Patient Demographics

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Social Security: _____

Physical Address: _____

Mailing Address (If Applicable): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: □ Single □Married □ Divorced □ Widowed Do you smoke? □ Yes □No

Race: _____ Ethnicity: _____ Religion: _____

How did you hear about our office? □ Facebook □ Google □ Family/Friend □ Doctor □ Other

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Relationship to Patient: _____ **Phone Number:** _____

I authorize Athens Healthcare for Women to leave medical information pertaining to my care or appointments by the following methods and will notify them when any information changes.

□ Home Phone □ Cell phone □Email

Please name all persons with whom medical care and information can be discussed.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Patient Signature: _____ Date: _____

Patient Demographics

Preferred Language: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Employer: _____

Job Title: _____ Employer Phone: _____

Insurance Information

Primary Insurance: _____

Insurance ID#: _____ Group Number: _____

Subscriber Name: _____ Subscribers Date of Birth: _____

Patients Relationship to Subscriber: _____

Secondary Insurance: _____

Insurance ID#: _____ Group Number: _____

Subscriber Name: _____ Subscribers Date of Birth: _____

Patients Relationship to Subscriber: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid to Athens Healthcare for Women, P.C. (AHW). I understand that I am financially responsible for any balance. I also authorize AHW to release any information required to process my claim(s).

Patient/Guardian Signature: _____ Date: _____

If under, please provide guardian contact information:

Name: _____ Relationship: _____

Date of Birth: _____ Phone Number: _____

Financial Policy

Thank you for choosing Athens Healthcare for Women, P.C. (AHW) for your OB/GYN care. This financial information was written to make you aware of our policies and what is expected at each appointment. Payment in full is due at the time of service. If you are unable to pay your co-payment at the time of service you will have to reschedule your appointment. For your convenience we accept cash, checks or credit card.

Appointments: Please arrive for your appointment minutes early and bring your most recent insurance card(s). If a co-pay is required or there is a balance on your account, it is to be paid at check in.

If you are more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.

It is your responsibility to verify that we are in network with your insurance and to obtain all required prior authorizations or referrals before your appointment. Failure to do so may result in you being responsible for 100% of the charges.

Please notify the receptionist of all changes in address, phone number or insurance.

Missed or Cancelled Appointments: Please make every effort to notify us as soon as possible if an appointment cannot be kept.

If you no show for more than 3 appointments you may be dismissed from our practice.

Payments and Collections: All Co-pays, co-insurance, deductibles and non-covered amounts are the insured/patient's responsibility. All co-pays and balances are required at check in. If you are unable to pay at this time, you may be required to reschedule your appointment.

Any amount not covered by the insured/patient's insurance is due within 30 days of date of service. Failure to pay balances may result in being sent to collections and discharged from the practice.

Any accounts unpaid after 90 days will be place to out outside collection agency. If this should happen, you will not be able to return to AHW for care.

Lab Fees: All Labs and Pap smears are billed by the lab. If you receive a bill for these services please contact the lab directly to pay or with any questions.

Refunds: Refunds will be processed approximately 30-60 days from the time of the established credit. Refunds of $50 or less will only be issued when requested by the patient. They will remain as a credit on your account to be used at future visits.

Financial Policy

Payment Guarantee: The undersigned agrees, whether signing as a patient or guardian, to guarantee payment of the account in accordance with the standard rates and terms of AHW. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where AHW has a specific contract with m PPO, HMO or third-party payor. I further understand that any balance remaining after my insurance approves or denies payment is my responsibility to pay, including any amount not paid by a secondary or supplemental insurance policy. In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (of both), I agree to be responsible for and pay, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collections fees, attorney fees, court costs, and contingent fees to collections agencies. AHW reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions.

The provider of service has the right to terminate services based on noncompliance of this agreement. If this occurs you will be notified by certified mail. You will be given 30 days to find a new physician. If you experience a medical emergency within the 30-day period, our physician will provide you with his/her services.

Release of Information: I hereby authorize AHW to release all medical information (including, but not limited to information relating to mental health evaluation and treatment, alcohol/drug abuse diagnosis and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists) to all my insurance carriers, other third party payors, including the Health Financing Administration (Medicare) or its agents, or the Social Security Administration, as may be required or requested for the processing of claims for insurance, social security, disability, or Workers' Compensation, or for other insurance purposes.

Authorization to Pay Insurance Benefits: I hereby authorize the payment of any insurance or other medical benefits directly to AHW.

THE UNDERSIGNED CERTIFIES THAT SHE HAS READ OR HAS BEEN READ THE FINANCIAL AGREEMENT, THAT SHE UNDERSTANDS THE FINANCIAL AGREEMENT, THAT SHE HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THAT SHE MAY HAVE CONCERNING THE FINANCIAL AGREEMENT, AND THAT SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THE FINANCIAL RESPONSIBILITY AGREEMENT.

Patient Name: _____ Patient Signature: _____

Guarantor's Name: _____ Relationship: _____ Date:_____

Consent to Diagnose and Treat A Minor

The parent(s) or guardian(s) accompanying a minor are responsible for providing valid insurance information for the patient as well as payment for the services rendered.

In compliance with HIPAA regulations, we are unable to discuss any details of the patients visits and are also unable to provide itemized bills for the patients unless otherwise specified by the patient.

I, _____ would like my child, _____, Date of Birth _____ to become a patient of Athens Healthcare for Women. I consent to her being treated for any gynecological and obstetrical conditions including, birth control, sexually transmitted diseases and pregnancy.

I understand that even though she is under 18 Athens Healthcare for Women is unable to discuss clinical information pertaining to the patient with anyone other than the patient unless otherwise documented.

Signature of Parent or Guardian: _____

Date: _____

I, _____ give permission for Athens Healthcare for Women to release information to _____.

Information to be released.

- ☐ Financial Information
- ☐ Appointment Information
- ☐ Clinical Information
- ☐ All information pertaining to me.

Patient Name: _____

Patient Signature: _____

Date: _____

Short-Term Disability and FMLA Authorization

Patient Name: _____

DOB: _____

Address: _____

_____

Phone: _____

Fax: _____

Start and end dates for leave: _____

This form will serve as an authorization for Athens Healthcare for Women to release my records to my employer and/or any disability companies relative to my Short-Term Disability or FMLA benefits.

Patient Signature: _____

Date: _____

Release of Records

Joshua Sepesi, M.D. and Jessica Swilley NP-C

1270 Prince Avenue Suite 308

Athens, GA 30606

706-552-1600

706-552-5370 Fax

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

_____ I authorize the physician/ facility listed below to release my records to Athens Healthcare for Women.

_____ I authorize Athens Healthcare for Women to release my records to the physician/ facility listed below.

Physician/Facility name: _____

Address: _____

Phone: _____ Fax: _____

I understand this authorization includes release of all medical records and protected health information.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____