Atlanta Infectious Disease Specialists, P.C.

NEW PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

EMPLOYMENT STATUS EMPLOYED ( ) FULL TIME STUDENT ( ) PART TIME STUDENT ( ) NA ( )	EMPLOYER NAME / SCHOOL NAME	TITLE / POSITION

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )

NAME OF PERSON RESPONSIBLE FOR MAKING HEALTHCARE DECISIONS FOR YOU	MARITAL STATUS SINGLE( ) MARRIED( ) OTHER( )

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( )

PRIMARY CARE PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( )

DO YOU REQUIRE A REFERRAL FOR OFFICE VISITS	DO YOU HAVE A CURRENT REFERRAL

IN CASE OF EMERGENCY CALL

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE ( )	WORK PHONE ( )

RELATIONSHIP

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBLITY

RESPONSIBLE PARTY'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE OF BIRTH / /	TODAY'S DATE / /

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE ( )

POLICY HOLDER (IF OTHER THAN PATIENT)	SEX	DATE OF BIRTH / /

SOCIAL SECURITY NUMBER (OF POLICYHOLDER)	PHONE NUMBER (OF POLICYHOLDER)	RELATIONSHIP TO PATIENT

EMPLOYER (OF POLICYHOLDER)				
ADDRESS (OF POLICY HOLDER)	CITY	STATE	ZIP CODE	PHONE ( )

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER			GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	PHONE ( )
POLICY HOLDER (IF OTHER THAN PATIENT)		SEX	DATE OF BIRTH / /	
SOCIAL SECURITY NUMBER (OF POLICYHOLDER)	PHONE NUMBER (OF POLICYHOLDER)		RELATIONSHIP TO PATIENT	
EMPLOYER (OF POLICYHOLDER)				
ADDRESS (OF POLICY HOLDER)	CITY	STATE	ZIP CODE	PHONE ( )

Atlanta Infectious Disease Specialists Payment Policy

Welcome to AIDS! We are happy to further extend our services by filing your primary insurance for you. However, the filing of secondary insurance is the patient's responsibility. Please select from the following payment choices:

___**Self Pay –** Please pay the balance in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service.
Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.

___**Worker's Compensation –** We will bill your Workers' Compensation Carrier for your charges. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage or your claims are controverted.

___**Primary Insurance –** We will bill your primary insurance. We assume payment of insurance benefits is not forthcoming on charges older than 45 days. Charges outstanding for more than 45 days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been processed by your primary insurance.

PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL MONIES DUE THAT YOUR INSURANCE WILL NOT COVER AT THE TIME OF SERVICE.

Patients will receive a statement of account via mail every 30 days. Payment of patient due portion is payable within 10 days. A $25 service fee will be charged for returned checks

Thank you for allowing us the opportunity to service you.

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMTION / CONSENT TO TREATMENT

HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO ATLANTA INFECTIOUS DISEASE SPECIALISTS, P.C. IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT. I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COST ASSOCIATED WITH THE COLLECTION OF THIS DEBT, INCLUDING, BUT NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. A SERVICE CHARGE OR INTEREST MAY BE CHARGED AT THE RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER FORTY-FIVE DAYS OLD. I HERBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF ATLANTA INFECTIOUS DISEASE AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS IS INTENDED AS A WAIVER OF LIABILTY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE	TODAY'S DATE