Elizabeth Street MD, Mary Pitcher MD, Laurie Leigh Robbins MD, Laura Cauthen MD, Angel S. Paas, MD

574 Church Street NE, Marietta GA 30060 770-427-0285 (office) 678-564-1033 (fax)

IT IS YOUR RESPONSIBILTY TO PRESENT YOUR INSURANCE CARD AND NOTIFY US OF ANY CHANGES AT EACH APPOINTMENT

Please print your full legal name

First _____ MI____ Last _____ DOB: ___/___/____

Address_____ Apt# _____ SSN _____

City_____ State_____ Zip _____ Employer/School_____

Primary Daytime Phone #_____ 2nd # _____ 3rd #_____
hm/wk/cell **hm/wk/cell** **hm/wk/cell**

Race_____ Marital Status: Single Married Divorced Widowed Spouse Name _____

Emergency Contact Information

Name_____ Relationship_____

Cell#_____ Home# _____ Work#_____

Primary Insurance_____ ID# _____

Policyholder's Full Name_____ MI _____ Last _____

DOB: ___/___/____ Group #_____ Employer _____

Relationship of Patient to Insured: Self Wife Child **

Secondary Insurance_____ ID# _____

Policyholder's Full Name_____ MI _____ Last _____

DOB: ___/___/____ Group #_____ Employer _____

Relationship of Patient to Insured: Self Wife Child **

Who referred you to us? _____

**** If Patient is age 19 or older, and covered under her parent's insurance, you must fill in the following: Not a Student___ Full time Student____ Part time Student ___**

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT: I authorize payment of medical benefits to Elizabeth Street, MD; Mary Pitcher, MD; Laurie Leigh Robbins, MD; Angel Paas MD; and/or Laura Cauthen for services rendered. I understand that if I have provided valid insurance information that my charges will be filed for any benefits due. However, I am financially responsible for any charges incurred and not covered by my insurance company (including out of network) and do hereby agree to pay for these services in full.

Notice of special charges: Return Check Fee $25.00; Disability/FMLA Forms, $5 per page

Signature_____ **Date**_____

Patient confidentiality is a top priority in our practices. Therefore, it is important that you provide us with the following information to ensure there is no violation of your privacy.

In the event that I, _____ am unable to be reached, this office may leave test results or other pertinent information with the following:

Name:	Relationship:	Primary #:
1._____	1._____	1._____
2._____	2._____	2._____

☐ **This office may leave test results on voicemail or answering machine.**

OR initials _____ This Office MAY NOT leave any form of health information without speaking directly to me.

I understand that if the status of any of the above information changes, it will be my responsibility to inform the doctor/staff.

Patient Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the Notice of Privacy Practices for this office.

_____ _____

Signature **Date**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS
(For insurance purposes)

I consent to the use disclosure of my protected health information by Drs. Street, Pitcher, Robbins, Paas & Cauthen for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations of Drs. Street, Pitcher Robbins, Paas & Cauthen.

I have the right to revoke this consent in writing at any time, except to the extent that Drs. Street, Pitcher, Robbins, Paas & Cauthen as taken action in reliance on this consent.

My "protected health information" means that health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

_____ _____

Signature of Patient Or Parent/Guardian **Date**