



Acct # _____

<input type="checkbox"/> Main Office	<input type="checkbox"/> Hillandale Office
1718 Peachtree St., NE Suite 360	6000 Hillandale Drive 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: _____

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: (____) _____

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ Work #: _____ Ext. #: _____

Emergency Contact #1 _____ **Relation** _____

Address _____

City: _____ State: _____ Zip: _____

Email _____ Phone _____

Emergency Contact #2 _____ **Relation** _____

Address _____

City: _____ State: _____ Zip: _____

Email _____ Phone _____



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 in my health insurance.

The undersigned agrees 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 be additionally responsible for all attorney's fees, court costs, or other expenses of collection, not less than 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 accounts 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.