PREMIER PRIMARY CARE
*Better Care. Better Health.*

# Demographics Verification Form

| **DEMOGRAPHIC INFORMATION** | | | |
|---|---|---|---|
| Patient Name: | | | |
| Mailing Address: | City: | State: | Zip Code: |
| Home Phone: | | | |
| Cell Phone: | | | |
| Work Phone: | | | |
| Date of Birth: | Sex: | Marital Status: | |
| Social Security Number: | | | |
| Employer Name: | | | |
| Employer Address: | | | |
| Primary Care Provider: | | | |
| Email: | | | |
| Select One: White ____ Black ____ Hispanic ____ Other: _____ | | Language spoken: | |
| OK to Leave Message: ☐ **Home** ☐ **Cell** | | ☐ **Brief** ☐ **Extended** | |
| | | | |
| **EMERGENCY CONTACT INFORMATION** | | | |
| Emergency Contact Name: | | | |
| Phone Number: | | | |
| Relationship to Patient: | | ☐**HIPAA** | |
| | | | |
| **GUARANTOR/RESPONSIBLE PARTY** | | | |
| Name: | | | |
| Guarantor Address: | | | |
| Guarantor Date of Birth: | | | |
| | | | |
| **PRIMARY INSURANCE INFORMATION** | | | |
| Insurance: | | | |
| Insured's Name: | Insured's Date of Birth: | | |
| Subscriber Number: | | | |
| Subscriber Address: | | | |
| Group Number: | | | |
| Insured's Rel to Pt: | | | |
| | | | |
| **SECONDARY INSURANCE INFORMATION** | | | |
| Insurance: | | | |
| Insured's Name: | Insured's Date of Birth: | | |
| Subscriber Number: | | | |
| Subscriber Address: | | | |
| Group Number: | | | |
| Insured's Rel To Pt: | | | |
| | | | |
| **PHARMACY INFORMATION** | | | |
| Pharmacy Name/Location: | | | |
| Pharmacy Number: | | | |
| Alternate Pharmacy Name/Location/Phone: | | | |

**I attest that the above information is correct and have read and understand the policies of Premier Primary Care, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Premier Primary Care to view my medication history from external sources.**

_____ **Date** _____

**Patient Print**

_____

**Patient Signature**

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## *FINANCIAL POLICY*

Listed below are our financial policies. If you have any questions, please discuss them with our Billing Manager.

**PATIENT RESPONSIBILITY**

1- All co-payments are due at the time of visit.
2- Co-insurance and unmet deductibles are your responsibility.
3- You are ultimately responsible for payment of charges for services you receive from our office.
4- In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. Any charges which are accrued because of failure of notification will be the responsibility of the patient. If we cannot verify insurance, you will be responsible for payment at the time of service.
5- **It is your responsibility to ensure that our physicians are in your insurance network.**
6- Cancellations **must** be received 2 business days in advance for a physical and 1 business day prior to an office visit to prevent the fees outlined below.
7- Payment is due for rendered services 15 days from receipt of your billing statement.

**Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our billing manager.**

**FEES**

1- The returned check fee is $ 30.00.
2- Failure to cancel or keep an appointment for an office visit will result in a $35.00 fee and $75.00 if the appointment is for a physical.
3- Medical records requests must be received in writing at least 5 days prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery.
4- There is a $25.00 fee for completion of documents such as FMLA and insurance forms, or any other paperwork which require time away from patient care for our doctors. Please allow 5 business days for completion.
5- All outstanding balances will be subject to a 10% APR finance charge.

**Patient's name (print):** _____ **Date of birth:** _____

**Patient's signature:** _____ **Date:** _____

Jose Dominguez, M.D. | David Dubose, P.A.-C | Kanani Floyd, P.A.-C

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**Tel:** 770-736-3008 | **Fax:** 770-687-2296

Policy Amended 10/29/2020

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# Notice of HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices,* including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. To choose this option, I and/or the Patient must notify your Business Office and must pay the bill for that health care service in full.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

To address any special needs you may have and to confirm your wishes, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If YES, please list names below for our record.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

***OFFICE USE ONLY***

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:

Staff Initials: Date: