Evolve Medical Care Clinic

3639 Lawrenceville Hwy Lawreceville, GA 30044

Tele: 678-643-5580 Fax: 888-542-9103

www.evolvemedicalcareclinic.com

Demographics Information		
Patient Name:	Date of Birth:	Sex: M F
Mailing Adress:		
Home Phone:	Cell Phone:	
Social Security Number:	Marital Status:	
Email Address:		
Primary care Provider:	Tele:	
Patient's Employer:	Employment status:	
Language Spoken:	Advance Directive: YES NO	
Ok to leave message: **Cell Home email**	**(please circle the method of contact)**	
Emergency Contact Information		
Emergency Contact name:	Relationship to patient:	
Contact Number:	Address:	
Primary Insurance Information:		
Insurance:		
Insured's Name:	Insured's Date of Birth:	
Subscriber Name:		
Subscriber Address:		
Group Number:	Insured's Relation to Patient:	
Secondary Insurance Information:		
Insurance:		
Insured's Name:	Insured's Date of Birth:	
Subscriber Name:		
Subscriber Address:		
Group Number:	Insured's Relation to Patient:	
PHARMACY INFORMATIONS:		
Pharmacy Name/ Locations:		
Pharmacy Number:		

I attest that the above information is correct and have read and understand the policies of Evolve Medical Care Clinic and accept my responsibility as stated in those polices. I hereby authorize release for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Evolve Medical Care Clinic to view my medication history from External Sources. I understand that I am financially responsible for all charges for services rendered to ME/my children's, including the balance after payment of possible insurance benefit's.

Patient Name: _____ Date:_____

Patient Signature: _____

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Financial Policy

Insured Patient Responsibility

- All Co-payments are due at the time of visit rendered. This includes outstanding balance, deductibles, Co-insurances other fees for services not covered by your insurance company, and expected charges for services rendered at the time of visit.
- It is you responsibility that our physician in your network.
- Co-insurance and unmet deductibles, and non-covered services are your responsibilities
- You are ultimately responsible for payment of charges for services you receive from our office.
- It is your responsibility to provide accurate insurance information and presents your insurance ID card at the time of visit. Any charges accrued because of failure of notification will be patient responsibility for payment at the time of services. **If you are not sure what your insurance covers, PLEASE CALL YOUR INSURANCE COMPANY DIRECTLY**.
- Payment is due for rendered services at the time of visit. Unpaid previous balance must be paid in full prior to any additional visit unless arrangement have been made.
- You will receive regular statement requesting payment of any unpaid balance. After two (2) statements, your balance will be forwarded to a third-party collection agency.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for office visit such as labs, medications, medical supplies, etc. I agree to pay my bill in full for services rendered by Evolve Medical Care Clinic.

Private Pay (No Insurance Coverage)

- If you do not have insurance coverage. Your payment is due at the time of service.
- After seeing the physician/nurse practitioner at check out, there may be additional charges depending on the level of service that was provided by the doctor/nurse practitioner and the additional charges for labs, or other services that may have been ordered or provided during the visit.
- If additional tests are ordered that need to be completed after the visit, and you anticipate a problem paying for the services please let your healthcare team know before leaving the office.

No Show Policy

- Appointments must be cancelled at least 24 hours prior to the scheduled appointment time on the clinic line ONLY . A cancellation charge, equal to the cost of your missed appointment, will be charged to your credit card on file for failure to call a minimum of 24 hours prior to appointment.
- In the event a patient arrives late as defined by “late arrival” to their appointment and cannot be seen by the provider on the same day, the patient will be rescheduled for a future clinic visit. A cancellation charge of $25.00 may be charged to your Account/ credit card on file.

I have read and understand the No Show & Cancellation policy and agree to the terms set forth.

Patient Name:_____ **Patient Signature:**_____

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Notice of HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare
- providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices,* including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. To choose this option, I and/or the Patient must notify your Business Office and must pay the bill for that health care service in full.

Patient Name:_____ Relationship to Patient :_____

Signature :_____ Date:_____

To address any special needs you may have and to confirm your wishes, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one

YES

If YES, please list names below for our record.

NO

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____Phone:_____

Name: _____Relationship: _____ Phone: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:_____

Staff Initials: _____

Date:_____ _____

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Consent for Routine Procedures and Treatment

we are required by law to obtain consent to treat and disclose "all material and alternative treatment". I understand that it is not possible to list everything material risk for every Procedures or Treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the procedures and treatments.

The Procedures may include but are not limited following to the following:

- Needle Sticks such as intermuscular injections, intravenous injections, Blood drawing, bodily fluids or tissue samples. The material risk associated with these types of procedure include but not limited to nerve damage, infection, infiltration, disfiguring scar, bleeding, infection at the site loss of limb, partial or full paralysis of the limbs and/or death. Alternative to needles sticks (if permitted and available) includes rectal, oral and/or topical medications each of which may be less effective. Apart from long term observation and/ or refusal of the treatment NO practical alternative exist.
- Administration of Medications: When Administering medication with either orally, rectally, topically and or eye, ears and nose there is a risk associated with this procedure such as but not limited to infections, allergic reactions, puncture or perforation, brain damage and/or death. Apart from varying the method of administration and/or refusal of treatments no practical alternative exists.
- Physical test, assessment and treatments such as incision and drainage, laceration repair, vital signs, internal body examinations, wound cleaning, wound dressing, range of motion check and other similar procedures. The risk associated with these types of procedures includes but NOT limited to, allergic reaction. Infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb functions, disfiguring scar, paralysis, worsening of the conditions and/or death. Apart from using modified procedures and/or refusal to treatment, no practical alternative exist.

By signing this form:

- I consent to Healthcare Professional Performing Procedure as they deem reasonably necessary in the exercise of their professional judgement, Including those procedure that may be unforeseen or not known to be needed at the time this consent is obtained.
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risk of the procedures and practical alternatives to the procedures.
- If I have any questions or concerns regarding these Treatments or procedures, I will ask my provider to provide me with additional information's.
- In order to insure medication safely and lack of drug interaction, I grant Evolve Medical Care Clinic and it's staff the right to access my electronic prescriptions information from my pharmacy.

Patient Approval form for Nurse Practitioner, This practice has a certified Mid-Level Provider available to treat patient for the level of care, which have been approved by Georgia State Board of Medical Examiners, Your signature on this form conveys that you are in agreement with being treated by mid-level provider, who is acting under the direct supervision of a Physician. \

Patient Name: _____ Patient Signature: _____

Reason if Patient is Unable to sign: _____

Signature of Authorized person to Sign: _____