

____
Patient (Print Name)

____
Patient’s Printed Name (or person authorized to sign for patient)

____ ________________
Signature of Patient (or person authorized to sign for patient) Date

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POLICY ON NARCOTIC DRUGS FOR NEW PATIENTS

Patient Name: ____ Date of Birth: _____________

Bowers Family Medicine does not prescribe or refill any narcotic medications for pain, anxiety, weight loss, or Adult Attention Deficit Disorder. These medications include, but are not limited to, the following:

- Adipex
- Alprazolam
- Ativan
- Avinza
- Carisoprodol
- Clonazapam
- Darvocet
- Demerol
- Diazepam
- Dilaudid
- Duragesic
- Fentanyl
- Hydrocodone
- Klonopin
- Librium
- Lorazepam
- Lorcet
- Lortab
- Mepergan
- MS Contin
- Norco
- Oxycontin
- Percocet
- Percodan
- Phentermine
- Provigil
- Redux
- Soma
- Stadol
- Tylenol # 3
- Tylenol w/Codeine
- Tylox
- Valium
- Vicodin
- Vicoprofen
- Xanax
- All Attention Deficit Disorder medications (applies only to patients age 18 and over)

I acknowledge notification that Bowers Family Medicine will not provide prescriptions or refills for any narcotic medication. I understand that my choice to continue or initiate these medications will require me to make arrangements with the original prescriber or another provider for management of these medications.

____ _____________________________
Patient (or person authorized to sign for patient) Date

____ _____________________________
Witness Date

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