Acct #____________

| ☐ Main Office | ☐ Hillandale Office |
|---|---|
| **1718 Peachtree St., NE<br>Suite 360** | **6000 Hillandale Drive<br>Suite 140** |
| **Atlanta, GA 30309** | **Lithonia, GA 30058** |

How do you prefer to receive information from our office?

Phone ☐ (can we leave a voice message?) Yes___ No__ Email ☐ Mail ☐

If you are a first time patient, how did you hear about our practice? ☐ Family/Friend ☐ Newspaper

☐ Physician Referral ☐ Social Media ☐ Direct Mailer Other:______________

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**Patient Information** *(circle one)* Mr. Mrs. Miss. Ms. Other:____________________________

Patient's First Name: _________________________ Middle Initial: _____ Last Name: ____________________________

SSN _________________________ ; Date of Birth _____________ ; Age _____ Sex: ☐ Male ☐ Female

Marital Status: Single Married Divorced Widowed Email Address:_________________________@__________

Address:__________________________________ Apt. #:_____ City ________________ State_______ Zip_________

Home#: (____) ____________________Work#: (____) ______________________Cell#: (____) ______________________

Referred by: _______________________________________ Phone: (____)________________________

Primary Care Provider: _______________________________ Phone: (____)________________________

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**Employment Information**

Are you: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Student ☐ Home Maker ☐ Retired ☐ Disabled

Employer Name:___________________________________Occupation: ______________________________

Address:________________________________________________________________________________

City:______________________State:________Zip:________Work #:_Ext. #:______________

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**Emergency Contact #1**________________________________ **Relation**_________________ **Phone**_________________

Email___________________________________

**Emergency Contact #2** ________________________________ **Relation**_________________ **Phone**_________________

Email___________________________________

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**Insurance Information:** (Please have your insurance card(s) available to be copied.)

Primary Ins Company Name(s)__________________________________ HMO__PPO__POS__Open Access__Medicare__

Policy Holder's Name: ______________________________ DOB_____________Relationship: Self___Spouse___Child__

Employer's Name:______________________________ Work # ________________Member/Group #_________________

Second Ins Company Name(s)__________________________________ HMO__PPO__POS__Open Access__Medicare__

Policy Holder's Name: ______________________________ DOB_____________Relationship:Self___Spouse___Child__

Employer's Name: ______________________________ Work # ______________Member/Group#_________________

***Assignment Of Benefits*** I hereby assign payment directly to Georgia Vascular Specialists, PC, all medical benefits otherwise payable to me under terms of my insurance contract as payment towards the total charges for professional services rendered. I understand that I am responsible for charges not covered under this assignment. I also understand it is my responsibility to inform this office of any change I my insurance company.

The undersigned agree that they are jointly and severally liable for the payment for any service, medications, or other items provided to the patient. The acceptance of insurance by this office is a courtesy and shall not act to amend nor void your obligation to pay the balance due. All obligations are due and payable upon receipt of statement. If any amount due shall require collections by or with the assistance of an attorney the undersigned shall by additionally responsible for all attorney's fees, court costs, or other expenses of collection, not less that 15% of the balance at the time of placement for collections.

***Authorization to Release Information***: I hereby authorize Georgia Vascular Specialists PC to release to my insurance company any medical information or any other information requested by the insurance company to ensure payment.

***Responsibility of Patient***: I do hereby expressly guarantee payment in full on any and all claims and charges in consideration for medical services rendered or to be rendered to the patient. All delinquent account will be subject to payment of costs or reasonable collection fees and attorney's fees. I understand that a $50.00 no show fee may be applied to my balance for any appointments that are missed without rescheduling or cancelling within 24 hours of my appointment. I also understand that a $75.00 no show fee will be applied to my balance for any procedure that is missed without rescheduling or cancelling within 48 hours of my appointment.

***Privacy Practice Acknowledgement:*** I have been provided the opportunity to view and receive a copy of the Notice of Privacy Practices.

**Authorized Signature**:_____________________________________________________**Date:**____________________
**By signing above, I agree to the terms of this agreement**.