Athena Medical Clinic and Sleep Medicine Associates

Patient Information (Please complete entire form)			FOR VA ONLY:
Name:	Date of Birth: ___/___/_____		SS#: ___-___-_____
Address:	City:		State, ZIP:
Primary Phone #:	Secondary Phone #:		
Emergency Contact:	Phone:	Relationship:	
Email:	Referred By:		
Pharmacy:	Phone:		
Sex: ☐ Male ☐ Female ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Hispanic ☐ Other _____			
Ethnicity: ☐ Hispanic ☐ Not Hispanic Language: ☐ English ☐ Spanish ☐ Other _____			

Employment Information

Employer's Name:	Employer's Phone:	Job Title:

Spouse/Guardian Information

Name:	Date of Birth: ___/___/_____	
Employer's Name:	Employer's Phone:	Job Title:

Release of Information I give permission for Athena Medical Clinic and Sleep Medicine Associates to discuss my medical issues with the following individuals:	
Name:	Name:
Relationship:	Relationship:
Phone:	Phone:
Date of Birth:	Date of Birth:

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to Athena Medical Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Athena Medical Clinic to release all information necessary to secure payment. This release is limited to Office Notes and other procedures that are done at Athena Medical Clinic; it does not include records from hospitals or other physicians. Companies or individuals who are in need of those records should contact that facility. I further authorize the release of these records when they include information concerning drug/alcohol abuse, venereal disease and other statutorily protected diseases, psychiatric records, or AIDS/HIV treatment records. I have reviewed the above information, completed on my behalf, and confirm the accuracy.

I, _____ (patient's printed name or representative), acknowledge all the above to be true and accurate to the best of my ability.

Patient's Signature: _____ Date: ___/___/_____

(Parent or Guardian signature if patient under 18)

Athena Medical Clinic and Sleep Medicine Associates
HIPAA – Health Insurance Portability and Accountability Act Receipt

I, _____, have been offered a copy of the Health Insurance Portability and Accountability Act from Athena Medical Clinic and Sleep Medicine Associates. I have had the opportunity to ask questions and the notice has been explained to me.

Patient Signature: _____ Date: _____

Athena Medical Clinic and Sleep Medicine Associates
Missed Appointment Policy

We understand that occasionally an appointment will need to be cancelled or rescheduled. To allow for the appointment time to be given to another patient, we require that all cancellations or reschedules be made with **at least 48 hours (business day) notice.**

Please contact our office at 706-850-6383 if you need to cancel or reschedule your appointment.

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I understand the above policy and hereby agree to be present at my scheduled appointment. In the event that I either miss an appointment or cancel with less than 48 hours notice, I understand I am responsible for that missed appointment, regardless of insurance coverage.

The fee for a regular missed appointment is $25.00 and the fee for a missed, late Cancellation or late Reschedule of Sleep Study appointment is $250.00.

Patient Signature: ______________________________ Date: ____________

Athena Medical Clinic and Sleep Medicine Associates
HIPAA – Health Insurance Portability and Accountability Act

I, ____________________________________, understand that a copy of the HIPAA Policy is available, should I want a copy. I have had the opportunity to ask questions and the notice has been explained to me.

Patient's Signature ______________________________________ Date ________________
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Athena Medical Clinic and Sleep Medicine Associates
Office Policies 2018

We reserve the right to change the Office policies. The following policies will be in effect this year:

* * In 2018 we will continue to see countless changes and modifications to our healthcare system as a result of the Affordable Care Act. Unfortunately some of these changes will prove financially burdensome to our patients as more costs have been shifted to them by their healthcare plans. As businesses must pay more to purchase government-compliant plans, they will require employees to pay higher co-pays and deductibles before coverage begins. As such, we have no option but to collect any foreseen deductibles and co-pays *prior to your appointment*. We regret that the current healthcare environment forces us to become financially proactive, this is necessary for our survival as a small medical office in a rapidly changing healthcare environment We will do our best to determine from your insurance company any deductibles or co-pays that are your responsibility and will collect that amount prior to your visit.

** Any monies owed to this practice must be paid in full before the time of service. Self-pay patients may be required to pay for part of their visit before being seen. Co-payments, applicable deductibles and co-insurance amounts will be collected at the time of the visit.

** Our office will assess a $25.00 non-sufficient fund (NSF) fee on any bad checks.

** Please note that we file insurance as a courtesy to our patients. Verification of benefits is not a guarantee of payment. It is your responsibility to consult with your insurance regarding your coverage levels and to confirm that our office accepts your current insurance plan. It is your responsibility to ensure your PCP handles any needed insurance referrals for Sleep Medicine.

** We do not file insurance if you have been involved in a motor vehicle accident injury. Full payment is due at the time of service.

** We require 24 hours notice for the cancellation of a routine or follow-up appointment; failure to do so may result in a $25.00 "No Show" charge. Forty-eight hours notice is required for cancellation for a Sleep Study; there will be a $250.00 "No Show" charge for missed Sleep Studies.

** You agree in order for us to service our account or to collect any amounts you may owe, that we (or our billing service) may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending e-mails if applicable.

On behalf of the patient, our office will contact insurance for benefits, eligibility and precertification for sleep studies. The benefits that are quoted to us will be referenced to you, the patient; however, **any quotes given are not a guarantee of payment.** It is advised that patients should also check with their insurance plan to secure any benefit and payment questions prior to scheduling/proceeding with sleep study procedures and DME supplies. **I have read and agree to the above new office policies. I understand that I am personally responsible for payment on my account.**

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient or Guarantor's Signature Date