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Dear Prospective Patient,

We greatly appreciate your interest in becoming a new patient with Family Physicians of Evans.

Please fill out the enclosed new patient packet and return it to us by fax, mail, or email.

In order to expedite the new patient process, please complete the following items:

- Include a copy of your photo ID and insurance card (both sides).
- Carefully review our policies prior to signing.
- If you prefer a certain physician, be sure to mark it on the next page.
- Be sure that your email is printed clearly on the next page.
- Visit www.fpevans.followmyhealth.com and sign up for the patient portal.

Once received, your paperwork will be sent to your requested provider for approval and you can expect a return phone call from our staff to schedule your appointment.

If you have any questions or need any assistance with this paperwork, give us a call and we will be happy to help.

Thank you for choosing Family Physicians!

New Patient Registration Form

Today's Date:	Reason for Visit:
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Requested Physician: Barinowski Harrover Hogue Merrill Mondt Schmidt

PATIENT INFORMATION

Full Name:	Birth Date:
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Social Security Number:	<input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:
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Address:

Race: African-American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander White

Ethnicity: Hispanic/Latino Not Hispanic/Latino Language: English Spanish Other

COMMUNICATION PREFERENCES

Home Phone:	Cell Phone:	Work Phone:
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Email Address: *(for statements and patient portal)*

How Would You Like To Receive Appointment Reminders? <input type="checkbox"/> Home Phone Call <input type="checkbox"/> Cell Phone Call <input type="checkbox"/> Work Phone Call <input type="checkbox"/> Text Message <input type="checkbox"/> Email	May we leave detailed voicemails? <input type="checkbox"/> Yes <input type="checkbox"/> No
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The office may speak with the following people about my healthcare:

EMERGENCY CONTACT

Name:	Relationship to Patient:
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Home Phone:	Cell Phone:	Work Phone:
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INSURANCE

YOU MUST SUBMIT PHOTO COPIES OF THESE CARDS (FRONT & BACK) WITH YOUR PACKET

Primary Insurance:	ID#:
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Secondary Insurance:	ID#:
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GUARANTOR INFORMATION

Name:	Relationship to Patient:
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Address:	Home Phone:
	Cell Phone:

By signing below, I am acknowledging the following:

- I have reviewed the information above for correctness and have made any and all changes necessary.
- 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 services.
- A copy of the Notice of Privacy Practices for Family Physicians of Evans has been made available to me on the website and in the office. I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Patient/Guardian signature	Date
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POLICIES

You will be asked to present your active and correct insurance card(s) at every visit. If your insurance policy has changed or is no longer active, you must notify staff at check-in prior to being seen. If you fail to do so, you risk being financially responsible for any services provided.

As a result of federal regulations on healthcare, insurance providers are shifting more financial responsibility onto you. Because of this shift, you may see an increase in the amounts that you owe for your healthcare. All copays, deductibles, and coinsurances are due at the time of service. If you dispute any copays, deductibles, or coinsurance charges that you owe, it is your responsibility to contact your insurance company as your coverage is a contract between you and your insurance company. We are unable to negotiate these fees on your behalf. It is your responsibility to know your plan including benefits, copays, deductibles, and coinsurances. You are responsible for knowing your preferred providers for labs, procedures, or specialist referrals. Unless otherwise notified, we will perform your labs in the office.

AT EACH VISIT, YOU WILL BE ASKED TO CHOOSE BETWEEN 2 PAYMENT OPTIONS:

OPTION 1: <u>CREDIT CARD ON FILE</u>	OPTION 2: <u>PAYMENT AT CHECK-OUT</u>
<p>At check-in, we will request a debit or credit card to place on file in our secure electronic system. You will sign an authorization for up to \$250 that allows us to charge your card for your balance after your visit. Once your insurance company has paid their portion, we will notify you VIA EMAIL that we will be processing your card for your portion in 3 business days.</p> <p>If you need to stop a payment, you must call the billing office as soon as possible to make arrangements. If you do not contact us and your card declines, we will charge a returned payment fee of \$30.</p> <div data-bbox="110 661 950 756" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <pre> graph LR A[Place a card on file at check in.] --> B[We file a claim to your insurance.] B --> C[Insurance tells us what you owe.] C --> D[We charge your card for your balance.] </pre> </div> <p>This is the preferred method of payment:</p> <ul style="list-style-type: none"> • Our system is secure and compliant with Payment Card Industry security standards. • Nothing is charged to your card at the time of service (except your copay). • You are only charged what you owe, not an estimated amount. • Your card can only be used for one date of service. We will not charge your card without your authorization and notification. 	<p>We will collect your copay at check-in. At check-out, we will calculate an estimate of your amount owed for the services you received.</p> <p><i>**If you have a deductible/coinsurance, you will be required to pay the full price for your visit. **</i></p> <p>We will file a claim to your insurance. If you still have a balance, we will EMAIL you a statement. Payment is due upon receipt. If you overpaid for your service, we will place a credit on your account for your next visit. If you do not have an upcoming appointment, we will issue a refund check. You may ask for a refund of your credit at any time.</p>
<p>If you refuse both options, you will be required to reschedule your appointment. Unfortunately, we are not able to make exceptions based on insurance or billing history.</p> <p>ALL STATEMENTS WILL BE DELIVERED VIA EMAIL. It is your responsibility to monitor your email and to be sure that the address we have on file is correct and up-to-date.</p> <p>We accept checks, cash, debit, and most major credit cards. We do have a returned payment fee of \$30 for any declined cards or checks.</p>	

BALANCES: If you owe a balance, you will be asked to clear your debt prior to being seen. If you are unable to do so, you will be asked to reschedule your appointments. We may make payment plan arrangements for eligible patients; you will need to contact the billing office to discuss your account. We use the services of an outside collection agency for delinquent accounts. If we turn your account over to collections, we will charge your account 25% to cover the costs incurred by the agency.

MINORS: All services rendered to minors will be the responsibility of the accompanying adult.

APPOINTMENT POLICY: We ask that you arrive 15 minutes prior to your appointment time. If you arrive more than 15 minutes late, you may be asked to reschedule your appointment. There is a \$50 fee for missed appointments. If you need to cancel or reschedule your appointment, please do so at least 24 hours prior to your appointment to avoid a late cancellation fee of \$50. Patients who do not respect our appointment policy and continue to arrive late or have a pattern of same-day cancellations or no shows will risk being discharged from the practice.

WORKMAN'S COMPENSATION: We are not a workman's compensation provider. If you are injured on the job, you must contact your employer for information on where to seek treatment.

ADMINISTRATIVE VISITS: In most cases, we will require an appointment for the completion of paperwork, including but not limited to the completion of forms related to pre-employment, school admission/attendance, sports participation, immunizations, and accidents/disability. If we determine this is not necessary, we will charge \$25.

MEDICARE PATIENTS: You authorize any holder of medical or other information about you or your 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 the assignment. Regulations pertaining to Medicare assignment of benefits apply.

Please initial each statement as an acknowledgement:

- _____ I must bring my current insurance card to every visit.
- _____ All copays, deductibles, and coinsurances are due at the time of service.
- _____ I must put a credit card on file or pay an estimate at each visit. If I refuse, I will need to reschedule.
- _____ I am responsible for checking my email for billing information.
- _____ It is my responsibility to know my benefits and preferred providers (for labs and other services)
- _____ I must arrive 15 minutes prior to my appointment time.
- _____ I must notify the office at least 24 hours prior to my appointment if I am unable to make it.

I have read and understand all of the above policies. I agree to be bound by their terms.

Patient/Guardian Signature

Date

Patient Name (Printed)

Date of Birth

HEALTH MAINTENANCE			
When was your last...	Date	Provider/Location	Results
Colonoscopy			
Pap Smear			
Mammogram			
PSA (Prostate Screen)			
DEXA (Bone Density Test)			
Eye Exam			
Pneumonia Shot			
- Pneumovax			
- Prevnar			
Flu Shot			
Shingles Shot			
Tetanus Shot			

FAMILY HISTORY

Do you have a family history of...	Who?	Do you have a family history of...	Who?
Breast Cancer <input type="checkbox"/> Y <input type="checkbox"/> N		Colon Cancer <input type="checkbox"/> Y <input type="checkbox"/> N	
High Cholesterol <input type="checkbox"/> Y <input type="checkbox"/> N		Prostate Cancer <input type="checkbox"/> Y <input type="checkbox"/> N	
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N		Osteoporosis <input type="checkbox"/> Y <input type="checkbox"/> N	
Heart Attack <input type="checkbox"/> Y <input type="checkbox"/> N		Anxiety/Depression <input type="checkbox"/> Y <input type="checkbox"/> N	
Heart Problems <input type="checkbox"/> Y <input type="checkbox"/> N		Psych/drug/alcohol problems <input type="checkbox"/> Y <input type="checkbox"/> N	
Stroke <input type="checkbox"/> Y <input type="checkbox"/> N		High Blood Pressure <input type="checkbox"/> Y <input type="checkbox"/> N	

SOCIAL HISTORY

Do you currently use tobacco? No, Never No, Former Smoker Yes, Cigarettes/Cigars Yes, Smokeless Tobacco

If you do use tobacco, how often/how much do you use? I am interested in quitting.

Do you drink alcohol? No Yes - How Much/Often?

Do you currently exercise? No Yes - Type of Exercise? How Often?

What is your marital status? Single Divorced Widowed Separated Married Engaged

Who lives with you in your home?

Do you have children? No Yes - What are their names and ages?

Are you employed? No Retired Yes - Where?

Do you attend religious services? No Yes - Where?

What are your hobbies?

How did you hear about our practice?

Do we currently see any of your family members? If so, what are their names?

Patient Name (Printed)

Date of Birth