Atlanta Obstetrics & Gynecology Associates

Atlanta Location
275 Collier Road NW, Suite 100C
Atlanta, GA 30309

Brookhaven Location
3925 Peachtree Rd, NE, Suite 240
Atlanta, GA 30319

Phone: 404.355.0320 Fax: 404.351.0909

Patient Information Sheet

Patient Name: _____
Last First Middle Maiden

DOB: _____ SS# _____

Driver Lic# _____ Marital Status: _____

Address: _____
Street Apt #

_____
City State County Zip

Phone: Home _____ Work _____

Cell _____ Primary (Main Contact Number): _____

Fax _____ Pager _____ EMAIL _____
Please give a private email address

Where can we leave a message? ☐ CELL ☐ HOME ☐ WORK ☐ NONE

Employer : _____ Hire Date _____

Occupation _____ Phone/Ext _____

Spouse/Partner Name: _____

DOB: _____ Phone: _____

SS#: _____

Emergeny Contact Name: _____

Tel# _____ Relationship _____

Ins. Company _____ Policy Holder _____

Relationship _____ DOB: _____

SS# _____ Policy Holder's Employer _____

Occupation _____ Tel# _____

Policy # _____ Group # _____

Secondary Ins.Company _____ Policy Holder _____

Relationship _____ DOB: _____

Policy # _____ Group # _____

_____ _____
Signature Date

Atlanta Women's Healthcare Specialists, LLC

275 Collier Road, NW Atlanta, Georgia 30309

FINANCIAL POLICY

Patient Name: _____
(Please print)

Atlanta Women's Healthcare Specialists (AWHS) providers are committed to meeting your health care needs! We are pleased that you have chosen us. Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit. Postdated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, I will be notified of the payment amount and due date.
3. I am responsible for payment of charges for services I receive from AWHS office. As a convenience, this practice will submit claims for reimbursement with your insurance provider; however all payment responsibility is ultimately yours.
4. In accordance with your insurance member handbook, it is my responsibility to provide accurate insurance information and to present my insurance ID card at the time of my visit. If I do not have insurance or do not present a valid insurance card, I will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is my responsibility to ensure that AWHS physicians are in your insurance network.
6. If my plan requires a referral, it is my responsibility to obtain this prior to being seen by our provider.
7. It is my responsibility to notify the office of any changes in my mailing address, phone number(s), email, and insurance information.
8. Failure to divulge or misrepresent all active insurance policies to the practice will result in the full charge amount being your responsibility.
9. Cancellations for appointments and procedure must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
10. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.
11. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or check for services rendered at the time of service.
12. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan.
13. I understand that my signature and payment information will be maintained on file digitally for payment plan arrangements with the practice. The applicable payment card or check information will be truncated & "tokenized" by the payment agent in order to help maintain the security of my payment information. Credit card or check information will be obtained through a card swipe, manual entry, voided check, or orally in person or over the phone. I authorize AWHS and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, medical record requests, including (i) amounts agreed as part of a payment plan, (ii) copays, (iii) coinsurance, (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation, or returned check fee.
14. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive monthly statements for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying interest on the balance.

15. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
16. I authorize AWHS and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

Fees

1. The returned check fee is $30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charges a $50.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. No more than 5 pages may be faxed. *We strongly discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.*

Administrative Services

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of $15.00 per office visit for Gynecologic visits and $75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers all forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE**; however, if you choose not to pay the fee there is a $20.00 charge for **each** required Administrative Service, payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

_____ (Initial) I accept the Administrative Service Fee. I will pay $15.00 per visit. (GYN)

_____ (Initial) I accept the Administrative Service Fee. I will pay $75.00 today. (OB per pregnancy)

_____ (Initial) I decline the Administrative Service Fee. By declining the Administrative Service Fee. I understand that I will be charged $20.00 charge for each Administrative Service requested.

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialists, LLC, when insurance is filed on my behalf.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature _____

Date _____

AOG

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PHYSICIANS:
H.M. McFarling, III, MD, FACOG
Deborah S. Lee, MD, FACOG
Jacqui Fisch, MD, FACOG
Mimi Vanoyan, MD, FACOG
Peter J. Barratt, MD, FACOG
Jayasri Bukkapatnam, MD FACOG
Laura Almquist, MD

CERTIFIED NURSE MIDWIFE
Judith Cox, CNM

CERTIFIED NURSE PRACTITIONERS:
Mariae Kilroy, RNCNP
Susan Whitlock, RNCNP

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, acknowledge that I have read a copy of the Notice of Privacy Practices of Atlanta Obstetrics & Gynecology Associates, a Division of Atlanta Women's Healthcare Specialists, LLC.

_____ _____

Signature of Patient Date

Atlanta Obstetrics & Gynecology Associates
A Division of Atlanta Women's Healthcare Specialists, LLC

Patient Name:_____ Date of Birth:_____ Date:_____

Atlanta Women's Healthcare Specialist, LLC is participating in the U.S. Department of Health and Human Services' " Meaningful Use" program in order to provide better patient care. This program will lead to improved electronic communications and easy access to your medical records. As part of this program, we are required to collect specific patient information such as race, ethnicity, and primary language. If you prefer not to share this information, please feel free to choose the decline option.

Please choose one from each section.

Race:

- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian/Pacific Islander
- ☐ Multiracial
- ☐ White
- ☐ Unknown/Unsure
- ☐ Decline

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown/Unsure
- ☐ Declined

Preferred Language:

- ☐ English
- ☐ Other (List preferred language):_____

AOG

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Jayasri Bukkapatnam, MD FACOG
Sharon L. Rubin, MD, FACOG

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Judith Cox, CNM

CERTIFIED NURSE PRACTITIONERS:
Mariae Kilroy, RNCNP
Susan Whitlock, RNCNP

Authorization to Release Information For Purposes of Short Term Disability and/or FMLA

Date _____

Patient _____
(please print)

DOB _____

Address _____

_____

Phone _____ _____
(home/cell) (work)

To Whom It May Concern:

This will serve as authorization for Atlanta OB/GYN Associates to release my medical information to my employer and/or disability company relative to my request for leave under FMLA and/or short term disability benefits.

This authorization will be valid for a period of one (1) year.

Patient Signature _____