Clark Medical Group

1550 Brampton Avenue
Suite B
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www.clarkmedicalgroup.com

Welcome,

We would like to greet you as a new patient of Clark Medical Group. We are glad that you have chosen us as your primary health care provider.

For all established patients, thank you for continuing to choose us as your primary care provider. Please assist us by completing this packet in order to update and ensure the accuracy of our patient records.
Attached are new patient and / or account update information forms. Please answer each question to the best of your knowledge. Return this packet on your first appointment with the following information:

- Photo Identification (Preferably a State Driver's License)
- Insurance Card
- Copayment, Deductible, etc. (if applicable or required)
- All Current Medications
- Social Security Number (Or Government ID number)

At each visit, please be prepared to give us your insurance card (s) and your co-payment.

If you are unable to keep scheduled appointment, we ask that you give us a twenty-four (24) hour notice. Please be advised that if you are fifteen (15) minutes late for your appointment, you will have to reschedule. We prefer each patient to arrive early, in order for us to verify all information and insurance before your appointment time.

Three (3) "no show" appointments could result in dismissal from the practice.

Our Physicians and staff believe that every patient deserves our best treatment. We also believe that every person should be treated with dignity and respect, because every person is created in the image of God. We will try to serve you in any way we can and treat you in a respectful manner. We ask that you also treat our physicians and staff with respect.

We thank you for your continued assistance and support in providing all patients with the highest standard of patient care.

Thank you!

Clark Medical Group, LLC

Patient Information

Patient Name: _____ _____ _____
(Last) (First) (Middle Initial)

Mailing Address: _____

City_____ State_____ Zip Code_____

Home Phone: _____ Cell Phone: _____ Other: _____

Date of Birth: _____ Age: _____ Sex: _____ Email Address: _____

Marital Status (circle one): Married Divorced Widowed Single Separated SSN: _____

Employment: _____ Work Phone: _____

Spouses Information

Name: _____ DOB: _____ Phone #: _____

Do you want your spouse to be your EMERGENCY CONTACT? (Circle One) Yes No

Additional Emergency Contacts:

I authorize the following individuals to request/ discuss services/ conditions (regarding refills, appointments, medications, care, etc.) on my behalf:

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

Responsible Party Information (if different from patient):

Name of Responsible Party_____ Relationship to Patient _____

Address_____

Home #_____ Cell #_____

Insurance Information:

Insurance Company: _____

Patient ID: _____ Group #: _____

If you are NOT the policyholder, please fill out below:

Name_____ DOB_____ SSN: _____

Mailing Address_____

Phone#_____

Relationship to patient_____

CONSENT STATEMENTS:

I have been offered and ready a copy of the Notice of Privacy Practices of CLARK MEDICAL GROUP. I authorize the release of any information concerning my healthcare, advice, and treatment provided for the purpose of evaluation and administering claims for insurance or workman's compensation benefits. **I acknowledge full financials responsibility for services rendered.** I understand that my co-payment is due upon check-in and prior to services being rendered. I understand that payment in full is due at the time of service. If at any time my account is turned over to a collection agency, I agree that CLARK MEDICAL GROUP has the right to charge me all fees associated with my debt collection.

If for any reason my insurance claim is processed and is denied or determined to be invalid, **I am responsible for the FULL balance on the account.** I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance information. _____Patient Initials

CONTRACT SUB-AGREEMENT:

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of pain, which is strictly regulated by both state and federal law. This agreement protects you, CLARK MEDICAL GROUP, and your physician by establishing guidelines within laws for proper controlled substance use.

- All controlled substances must come from your physician, or during his/her absences, by the covering physician unless specific authorization is obtained for exception. **I understand that I must tell the physician all medications/drugs I am taking, have purchased, or have obtained (including over-the-counter medication.)**
- Failure to do so may results in drug interactions and overdoses that could result in harm to me, including death.
- I will not seek prescriptions for controlled substances from any other physician health care provider, or dentist.
- I understand that it is unlawful to be prescribed the same controlled medication, or a similar medication for the same condition, by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting fact, or knowingly withholding facts, from a physician or his/her staff (including failure to inform the physician and / or his/ her staff of all controlled substances that I have been prescribed.
- **All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change your choice of pharmacy; our office must be notified immediately.**
- You may not share, sell, or otherwise permit others, including your spouse or family members to have access to any controlled substances that you have been prescribed.
- **CLARK MEDICAL GROUP IS NOT A PAIN MANAGEMENT CLINIC.** If a patient needs pain management services, then we will be happy to make a referral to a pain management clinic. Any patient who expects to receive on going pain management will be expected to receive those specific services elsewhere. Failure to comply with one of our practitioner's plans of service or suspected abuse of prescribed or illegally obtained main medications will result in dismissal from **CLARK MEDICAL GROUP**.
- Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology may result in your discharge from Clark Medical Group.

_____Patient Initials

- I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that while driving under the influence of any substance, including prescribed controlled substances, or any combination of substances, which impairs my driving ability, may result in DUI or similar charges by law enforcement officials.
- Medication or writing prescription may not be replaced it they are lost, stolen, wet, destroyed, etc.
- Early refills will not be given. Prescription refills are based upon keeping scheduled appointments.

Please do not call for prescriptions after hours or on weekends.

- In the event that you are arrested or incarcerated for related illegal drugs or controlled substances (including alcohol), **NO REFILLS** of controlled substances will be given.
- I understand that failure to adhere to these polices may result in cessation of therapy with controlled substances prescribed by this physician and other physicians of CLARK MEDICAL GROUP, and that law enforcement officials may be contacted.
- I affirm that I have full right and powers to sign and to be bound by this agreement, and that **I have read it and understand and accept all of its terms**. A copy of this document had been given to me upon my request.

SELECTED PHARAMCY: _____ Location: _____

_____ _____

Patients Signature Date of Signature

LABS:

ALL labs will be sent to **LABORATORY CORP. OF AMERICA (LABCORP).**

All **SELF-PAY** patients will be responsible for the laboratory testing, charges, and fees, including a drawing fee; at the time services are rendered. If for any reason our office would need to bill you for laboratory charges, a $5.00 service charge will also be applied to your account. _____Patient Initials

IMMUNIZATION RECORDS:

I authorize the Georgia Department of Community Health (or similar state for federal agency) to release any immunizations records related to the above-mentioned patient. Furthermore, I authorize CLARK MEDICAL GROUP to release to the aforementioned agency notification of any immunizations I obtain through my treatment at CLARK MEDICAL GROUP.

_____Patient Initials

FINANCIAL POLICY:

It is our firm belief that all patients who come to this office except and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies.

1. We are "providers" for many insurance plans. If we are a participating provider in your plan, we will be listed in your group's "provider list" or "preferred provider directory." **It is your responsibility to know if we are in your network.** We will bill your insurance company directly and receive payment from them directly. Most plans require a "copayment" per visit, coinsurance, and/ or have yearly "deductibles." **We require that such payments be made at the time that you receive services, (upon check-in).**
2. If your insurance require approval, necessary documentations are your responsibility. You must give your referral form and/ or number to the receptionist when you check-in to see the doctor. If your insurance company does not pay your bill because of improper referrals, **you will be responsible for the full bill.**
3. If your insurance is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance claim forms for services you receive. **It is your responsibility to tell us about changes in your insurance**; therefore, we require copies of your insurance cards at each visit. These forms are processed on a daily basis and are sent to your insurance company. We are happy to help you by submitting insurance claims. It is important to remember that your insurance is a contract between you and your insurance company. Although we file claims for you, **you are still responsible for you bill regardless of the amount your insurance company pays,** except in cases of pre-negotiated insurance agreements and where legally prohibited.
4. **If you do not have insurance, full payment is expected at the time you receive services.** Payment will be accepted by cash, check, or credit card (Visa, MasterCard, Discover). Returned checks will result in a $ 30.00 charge being added to your account. In addition, your check may be sent to small claims court for collection.
5. Please remember when you receive your statement, you have already received healthcare from our Physicians and we have initiated your insurance claim. WE ask that you promptly pay in full your portion of the balance due. If your account is turned over to collections, you will be responsible for all collection/court cost incurred.

6. Clark Medical Group does not accept any letters of payment form any third party. All co-pays must be paid at each and very visit. In the event accident treatment is not covered service under you (health) insurance policy, any balance due must be paid in full at the time services are rendered. In the event we are uncertain as to whether your policy covers treatment for MVA's we will bill the carrier. If the carrier denies coverage, then the patient will be billed with the expectation of prompt payment.
7. In the event that this practice must bill the patient for any service(s) rendered, prompt payment is always expected. All statement/bills, which go unpaid for thirty (30) days, will begin accruing a late fee of 1.5%.
8. Your section initials and packet signature authorizes CLARK MEDICAL GROUP to act as your representative in the case of appeals or other insurance negotiations. _____Patient Initial

POLICIES & PROCEDURES:

In order for us to provide quality medical care for all patients, we feel that it is important that our patients understand our office policies and procedures as they pertain to patients.
Please be advised that if you are fifteen (15) minutes late for your appointment, you will have to reschedule.
We prefer each patient to arrive early, in order for us to verity all information and insurance before your appointment time.

OFFICE HOURS: Our office is open Monday through Friday. Our hours are 8:00 AM to 5:00 PM. Phone calls can be taken during this time, and will be returned as soon as possible. *If you have not received a return phone call within 24 hours, please contact the clinical supervisor.* In case of emergency after hours, please call 911 or go to you're nearest emergency room.

CONFIDENTIALITY: Please rest assured that our office staff is trained to keep patient information strictly confidential. Absolutely no information about you or your treatment will be released to anyone without your written authorization or consent. In turn, we also ask that you respect the confidentiality of other patients by not discussing people you see in our office.

PAYMENTS FOR SERVICES: Patients are responsible for payment at the time of service. Specifically, you are responsible for what your insurance company will not cover. If you do not have insurance, you are responsible for your payment in full. If you anticipate having difficulty with payments, please notify the office manager. As a courtesy to you, our office will file claims with your insurance company. However, we cannot be responsible for collecting or negotiating settlements of disputed claims. Therefore, **you are responsible for any balance left on your account that your account that your insurance does not cover.**

CANCELLATIONS: Your appointment is a specific period of time reserved just for you. If you need to cancel, **we ask that you call our office 24 hours prior to your scheduled appointment time.**

THREE (3) no shows could result in your termination from our practice.

FORMS: We require 15 business days to complete any forms. The minimum fee is $25.00

PRESCRIPTION RENEWALS:

To the extent possible, we ask that you request prescription refills at the time of your visit. If you do need a refill, please call your Pharmacy and they will contact us to refill your prescription. Please DO NOT wait until you take your last pill to call for a refill, as this takes time to process. To avoid running out of medication please notify your pharmacy at least **72 hours in advance.** Please check with your Pharmacists to see if your prescription is ready. **For written Prescriptions: Please notify our office 2-3 days in advance.**

APPOINTMENTS:

If you are not the patient, a guardian of the patient, or someone who is needed to assist the patient with their appointment we ask that you please remain in the waiting area. **If you have another family member that needs to be seen, please notify the appointment scheduler and let her schedule you an appointment.** Again, we encourage you to actively participate in your treatment, and to ask any questions you may have. Please let us know how we can better serve you.

RIGHTS/RESPONSIBILTIES:

CLARK MEDICAL GROUP recognizes the importance of basic rights of all patients. At the same time, CMG has the right to expect reasonable and responsible behavior on the part of the patients, their relatives, and friends. The following rights and responsibilities of patients are considered reasonable and CMG will endeavor to protect the same.

PATIENT RIGHTS:

1. To be afforded impartial access to treatment regardless of race, creed, sex, national origin, handicap condition, or age and to be treated with respect and dignity at all times.
2. To refuse to talk with or see anyone not directly involved in the patient's care or treatment.
3. To wear appropriate clothing and/ or religious symbols, as long as such clothing and/ or symbols do not interfere with treatment or diagnostic procedures.
4. To be interviewed and examined in privacy and to have someone of the patient's own gender present if requested.
5. To expect that his or her care and treatment be handled in confidence and that his or her medical record will be read only by authorized individuals.
6. To expect that our office practices and its environment are reasonably safe at all times.
7. To know the identity of all persons providing services to him or her and the identity of the physician who is primarily in charge of his/her care.
8. To expect complete and current information concerning his/her diagnosis (if known) treatment and prognosis is in understandable terms.
9. To expect that diagnostic procedures or treatments will be performed only with consent.
10. To request, at his/her own expense, a consultation with a specialist.
11. To refuse treatment with the understanding that the office/patient relationship may be terminated with reasonable notice, and to refuse transfer to another facility.
12. To request and receive an itemized and detailed explanation of his/her bill.
13. To initiate a complaint at any time during the course of treatment and to expect that it will be reviewed and resolved, if possible, in a reasonable period of time.
14. To have pain assessed and managed, and to have information about pain and pain relief measures.

PAITENT RESPONSIBILTIES:

1. To provide accurate and complete information about your current complaints, past illnesses, medications and financial status.
2. To comply with all office rules and regulations: to follow the orders of your provider and to be responsible for your own actions and outcomes if you refuse treatments or do not follow instructions.
3. To assure that the financial obligations of your healthcare are fulfilled promptly.
4. **To be considerate of the rights of others and to assist us in controlling noise,** the number of visitors allowed and any other distractions, which may affect patient care.
5. To accept responsibility for all personal property and valuables brought into the office.
6. To ask your doctor or nurse what to expect regarding pain and pain management: to discuss pain relief options with your doctor or nurse: to ask for pain relief when pain first begins; to help the doctor and nurse measure your pain and to tell the doctor and nurse if your pain is not relieved.
7. To report any risks in your care and any unexpected changes in your health condition.
8. To help the clinic improve services by providing feedback about your healthcare needs and expectations.

Patient Signature: _____ Date: _____

By signing above, I agree that all information provided by me in this packet is accurate to the best of my knowledge.

I understand my responsibility to promptly notify CLARK MEDICAL GROUP of any changes.

Clark Medical Group Appointment Policy

Our goal is to provide quality, individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment: In order to be respectful of the medical needs of other patients, please be courteous and call Clark Medical Group's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment: To cancel your appointment, please call 912.623.2155. If you do not reach the receptionist you may leave a detailed message on our voice mail. Please leave your name and phone number If you would like to reschedule your appointment. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice.

No Show Policy: A "no-show" is a patient who misses an appointment without cancelling it. Failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show." This includes arriving 15 minutes after your scheduled appointment.

The first time there is a "no-show," late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient. A 2nd occurrence will result in a fee of $25.00. The 3rd occurrence will be the fee of $25.00 visit and the patient may be discharged from the practice.

For our New Patient's first visit, a no show or late cancellation will result in a discHarge of the practice.

Print_____ Date _____

Sign_____ Date _____