

FAMILY PHYSICIANS OF EVANS, INC.

465 North Belair Road, Suite 1C, Evans, GA.

Office (706) 854-2160 Fax: (706) 854-2930

Last Name		First Name		MI	Maiden Name		Birth Date	Today's Date
Address					City		State	Zip Code
Home Phone	Work Phone	Cell Phone		Social Security #			Marital Status M W D S	Gender
Emergency Contact			Contact's Home Ph#	Contact's Work Phone		Contact's Relationship to Patient		
The office has permission to speak with the following:							PCP:	
The office can leave a message on my answer machine (Y or N)					How did you hear about the practice?			
The office can leave messages about appointments (Y or N) lab results (Y or N) referrals (Y or N)					<input type="checkbox"/> Newspaper <input type="checkbox"/> Phone Book <input type="checkbox"/> Mailer <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Physician <input type="checkbox"/> Prompt Care <input type="checkbox"/> Ask A Nurse <input type="checkbox"/> Other			

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name		First Name		MI	Relationship to Patient		
Address				City		State	Zip Code
Home Phone	Work Phone		Social Security #			Birth Date	Gender
Employer's Name			Employer's Address, Phone				

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Name			Insurance Name		
Claims Address			Claims Address		
City, State, Zip		Ins Ph. No.	City, State, Zip		Ins Ph. No.
Subscribers Name		Gender M <input type="checkbox"/> F <input type="checkbox"/>	Subscribers Name		Gender M <input type="checkbox"/> F <input type="checkbox"/>
Subscribers ID		Group No.	Subscribers ID		Group No.
Subscribers Birth Date		Effective Date	Subscribers Birth Date		Effective Date
Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			Patient's Relation to Subscriber: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		

I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for medical services. I understand it is my responsibility to see that pre-certifications and authorizations are completed for me and my dependents (Initials) _____. I understand it is my responsibility to know which facilities (for radiology, labs, and other procedures are in-network with my insurance. (Initials) _____ I understand I am personally responsible for any amount not covered by insurance for services rendered to myself and my dependents, whether this is due to deductibles, non-covered services or out-of-network situations. (Initials) _____.

HIPAA Patient Acknowledgement: I acknowledge that a copy of the Notice of Privacy Practices for Family Physicians of Evans has been available to me. I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature: _____ Date: _____

MEDICARE PATIENTS ONLY I also authorize any holder of medical or other information about me or my dependents to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payments of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. Signature: _____ Date: _____

I have read the above statements, have reviewed the above information for correctness, and have made any and all changes necessary. Signature: _____ Date: _____