3890 Redwine Rd, SW
Suite 210
Atlanta, GA 30331
404.691.6688

Patient Information **Physician Name:**______________________

Name:____ ❐ Mr. ❐ Mrs. ❐ Ms.
Last First MI

Nickname: ______________ SSN: ______________________________ Date of Birth ______________

Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Widowed ❐ Domestic Partner Sex: ❐ Female ❐ Male

Race: ❐ Asian ❐ African American ❐ Caucasian ❐ Hispanic ❐ Multiracial ❐ Native American Indian ❐ Other

Address: ______________________________ City: ____________________State: __________Zip:____________

Home Phone: ____________________________ Work Phone:______________________________________

Cell Phone: ____________________________ E-mail:____

Employer: ______________________________ Address: _______________________________________

City:__________________________________ State:____________________ Zip Code:________________

If Patient is a Minor, please list Mother's Maiden Name: ____

Whom may we thank for your referral?____

Responsible Party Information - ❐ Same as above

Name:____ ❐ Mr. ❐ Mrs. ❐ Ms.
Last First MI

SSN: ______________________ Date of Birth ______________ Sex: ❐ Female ❐ Male

Address: ______________________________ City: ____________________State: __________Zip:____________

Home Phone: ____________________________ Work Phone:______________________________________

Employer: ______________________________ Address: _______________________________________

City:__________________________________ State:____________________ Zip Code:________________

Type of Insurance Coverage ❐ Self-Pay ❐ W/C ❐ MVA ❐ HMO ❐ POS ❐ PPO

Insurance Name:____

Policy Holder's Name:____

Policy Holders Date of Birth ________________ Relation to Patient:_____________________________

HIC/Policy Number:____________________________________

Group Name:______________________________________ Group Number:_____________________________

Effective Date:___________________________ Co-Payment Amount:__________________________________

In case of an emergency, please notify:

Name: ______________________________ Relationship:____

Home Phone: ____________________________ Work Phone:_______________________________________

PLEASE PRESENT ALL INSURANCE CARDS AND PHOTO ID TO BE COPIED.
PAYMENT IS EXPECTED AND APPRECIATED AT TIME OF SERVICES

I. AUTHORIZATION TO RELEASE INFORMATION: Meridian Internal Medicine are authorized to release information contained in my medical record, before, during or after date of service, via copy, telephone, or fax:

1. To my insurance company(s), their agents, or other third party payor, and/or government or social service agencies, which may or will pay for any part of the medical expenses incurred or authorized by representatives of Meridan Internal Medicine and Primary Care Inc.
2. As mandated by law.
3. To alternate care providers, including community agencies and services, as ordered by my physician or as requested by me or my family for post-hospital care or out-patient services.

This information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; Information about drug and or alcohol abuse or treatment of same; and/or psychiatric or psychological information. I waive any privilege pertaining to such confidential information.

Meridian Internal Medicine and Primary Care Inc, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. I acknowledge that this consent is valid until such time as all bills related to medical care have been paid and/or post-care arrangements have been made. I further understand that I can withdraw this consent for release of information at any time prior to expiration (noted below) except to the extent action has been taken in reliance hereon.

II. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I, the undersigned, hereby authorize payment directly to Meridian Internal Medicine and Primary care Inc and treating physicians of the insurance benefits otherwise payable or due to become payable. I understand and agree that I am financially responsible for any charges not covered by this assignment of insurance benefits. Also, I hereby assign to Meridian Internal Medicine and primary Care Inc my rights under Georgia Law to have any insurance claim processed and/or paid within 15 working days of the receipt of the claim by the insurance company. It is further agreed that any credit balance resulting from insurance payments or other sources that are refundable to the responsible party will be applied to any other account owed the
Meridian Internal Medicine and Primary Care group by my family or myself.

III. ASSIGNMENT OF MEDICARE AND MEDICAID BENEFITS, PATIENT CERTIFICATION AND PAYMENT REQUEST: I hereby certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I request that payment of this authorized benefits be made and assign the benefits payable for services rendered during this visit to the physician or organization furnishing the services. The undersigned if other than the patient, and the patient are responsible for and agree to pay charges not covered by this assignment, including any Medicare deductibles.

IV. POTENTIAL LIABILITY: The health insurance option I have selected may require prior authorization for coverage of some services. If coverage of services that have been requested in this case are not approved by my insurance company based upon medical information provided by the physician and/or myself, I will be liable for total charges or a portion of the charges in accordance with my insurance program.

_____________________________________ ________________________
Signature of Patient/Guardian **Date**