SOUTH FORSYTH FAMILY MEDICINE AND PEDIATRICS

PATIENT LAST NAME_____**FIRST**_____**M.I.**_____

ADDRESS _____**CITY**_____

STATE_____**ZIP**_____ **(HOME) PHONE**_____

(CELL) PHONE_____ **(WORK) PHONE**_____

SSN_____**BIRTHDATE**_____ **SEX** (Circle) MALE FEMALE

MARITAL STATUS (Circle) Single Married Divorced Separated Widowed Other _____

RACE (Circle) Asian African Am. Hispanic White Refuse Other _____

PREFERRED LANGUAGE_____ **ETHNICITY** (Circle) Hispanic Not Hispanic Refuse

EMAIL ADDRESS: _____

PHARMACY NAME: _____**PHONE NUMBER:**_____

PHARMACY LOCATION: _____

EMERGENCY CONTACT NAME: _____**PHONE NUMBER:**_____

RELATIONSHIP:_____

IF PATIENT IS UNDER 18 YRS OF AGE, COMPLETE THIS SECTION

FATHER'S NAME_____**DOB**_____**SSN**_____**PHONE**_____

ADDRESS:_____**CITY**: _____**ZIP**:_____

MOTHER'S NAME_____**DOB**_____**SSN**_____**PHONE**_____

ADDRESS:_____**CITY**: _____**ZIP**:_____

INSURANCE CARRIER_____**INSURED'S SSN**_____

MEMBER ID_____**GROUP #**_____

INSURED'S NAME_____**INSURED'S BIRTHDATE**_____

I voluntarily give consent to the providers of South Forsyth Family Medicine and Pediatrics for my medical treatment or my child's medical treatment. I fully understand that payment is required at the time of service and should my claims be filed to my insurance company, any unpaid balance is my responsibility. When necessary, I further authorize the release of medical records to my insurance company. In the event that the physician files to my insurance, I authorize benefits to be paid directly to the physician.

_____ _____

Signature **Date**

I consent to have messages regarding test results and appointment reminders left on the following:

Home voicemail Cellular voicemail Email Address

To whom may we thank for referring you to our practice? _____

SOUTH FORSYTH FAMILY MEDICINE AND PEDIATRICS

1845 Lockeway Drive, Suite 404

Alpharetta, Ga 30004

Phone: 770-343-9112; Fax: 770-343-8911

David S. Boaz, M.D. Mark Glodener, M.D. Giouzel Glodener, M.D.

*******FINANCIAL POLICY*******

The physicians and staff at South Forsyth Family Medicine and Pediatrics strive to provide the best care for you and your family. Our goal is to keep your financial arrangement as simple as possible by timely filing of claims and using the following guidelines

1. You are ultimately responsible for payment of charges for services received at our office. We will make every effort to file the charges through your insurance company, **but please note that some charges may not be covered through your insurance.**
2. During a routine physical, if non-preventative information is discussed or conditions are found which need to be addressed, then **copay or deductible may apply.**
3. A fee of **$30** will be added to your account for any check not honored by the bank.
4. It is your responsibility to provide us with your current address, phone number and insurance information at each visit.
5. It is your responsibility to confirm with your insurance carrier that our doctor is your PCP prior to seeing the doctor. If you choose to see the doctor who is not on your plan you will be responsible for the payment in full.
6. ***Please contact our office within 1 business day prior to your scheduled appointment if you need to cancel. If you cancel your appointment less than 1 business day from the appointment time, you may be charged a $25 no-show fee for routine office visits and $80 for physicals and/or second missed appointments. Additional missed appointments will be charged an $80 fee.***
7. Certain services may be charged an Administrative Fee including but not limited to disability, life insurance forms, chart copying and adoption forms. There is no charge for school/camp physical forms when accompanied by an office visit. If you have any questions about the cost of a particular form, please contact our office.

TEST RESULT POLICY:

It is our policy to contact you as soon as possible by phone or mail for all lab and test results, even normal results. If you have not been contacted within two weeks, please call our office to obtain your results.

REFERRAL POLICY:

It is our policy to obtain referrals as soon as possible. If you do not receive notification for a routine referral within 10 business days, please call our office.

I have read the financial policy above and accept the conditions as listed.

Patients Name: _____ Date of Birth:_____

Patient Signature:_____Date:_____

Guarantor's Signature (person financially responsible if the patient is a minor or person financially for the above listed patient.

_____Date:_____