



Patient Demographic Form

"PARTNERS IN CARE"
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Please print clearly and complete ALL pages.

This document is part of your permanent record.

Patient Full Legal Name: _____ DOB: _____ Age: _____

Patient Address, City, State, Zip: _____

Patient SS #: _____ - _____ - _____ Marital Status: S M D W Gender: M F Race: _____

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Employed Full-Time Part-time / Student Full-Time Part-time / Retired / Disabled / Not Employed

Name of Employer or School: _____ Phone Number#: _____

Spouse Name: _____ Spouse DOB*: _____ (*We MUST have for insurance filing)

Spouse Employer: _____ Work Phone #: _____

Emergency Contact

Name (other than spouse) _____ Relationship: _____

Emergency Contact Phone#: Home _____ Cell _____ Work _____

If you become unable to handle your finances, who will be responsible: _____

Please list any allergies you have: _____

Please answer the following: Do you have a Living Will? Yes No

Do you have a Power of Attorney for Healthcare? Yes No

Physician Information

(Include first AND last name of physician)

Who referred you to our office? _____ Phone _____

Who is your primary care physician? _____ Phone _____
(please indicate full name of physician)

Which of our physician's are you scheduled to see? _____

Please list the full name of other physician(s) that you are current seeing: 1.) _____

2.) _____ 3.) _____ 4.) _____

Please go to the next page and complete ALL information.

Once the packet is completed please bring a Picture ID and your insurance card(s) to the receptionist.



Financial and Payment Policy

We would like to say “**thank you**” for choosing Peachtree Hematology-Oncology Consultants, P.C. for your hematologic or oncologic care! Our physicians and staff are very concerned about the cost of your health care and want to inform you of our policies regarding payment.

1. In order to bill your insurance company for your health care costs, **it is extremely important that we obtain complete information about your primary and supplemental insurance companies, including phone numbers, addresses and a copy of your insurance card.** If this information is not provided, you will be required to pay any charges in full at the time of service. We will also use the information you provide to help you with your insurance company’s pre-authorization process, if required.
 - a. **If your insurance changes at any time we require a 48 hour notice** to verify benefits and complete required treatment precertification or authorizations when necessary. Failure to notify our Patient Accounts Department within this timeframe may result in a delay in receiving services or require that your visit be rescheduled.
 - b. To maintain accuracy in filing your claims **a copy of your picture ID and your insurance card(s) is required** at your first visit, any time your coverage changes and yearly.
2. At the time of your first appointment in our office you will meet and discuss your insurance plan with a representative from our Patient Accounts Department. Whenever possible, Peachtree Hematology-Oncology Consultants, P.C. (hereinafter “PHOC”), will assist you with your understanding of your insurance policy details. However, **PHOC can not guarantee confirmation of your coverage or benefits by your insurance company.**
3. **Payment in full is expected** when services are rendered unless other specific arrangements are made in advance with our Patient Accounts Department. For your convenience **we accept Visa, MasterCard, and Discover as well as personal checks, money orders and cash.**

Fees – Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of the care rendered and the skill and expertise required for your care. We have ensured that our fees are comparable to that of other physicians providing the same quality and level of care. Many private insurance companies, **in an effort to discount physician fees, restrict payment indicating that fees are over their “Usual and Customary” fees for this area. We will not allow insurance companies to set our fees for us.**

Copays/Coinsurance/Deductibles - Our Financial and Payment policy requires **payment for your deductible and/or co-insurance at the time of service for office visits and procedures.** We will file a claim for services on your behalf. In the event there are any additional balances, which may be your responsibility, **you will receive a statement that is to be paid before the end of the month.**

Medicare – **We are a participating provider with Medicare.** We will submit your claim to Medicare who will process any payment due directly to us. **You are responsible for your deductible and copays at the time of service.** If you have a Medigap policy Medicare will automatically submit your secondary claims for you.

Medicare Advantage – **We participate with PFFS plans ONLY.** We do not participate with any Medicare Advantage PPO or HMO plans. If you have a **PPO plan you may have out of network benefits.** If you choose to have services rendered at PHOC you may have a **higher copay, coinsurance and/or deductible that will be due at the time service is rendered.**

Referrals – If your insurance carrier requires a referral or authorization for your visit, **it is your responsibility to make sure that our office receives current valid authorization.** If you do not have a valid referral or authorization at the time of service, you may be sent back to your Primary Care Physician to obtain authorization prior to being treated or full payment will be expected at the time of service. **Please remember that it is your responsibility to make sure we are on your plan’s provider listing.** We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies.

Medicaid – We participate with Georgia Medicaid. If you have a managed care plan such as Georgia Better Healthcare, PeachState, Wellpoint or Amerigroup a referral is required for each visit which must be obtained from the Primary Care Physician (PCP) listed on your Medicaid card. A copay may be applied which is due at the time service is rendered.

Secondary Insurance – As a courtesy to you, our Patient Accounts Department will file your claim if we have valid information on file.

HMO, EPO, POS and PPO Contracted Insurance – We participate with most major insurance carriers and will file your claim for you. **You are responsible for your copay, coinsurance and/or deductible at the time of service and for any amounts not covered by your insurance.** If coverage is denied for any reason, you are responsible for payment of the entire balance.

NON-Contracted Insurance (Out of Network) – If you have an insurance plan that we do not participate with, you may have out of network benefits. **These benefits typically have a higher copay, coinsurance and/or deductible out of pocket cost.** If you choose to have services rendered at PHOC these amounts will be due at the time service is rendered. **You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.**

Uninsured/Self-Pay – We offer a 25% discount to all of our self-pay patients. **Payment in full is expected at your first visit.** All other ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment.

Termination of Benefits – It is your responsibility to contact us within 48 hours of any appointment if you have any change in insurance coverage including COBRA benefits (see COBRA section below).

COBRA – It is our financial and payment policy that we verify current coverage within 48 hours of your appointment for all patients who receive COBRA benefits. **If current coverage can NOT be verified, ALL treatment will be scheduled at an Outpatient Infusion Center.** It is your responsibility to contact us immediately of any insurance change.

Returned Checks – Returned checks are subject to a \$30 service charge. If multiple returned checks are received, we reserve the right to refuse further checks from you and request that all payments be received in cash, money order, cashier’s check or credit card.

Non-Payment – If any account becomes delinquent PHOC reserves the right to have a collection agency take over the account. **If any account is placed with a collection agency, the patient will be responsible for all costs of collection and any legal proceedings.** Timely payment will prevent consequences to your credit rating.

We will work with patients in any way we can to ensure that their medical care is the finest available and that this care does not become a financial burden. If you have any questions about our financial policy or your insurance reimbursement, please contact our Patient Accounts Department.

Please sign and date this form, acknowledging that you have read and understand our financial policy.

Signature of Patient

Date



Assignment of Benefits

I hereby assign all healthcare and medical benefits payable (i.e. "Payer"; Commercial Insurance Coverage, ERISA Plan, Governmental Health Benefit Plan, Medicare, Medicaid, etc.) and related rights existing under the Payer coverage to Peachtree Hematology-Oncology Consultants, P.C. (hereinafter "PHOC") and d/b/a Peachtree Hematology-Oncology Pharmacy (hereinafter "PHOP") for services provided to me by PHOC and/or PHOP. I hereby certify that the Payer information that I have supplied PHOC and/or PHOP is true and accurate as of the date of service. I am fully aware that having healthcare benefits does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand different Payers have different requirements for payment including, but not limited to, pre-certifications, authorizations or that the services be medically necessary. I understand that it is my obligation to know my Payer's requirements and ensure that they have been fulfilled. I also understand that my Payer may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by the identified Payer. **I agree to immediately notify PHOC if any of the information I have supplied changes at any time during my treatment.**

I hereby authorize PHOC and/or PHOP to submit claims, on my behalf, to the Payer listed on the current benefits card I have supplied PHOC and/or PHOP. I hereby instruct and direct my Payer to pay PHOC directly. If my current policy prohibits direct payment or assignment to PHOC and/or PHOP for services, I hereby instruct and direct my Payer to make the check payable to me, but to mail it directly to PHOC for the professional for medical expense benefits allowable, and otherwise payable to me under my current benefits under Payer's policy for payment towards the total charges for medical services rendered. Upon receipt of said check, I authorize PHOC and/or PHOP to deposit checks received on my account when made payable to me.

This is a direct and express assignment of my rights and benefits under policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of medical service charges over and above this payment (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries). I hereby acknowledge and give my express permission for PHOC and/or PHOP or its legal representative to release any of my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. Furthermore, I authorize PHOC or its legal representative to obtain information concerning my medical benefits directly from Payer (including but not limited to, the policy or plan governing my benefits).

In the event that my policy prohibits assignment of certain rights; (such as right to file appeals or to file suit in state or Federal court) I expressly authorize PHOC at its sole discretion to by my personal representative which allows PHOC to: (1) submit any and all appeals, when my Payer denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my Payer; and (3) initiate formal or informal complaints to any State or Federal agency that has jurisdiction over my benefits; this includes express permission for PHOC or its legal representative to file suit against Payer for healthcare and medical benefits to which I may be entitled. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against my Payer will be paid to PHOC for acting as my personal representative.

The assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this Assignment shall be considered effective and valid as the original.

Signature of Patient/Policy Holder

Date

Witness

Date



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Request and Informed Consent

Do NOT sign this form until you have read it and fully understand its contents

Patient's name: _____ Date: _____
(Please print full name clearly)

I acknowledge and understand that the following procedure or treatment has been explained to me and is to be performed on me/the patient: *Venipuncture for blood collection.*

The follow has been explained to me in layman's terms and I understand that:

- 1) The patient's diagnosis is:

- 2) MATERIAL RISKS OF THIS PROCEDURE OR TREATMENT:

The material risks associated with this procedure or treatment may include but are not limited to: *pain at site, bleeding at site, bruising at site, possible infection.*

- 3) Available alternatives to this procedure or treatment include: *no treatment.*

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure or treatment which has been explained.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.

I understand that during the course of the procedure or treatment described above it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decision concerning such procedures and treatments. I also consent to and authorize the performance of such additional procedures and treatments as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or procedure or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues, specimens, organs or limbs removed from the patient's body in the course of any procedure or treatment may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

BY SIGNING THIS FORM:

- a. I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME
- b. THAT I FULLY UNDERSTAND ITS CONTENTS
- c. THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY.
- d. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.
- e. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION, INCLUDING BUT NOT LIMITED TO, THE MATERIALS LISTED BELOW, RELATED TO THE TREATMENTS AND PROCEDURES DESCRIBED HEREIN.

I hereby voluntarily request and consent to the performance of the procedures or treatments described or referred to herein by Dr. _____ and any other physicians or other medical personnel who may be involved in the course of my treatment.

Signature of Person giving consent

Relationship to patient if NOT the patient

Patient was unable to sign because of _____

Additional materials used, if any, during the informed consent process for this procedure or treatment include: _____

