Southern Family Medical Center
3736-A Mike Padgett Hwy.
Augusta, GA 30906

Patient Registration Form

Payment Policy:

- Outstanding balances are expected to be settled at check-in including co-pays. Payment plans are offered with a card on file for automatic deductions.
- Contracted insurance companies are billed as a courtesy. Any remaining balance for non-covered benefits, coinsurance and deductibles are your responsibility. Payment is expected within 30 days of your statement.

Appointment Policy:

- If more than 15 minutes late to appointment patient will be asked to reschedule or wait for next available appointment

EMPLOYMENT/ SCHOOL

Patient's Full Name: _____ **Date of Birth:** _____
Last First MI

Sex: ☐Male ☐Female **SS#:** _____ **Patient's Former Last Name:** _____

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

Home Phone: _____ **Cell Phone**: _____ **Email:** _____

Preferred Contact Method: ☐Home☐Cell☐Portal ☐Mail **Maritial Status:** ☐ Married ☐Single ☐ Minor ☐ Separted ☐Divorced ☐ Widow

Race: _____ **Ethnicity:** ☐ Not Hispanic ☐ Hispanic ☐ Other _____

EMPLOYMENT/ SCHOOL

If patient is a minor (17 years and younger) list occupation of Parent/ Guaradian and school for child.

Employer: _____ **Occupation:** _____

School: _____ **Work Phone:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

GUARANTOR INFORMATION

If patient is a minor (17 years and younger) list person financially responsilbe for minor.

Guarantor's Name: _____ **Relationship to Patient:** _____

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

Sex: ☐Male ☐Female **Home Phone**: _____ **Cell Phone**: _____

Date of Birth: _____ **SS#:** _____ **Guarantor's Email:** _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Policy#**: _____

Policy Holder Name: _____ **DOB**: _____ **Group#:** _____

Secondary Insurance Company: _____ **Policy#**: _____

Policy Holder Name: _____ **DOB**: _____ **Group#:** _____

Barcode

ELECTRONIC COMMUNICATION

Electronic Communication: For the convience of our busy families, Southern Family Medical Center uses e-mails and text messages to contact our patients. I understand the confidentiality of electronic communicatiions (e-mail,text messages, etc) cannot be guaranteed and Southern Family Medical Center is not responsible for the confidentialtiy or security of any message sent to or by me. If any of my contact information changes or at anytime I wish to revoke this consent, I agree to noficy Southern Family Medical Center in writing or in person.

Text Message for appointment confirmation and notifications: ☐ Yes ☐No
E-mail for appointment notifications and confirmations: ☐ Yes ☐No
E-mail for general account, insurance and/or billing questions: ☐ Yes ☐No

MEDICATION / IMMUNIZATION HISTORY CONSENT

By signing below I give permission for Southern Family Medical Center, PC to access my pharmacy benefits data electronically through Surescripts and Immunization history through the Georgia Registry of Immunization Transactions and Services (GRITS). This consent will enable Southern Family Medical Center, PC to:

- Determine the pharmacy benefits and drugs co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's health plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed / immunizations for patient by any provider.

In summary, we ask your permission to obtain prescriptions prescribed and any other pertinent formulary information by other providers using Surescripts or GRITS.

Print Name: _____ Signature: _____ Date: _____

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

I authorize the release of any medical or other information necessary to process all claims performed by Southern Family Medical Center. I also request payment of government and /or private benefits to myself or to the party who accepts assignment on this and all future claims. We are filing your insurance as a courtesy to you; therefore if your insurance fails to pay for any treatment on your behalf, you will be responsible for the balance due. By signing below, you agree to the above terms and conditions.

Print Name: _____ Signature: _____ Date: _____

HIPAA Notice

- You as a patient have a right under federal law to be assured of the privacy of your medical information.
- Southern Family Medical Center, PC operates under standard HIPAA Privacy practices; your medical records are kept in a secure location only accessible to your physician and their staff. We do not allow any third party to access your records for review or other purposes without your written consent.
- It is SFMC responsibility under federal law to maintain the security of your medical records.
- Your medical information will only be used to evaluate and treat your specific health problems. Some agencies may request certain information under the law without your consent (i.e. the courts, health department (For reportable diseases) and the police department).
- You may request or review your medical records, and to amend the information therein by submitting a written request. Your records will only be forwarded to a third party upon your written request (Office release of information form).
- I hereby acknowledge that SFMC will share my medical information, as permitted under federal law (H.I.P.A.A.) and Georgia state law, with my healthcare providers through a health information exchange.
- We may make your medical information available electronically through state, regional, or national information exchange services which help make your medical information available to other healthcare providers who may need access to it in order to provide care or treatment to you. Participation in health information exchange services also provides that we may see information about you from other participants

Contact our office at (706) 560-2273 regarding any questions pertaining to HIPAA. At you request we can provide a copy of the HIPAA Policy or you can view online at http://www.sfmcaugusta.com/.

I have read and understand and understand the above as required by federal law:

Print Name: _____ Signature: _____ Date: _____

Barcode