Northcrest Family Medicine
7768 Cumming Highway, Suite 300,
Canton GA 30115
PHONE 770-720-2113, FAX 770-704-7365

Patient Name:		
Mailing Address:		
Best Contact Phone:	**Secondary Phone:**	**Work Phone:**

Date of Birth:	**Marital Status:**
Social Security Number:	**Email Address:**
Employer Name:	**Address:**
Emergency Contact Name:	**Phone Number:**
Relationship:	
Responsible Party:	
Responsible Party Address:	
Primary Insurance:	**Phone Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**

Secondary Insurance:	**Phone Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**
Subscriber Name:	**Date Of Birth:**
Subscriber ID:	**Group Number:**

Do you have a *LIVING WILL* or *ADVANCE DIRECTIVE*?	***YES or NO***

Pharmacy Name:	**Pharmacy Number:**

I hereby authorize you to release any information, including the diagnosis and record of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me directly to Northcrest Family Medicine. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependent.

_____ _____

Patient's Signature (Parent's signature if patient is under 18) Date

The Doctors and Staff of Northcrest Family Medicine Want You to Know We Will Protect Your Family's Private Health Information

When you visit our office, it is very important that you feel safe in telling our providers and staff personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted in us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act (HIPAA).

The HIPAA rules require that our practice provide all our patients that we see after April 14, 2003 with the Notice of Privacy Practices. The Notice describes how the medical information we receive from our patients may be used or disclosed by our practice and patient's rights to access this information.

Thank you for your cooperation.

I acknowledge that I have been given the opportunity to receive a copy of the Northcrest Family Medicine Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name: _____

(Please Print)

Patient Signature: _____ Date_____

(If Patient is a minor the signature of a Parent/Guardian is required)

Relationship to Patient_____

Northcrest Family Medicine
7768 Cumming Hwy, Ste 300
Canton, GA 30114
770-720-2113
770-704-7365 fax

REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone # _____ Fax # _____

The following individual has asked that his/her medical records be released and forwarded to our office:

Patient Name: _____

Birth Date: _____ Social Security Number: _____

Please be sure to include X-ray films and reports.

Thank you for expediting this request. Please send these records to our office address shown above.

Patient Authorization

I hereby authorize the release of all my medical records to Northcrest Family Medicine

please forward them as soon as possible.

Patient's Signature: _____ Date_____
(Parent or guardian if patient is a minor)

Patient's Address: _____

City: _____ State: _____ Zip: _____

NORTHCREST FAMILY MEDICINE

PATIENT INFORMATION RELEASE FORM

Patient Name: _____ **DOB:** _____

Patient Address:

Street: _____

City: _____ **State:** _____ **Zip:** _____

Patient Phone #

Home: _____ **Cell:** _____ **Work:** _____

☐ **I do not want my medical information to be discussed with anyone other than myself.**

☐ **Medical information and/or test results can be given to the following person(s).**

1. Name: _____ Relationship to patient: _____

   Home # _____ Cell #_____

2. Name: _____ Relationship to patient: _____

   Home # _____ Cell #_____

*Leave telephone message on recorder concerning the following (write yes or no):

Prescriptions: _____ Test results: _____ Referrals: _____ Appointments: _____

Patient or Guardian Signature: _____

Date: _____ Office Witness: _____

CONSENT TO TREAT AND FINANCIAL POLICY

Thank you for choosing Northcrest Family Medicine as your health care provider. In an effort to keep patients informed about our policies, we ask that all patients **read and sign** a copy of the financial policy prior to receiving treatment. Below you will find the requirements as they pertain to **insurance billing and patient payment requirements.**

PAYMENT is expected at the time of check in. This includes all deductibles, coinsurance, and co-payments. Patients who have no insurance carrier with whom the practice has a valid contract will be responsible for all fees of service.

INSURANCE is filed for all primary carriers. Secondary or supplemental insurance is filed as courtesy. We allow 30 days for insurance processing. Please remember that it is the patient's responsibility to know the benefits/ coverage of their own individual plan.

RETURNED CHECKS will result in a $25.00 service charge. The check amount plus the service charge is to be paid within 10 days on notification. Failure to pay in full in 10 days will result in collection through the magistrate court.

STATEMENTS are sent to update patients as to the status of their account and whether the insurance company has fulfilled their obligation to you, the policy owner, to pay claims in a timely manner.

DELINQUENT ACCOUNTS are placed for collection 90 days from the date of service was rendered. Patients having financial difficulties are encouraged to discuss them with our financial counselor **before** the account has a delinquent.

NO-SHOW POLICY- We will make every effort to give you a reminder call at least 24 hours prior to your appointment; however in order to accommodate our other patients with appointments we request that you cancel at least 24 hours before your appointment. Failure to show up for your appointment without notification will result in a $35.00 fee which must be paid **before** your next appointment is scheduled.

FORM FEE - If you have forms that need to be filled out by our doctor without an appointment, there will be a $25.00 form fee that must be paid before completion of the forms.

I, hereby make assignment of all disability, medical and major medical insurance benefits payable to Northcrest Family Medicine. I understand that ***payment is expected at the time of check in*** and rendered unless prior arrangements have been made. I also, hereby make authorization for Northcrest Family Medicine to release and medical information necessary to execute an assignment of benefits. ***I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to my account.*** I further agree that in the event of non-payment, to bear the cost of collection, and/or the court cost and reasonable legal fees should be required.

By signing this form I give Northcrest Family Medicine consent for treatment and to obtain any medical records, including pharmacy history, necessary for treatment.

I have read the consent to treat and financial policy of Northcrest Family Medicine. I understand and agree to adhere to the policies as outlined.

_____ **Please Print Patient Name**

_____ **Signature of Responsible Party**

_____**Date** _____

Office Witness Signature and Date