Community Family Practice & Urgent Care, P.C.
277 E. Crogan Street, Lawrenceville, GA 30046
Phone: 770-822-4411 **Fax**: 770-670-5727

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE:** _____

DATE OF BIRTH: _____ **SEX:** _____**SSN:** _____-_____-_____ **MARITAL STATUS:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____**ZIP:**_____

PHONE NUMBERS:

HOME: _____ **WORK:** _____ **CELL:** _____

EMAIL: _____

EMERGENCY CONTACT: LAST NAME: _____**FIRST NAME:**_____

RELATIONSHIP:_____**PHONE #:**_____

SPOUSE OR PARENT'S NAME: _____

SSN: _____ **DOB:** _____ **PHONE #:**_____

NAME OF WORK: _____ **PHONE:** _____

ADDRESS: _____

INSURANCE INFORMATION

POLICYHOLDERS NAME: _____ **EFFECTIVE DATE:** _____

NAME OF INSURANCE:_____ **POLICY#** _____

GROUP#_____

MEDICAID: YES/NO **EFECTIVE DATE:** _____

ANY MEDICAID PATIENT WITH OTHER INSURANCE MUST INFORM OUR STAFF, OTHERWISE, IN THE EVENT THAT MEDICAID REQUEST REFUND OF MONEY DUE TO OTHER INSURANCE COVERAGE, PLEASE NOTE YOU WILL BE FULLY RESPONSIBLE FOR YOUR VISIT.

CONSENT FOR TREATMENT:

- Permission is hereby given for any medical/ surgical procedures/ x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by Physician, Physician Assistant, or Nurse Practitioner.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by a Physician Assistant.
- In the case of an unemancipated minor, the consent below is given on his or her behalf.

ACKNOWLEDGEMNET OF PRIVACY RIGHTS:

By signing below I acknowledge that I have received the Community Family Practice & Urgent Care, P.C. notes of Privacy Practices and Individual Rights.

Signature: _____**Date:**_____

Community Family Practice & Urgent Care, P.C.

Thank you for choosing **Community Family Practice & Urgent Care, P.C.** for your medical needs. It is our goal to provide quality patient care in a professional and caring environment. **Please take a few moments to read the following information to ensure any questions you might need to clarify prior to check in.**

Name: _____ Date of Birth: _____

Insurance Information:
We accept most major insurance plans**.** Insurances are filed as a courtesy to our patients. You will be held responsible for any portion of the bill not covered by your insurance company. We are unable to file insurance for patients living outside the US boundaries: you will be required to pay for your visit in full. However, we will provide you with an itemized statement in order for you to file your own insurance.

Although we participate with many health care plans including HMO's, unfortunately there are plans that have not approved our facility for payment. If it is unclear whether our center participates on your plan, we will be happy to see you. However, you need to be aware that you will be held responsible for your entire bill should your insurance deny the visit. Other options for patients with non-participating plans include either seeking treatment at a local ER (covered by your insurance plan) or waiting for treatment from your primary care provider. It is our goal to participate on all plans; we would appreciate you discussing with your insurance carrier the convenience of our facility to meet your future medical needs.

Knowing your benefits is your responsibility; please contact your insurance company with any questions regarding your coverage.

Co-payment/Co-Insurance and/ or Deductibles
Co-pay and co-insurance are due at the time of services. Please note that all deductable balances are due at the time of service once the insurance benefits have been verified.

Self-Pay Patients
We offer a self-pay discount rate that is due at the time of service. Payment must be made in full at the time of service.

Patients in Collections with Community Family Practice & Urgent Care, P.C.
All patients will be sent three statements. If account is not settled after 15 days of mailing, the third statement will be forwarded to a collection agency unless prior arrangements have been made. There will be an additional collection agency fees added to all collection amounts. Any insufficient check will be charged an additional $30.

Picture Identification
We require some form of picture identification at the time of service. If you cannot provide picture identification, you will need to come back at a time that you have it with you.

Workers Compensation
Our facility will gladly treat any workers compensation injury. However, in the event that we are unable to verify with your supervisor and/or employer; or if your employer denies verification, you will be held responsible for all charges related to your visit. If you know that your company requires a drug screen to be completed, please inform our staff.

Claim Submission
We will submit your claims to your insurance company and assist you in helping to get your claims paid. It is your responsibility to provide your insurance company with any information that they may request directly from you. Any unpaid balance from your insurance company will be your responsibility whether or not your insurance company pays your claim.

Missed Appointments
Cancellation or rescheduling of your appointment is required within 24 hrs or you will be charged a $20 fee.

By signing below I acknowledge that I have read, understand, and agree to the terms and conditions listed above.

Signature: _____ Date: _____