

Greater Athens Physicians, Inc.

Raymond L. Gilbert, Jr., M.D. and G. Trippe Jone, Jr., M.D.
Watkinsville, GA

PATIENT INFORMATION			
Last Name	First Name	Middle Initial	Nick Name
Street Address	Apt, Lot # or PO Box	City, State, Zip	
Sex M / F	Employer Name	address	Student Full time/Part Time
Home Phone	Work Phone	Ext	Cell Phone
Date Of Birth	Social Security Number	Marital Status	Spouse's Name
Referred By		Relative or Friend not living with you	
Relative/Friend Address	Relative/Friend Phone	Relationship	

INSURED PARTY INFORMATION			
Insured's Last Name	Insured's First Name	Insured's Middle Name	
Sex M / F	Insured's Date of Birth	Insured's Home Address	City, State & Zip
Insured's Social Security #	Insured's Home Phone	Insured's Work Phone	
Insured's Employer	Insured's Employer Address and Phone Number		

PRIMARY INSURANCE INFORMATION		
Please present your card/s to the receptionist so she may copy the card for your file. Thank you		
Insurance Company's Name	(HMO,PPO,POS,etc)	Attention To:
Insurance Address	City, State and Zip	
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

SECONDARY INSURANCE INFORMATION		
Insurance Company's Name	Attention To:	
Insurance Address	City, State and Zip	
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

Insurance Payment

All services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Payment is due at the time of service.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services.	<div style="text-align: right;">Signature _____</div> <div style="text-align: right;">Date _____</div>
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.	<div style="text-align: right;">Signature _____</div> <div style="text-align: right;">Date _____</div>

Raymond L. Gilbert, Jr., M.D.
G. Trippe Jones, Jr., M.D.
1550 Mars Hill Road
Watkinsville, GA 30677

Name _____

DOB _____

Medical History: (check if you have had)

Scarlet Fever_____	Polio_____	Arthritis_____	Diabetes_____
Cancer_____	Rheumatic Fever_____	Neuritis_____	Meningitis_____
Anemia_____	Back Injury_____	Tuberculosis_____	Asthma/Hayfever_____
High Blood Pressure_____	Head/Neck Injury_____	Gonorrhea/Syphilis_____	
Electrocardiogram_____	Psychiatric Treatment_____ (when_____)		

Family History: (check if anyone in your family has had)

TB_____	Cancer_____ what type_____	Diabetes_____
Heart Disease_____	Epilepsy_____	Other_____

Allergies to Medicine: NO___ YES___ describe: _____

Surgical History:

Drugs: (list current medications)

Use Tobacco? NO YES How much? _____
Use Alcohol? NO YES How much? _____
Use Coffee? NO YES How much? _____

Women Only

1. Are you currently having periods? No___ Yes___
2. At what age did your periods begin? ___; how often___(days) how long___(days)
Cramps? No___ Yes___ Severe___
3. Year of last period, if stopped _____
4. Are you troubled by hot flashes? No___ Yes___ Severe___
5. Pregnancy:
Times Pregnant___ No. Full term___ No. Premature___
No. Miscarriages/Abortions___ No. living now___

Family Data:

Spouse: _____	Date of Birth _____
Child 1: _____	Date of Birth _____
Child 2: _____	Date of Birth _____
Child 3: _____	Date of Birth _____
Child 4: _____	Date of Birth _____
Mother: _____	Date of Birth _____
Father: _____	Date of Birth _____



Greater Athens Physicians, Inc.

In an effort to improve patient care and provide access to care, this Practice utilizes a Physician Assistant and a Nurse Practitioner. These clinicians are available to evaluate patients, provide counseling and initiate therapy under the supervision of the physicians here. For immediate or acute care situations, patients are offered the first available appointments with any of the clinicians. For an appointment with the clinician of choice the next available appointment will be scheduled.

I understand the above information.

Signature

Date

**FINANCIAL POLICY
GREATER ATHENS PHYSICIANS, INC.**

Greater Athens Physicians, Inc., participates with most major insurance plans as a convenience to our patients; however we expect patients to pay their share for our services, as outlined in your benefit contract. We will help you determine these amounts. All co-pays are due at sign-in.

We request payments of coinsurance and deductibles, etc., at the time of service.
WE ACCPT CASH, CHECKS, OR VISA/MASTERCARD.

To better serve you, if you have any changes in insurance carrier, employment, home address, home/work telephone numbers, name, etc., PLEASE inform our receptionist. IT IS YOUR RESPONSIBILITY TO INFORM OUR PRACTICE OF THESE CHANGES.

Your Insurance coverage is an agreement between you and your Insurance Carrier. It is your responsibility to make payments for charges denied by your Insurance Carrier.

We expect a denial from your Insurance company within 30 days of the initial claim. If an Insurance problem occurs, you will be asked to assist us in contacting your Insurance Carrier. We feel it is necessary to work together to resolve any Insurance Problems.

In the event that your Insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of fees at the time of service.

Returned checks will be subject to additional collection fees.

All patients refusing to make payments after 60 days of notice, without pending Insurance or a financial arrangement made, will force us to limit their future credit until the previous balance is paid in full.

Our practice believes that a good Doctor/Patient relationship is based on understanding and good communications. Our staff will make every effort available to you to clarify any misunderstandings you have concerning your balance. We hope to avoid any disagreement over payment for professional services.

If you have any questions concerning our policy or need assistance, please contact our practice immediately.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE

Greater Athens Physicians, Inc.

It is the desire of the providers and staff at Greater Athens Physicians, Inc. to consistently provide the care and concern that each patient deserves. Over the past few months we have made changes to improve our overall practice performance. In trying to meet the needs of every patient we looked at several areas. Please read the following new policies. If you have any questions or concerns, please do not hesitate to let us know.

LAB/DIAGNOSTIC TESTING RESULTS

Our medical assistants will notify you of abnormal results, depending on the test this could take several days. If you have not heard from us in **two weeks**, please call our office.

PRESCRIPTIONS

For prescription refills we will need **48 hours notice**. Always call **2 days prior** to your medicine running out. Have your pharmacy's telephone number ready when you call.

No nerve pills, sleeping pills or pain pills will be filled on Fridays or after hours.

APPOINTMENTS

The providers and staff are working hard in an attempt to reduce your wait time. When you call for an appointment please be specific about why you wish to see the doctor. This will allow us to allot the time needed for your appointment.

When you must cancel an appointment please call at the earliest possible time. We need at least **24 Hours**.

NO SHOWS

Appointments are booked weeks ahead. If you do not show up for your appointment, this leaves a time slot that could have been used by another patient. We have a new policy on no shows, you will **now be charged** for your appointment slot. This will not be billed to an insurance company this will be the patients responsibility to pay. If you miss **three** appointments and have not called to cancel or reschedule, you may be dismissed from the practice.

TARDY

If you are late for your appointment you may be asked to reschedule.

INSURANCE

Are we your PCP (Primary Care Physician)? Check your insurance card. Please become familiar with your insurance. Know your **BENEFITS**. Know what laboratory you must use. Do you know what hospital your insurance requires? There are certain procedures, diagnostic testing, etc., that must be prior authorized or pre-certified before the test is performed. Do you know if your insurance requires prior authorization or pre-certification? All this information is very important.

You will be asked at each visit to show your insurance card to verify the information we have on file. You may be asked to fill out a form to update your information. We know this

can be annoying, but keeping information updated can insure proper billing.

HOSPITAL SERVICES

The physicians of Greater Athens Physicians, Inc. utilize the hospitalists at St. Mary's and at Athens Regional Medical Center. Hospitalists are physicians who specialize in caring for patients in the hospital 24 hours everyday. Using the hospitalist enables your physician to be more available to you in the office with fewer interruptions and allows the hospitalist to be more available to care for you when you are the most sick. Once you are discharged from the hospital you will return to your physician for all follow up care.

PAYMENTS

Co-payments, coinsurance and deductibles are payable at the time of service. If they are not paid at the time of service you will be charged a \$4.99 fee for the cost of billing you.

CELL PHONES

Please turn your cell phone off when entering the office.

Thank you for your time spent reading our office policies. Please let us know if you have any questions.

Initial: _____

Date: _____