

Welcome to Classic City OB/GYN. We are glad you have chosen our practice to provide your obstetric and gynecologic care. In order to familiarize you with how our office works, we are providing this information which we hope you will find helpful.

OUR PRACTITIONERS

Our practice has two physicians and two nurse practitioners. Our physicians are Leah Lowman, M.D., and Dayna Smith, M.D. They specialize in obstetrics, gynecology, gynecologic surgery and infertility. Our nurse practitioners, Stephanie Johnson, N.P. and Sarah Hamilton, N.P., perform office gynecology and obstetrical care. We function as a team, and we are dedicated to providing you with the best care available.

APPOINTMENTS

In order to serve you most effectively, we see patients by appointment only. Appointments can be scheduled by calling **706-549-1111**. If you find that you are unable to keep your appointment, we ask that you inform us at least 24 hours in advance so that we may make that time available for someone else. You may be subject to a \$25.00 fee should you not show up for your appointment or fail to notify us in advance as stated above. We urge you to be on time for your appointment.

We recognize that your time is valuable, and we make every effort to keep to our schedule. Unfortunately, the nature of our specialty is such that deliveries can occur and surgical emergencies arise during office hours. If this should occur, we try to notify you in advance, reschedule your appointment, or arrange for you to see another one of our doctors or our nurse practitioner. We appreciate your patience and understanding.

TELEPHONE CALLS

Please call during our regular office hours with questions regarding your care, for prescription refills or lab results. Prescription refills will be completed within 48 hours of notification. Our clinical staff has been trained to answer your questions and will consult with your doctor in this regard. Please understand that we are unable to refill medications or provide lab results after office hours, as we do not have access to your medical records. Also, please remember that we cannot refill medications if it has been more than one year since your last annual exam.

EMERGENCIES AND LABOR

If you have an emergency or think you are in labor during office hours, please call the office. If it is after hours, you must call our office number, **706-549-1111**, and our 24-hour answering service will contact the physician on call to return your call promptly. All after-hour situations of a true emergency will be handled accordingly to provide you the best of care. If it is after-hours and you think you are in labor, you must call our number, **706-549-1111**, in order to have our on-call physician paged. Our physician will call you back to determine which hospital you will need to go to. If you are pregnant, since our physicians deliver at both Athens Regional Medical Center and St. Mary's Health Care System, it is imperative that you speak with the on-call physician and find out if she is currently at one of the hospitals. If you fail to coordinate this with our on-call physician, you are putting yourself at risk that your doctor might not be able to get to you for your delivery. If you go to the hospital where our doctor is not currently working, you will be released to the care of the Service Call physician, which could be any Obstetrician in the Athens area.

We are here to answer any problems or concerns you have. Please do not hesitate to ask for someone to help you understand any of the above policies.

I have read and understand the above office policies.

Signature: _____ Date: _____

Print Patient's Name _____ DOB: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

(PLEASE PRINT)

Patient's Name Last _____ First _____ Middle/Maiden _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Driver's License # _____ Date of Birth _____ - _____ - _____

E-Mail Address _____

Home Telephone # (____) _____ Work Telephone # (____) _____ Cellular/Pager # (____) _____

Home Address _____

City, State, ZIP _____

Employment Status Employed Full-Time Student Part-Time Student Self-Employed Unemployed

Employer _____ Occupation _____

Spouse Name Last _____ First _____

Spouse's Employer _____ Spouse's Date of Birth ____/____/____

Emergency Contact Name _____ Phone Number _____

Patient's Relationship to Emergency Contact _____

RESPONSIBLE PARTY INFORMATION (if other than self)

Responsible Party Name Last _____ First _____

Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Home Telephone # (____) _____ Work Telephone # (____) _____ Cellular/Pager # (____) _____

Address _____

City, State, ZIP _____

Employment Status Employed Full-Time Student Part-Time Student Self-Employed Unemployed

Employer _____ Occupation _____

Patient Relationship to Responsible Party _____

INSURANCE INFORMATION (MUST provide your insurance card to the front desk at check-in)**

Primary Insurance: _____ Secondary Insurance: _____

If insurance is not under patient's name, please fill out the following information about the subscriber:

Name: _____ Relationship: _____ Date of Birth: _____ SS#: _____

It is the responsibility of the **patient to know what physicians, hospitals, radiology, laboratories, and facilities are in network with her current insurance coverage. Please check with your insurance prior to going to any physician, radiology, laboratory, facility or hospital.*

Hospital: _____

X-Ray Facility: _____ Lab Facility: _____

Pharmacy: _____ Address: _____ Phone: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I hereby authorize Classic City OB/GYN, LLC to release to my insurance company and Health Care Financing Administration or its Intermediates or Carriers, information acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to Classic City OB/GYN, LLC. I understand that I am responsible for any unpaid balance. I further understand that I may be charged for appointments that I fail to keep without 48 hour prior notification and that office policy requires a \$25.00 fee for returned checks. I realize I am responsible for any billing fees and late charges on unpaid balances, as well as any collection/attorney fees that Classic City OB/GYN may incur in collecting any balance of my account. I further realize that should I need disability forms completed, I will be charged a modest fee of \$25.00 for completion of such forms.

X _____
 Signature of Patient/Guardian/Responsible Party Date

FINANCIAL & ADMINISTRATIVE POLICIES

- ✓ As a service to our patients, Classic City OBGYN is more than happy to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from Classic City OBGYN. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing Classic City OBGYN with the most current insurance information (.i.e. Insurance card, Spouse’s information, etc.). Patients who do not bring their insurance card for their appointment may be asked to pay for the services rendered. If and when the insurance is billed and payment has been received, Classic City OBGYN will gladly refund any credits due the patient.
- ✓ All insurance co-pays are due at time of service; patients may be re-scheduled if the co-pay is not made.
- ✓ Patients who are not on time for their scheduled appointment may be re-scheduled to a later date.
- ✓ In an effort to ensure that all of our patients can be seen in a timely manner, we ask our patients to provide our office advanced notice of at least two business days if you are unable to make your scheduled appointment. Patients who do not call within 24 hours of their scheduled appointment to cancel or who do not show up for their scheduled appointment will be charged a \$35.00 administrative fee.
- ✓ There is a \$25.00 administrative fee for completion of any disability or FMLA paperwork. Classic City OBGYN guarantees that the requested paperwork will be available within five business days. If it takes longer, the \$25.00 administrative fee will be waived.
- ✓ Classic City OBGYN will charge the patient account \$25.00 for any returned checks to cover the cost of the associated bank charges.

Authorization for Treatment & Financial Agreement

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received in writing within 30 days of statement date. I agree to pay all charges within 30 days of statement date. I agree to assign my insurance benefits to Classic City OBGYN, if applicable.

Authorization for Release of Medical Information

I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agents solely to determine benefits for services provided. Release of information for any other purposes will require written consent of patient/parent/guardian.

I have read and understand these policies and hereby acknowledge receipt of a copy of this form.

 Please Print Patient Name

 Signature

 Date

 Guarantor Name (if different)

DO YOU HAVE ANY OBJECTION TO
RECEIVING BLOOD OR BLOOD PRODUCTS, IN
THE EVENT THAT YOU HAVE A LIFE
THREATENING CONDITION, WHILE UNDER
THE CARE OF CLASSIC CITY OB/GYN?

YES

NO

PATIENT SIGNATURE

DATE

PRINT PATIENT NAME

DATE OF BIRTH

It is the responsibility of the **patient to know what physicians, hospitals, radiology, laboratories, and facilities are in network with her insurance plan. Please check with your insurance plan prior to going to any physician, radiology, laboratory, facility, or hospital.*

Please check below the laboratory your insurance considers in-network:

- LabCorp
- Regional Lab Outreach
- Quest Diagnostics

Patient Name _____

Patient DOB _____

Patient Signature _____

Date _____

Date: _____

Please check **ONE** of the following to indicate how you heard about us:

- Employer: _____
- Insurance Carrier: _____
- Relative: _____
- Friend: _____
- Other Physician: _____
- Newspaper: _____
- Magazine: _____
- Yellow Pages: _____
- Internet Search: _____
- Local Hospital: _____
- Other: _____

Thank you for your cooperation.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name

Birthdate

Signature

Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This notice takes effect on April 15, 2003 and remains in effect until we replace it.

1. Our pledge regarding medical Information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty:

Law Requires Us To:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available up on request.

3. Use and Disclosure of your medical information:

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

NOTIFICATION: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location,

general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

COURT ORDERS AND JUDICIAL ADMINISTRATIVE PROCEEDINGS: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

PUBLIC HEALTH ACTIVITIES: AS required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

4. YOUR INDIVIDUAL RIGHTS

You have a right to:

1. Look at or get copies of your medical information. You must make the request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice.
2. Receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact the The Privacy Officer, Amy Smock. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.