

# North Atlanta Surgical Associates, P.C.

Please Print The Following Information:

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

First Middle Last  
Social Security #: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Please indicate below what categories you may fall under. You do have an option to defer.

Race/Ethnicity:  White  American Indian  Alaskan Native  Asian  Black or African American  
 Hispanic or Latino  Native Hawaiian  Non-Hispanic  Other Pacific Islander  Defer

Preferred Language:  English  Spanish  Chinese  French  German  Russian  Japanese  Italian  Defer

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Please circle your preference(s) for receiving communications from our office: Phone: E-Mail: USPS: Fax:

Please list below your preferred Pharmacy Name, Location, Phone and Fax Number

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ E-Mail Address : \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Person Responsible For Bill: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize NASA to bill by insurance company for charges incurred during the course of treatment and to provide any medical information necessary to process insurance claims. I authorize payment to be made directly to NASA and a copy may be used instead of the original. I authorize my doctor to inquire about my account and to receive any information that may be necessary. I understand that NASA will file any claims with my insurance company for charges incurred. However, if my insurance company does not have a contract with NASA, I UNDERSTAND THAT I WILL BE PAYING FOR MY VISIT IN FULL. If my insurance company does have a contract with NASA, I agree that I will be responsible for all non-covered services and pre-existing conditions. I will be responsible for any co-payments and deductibles.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Guarantor's Signature (If patient is a minor)

\_\_\_\_\_  
Date

**North Atlanta Surgical Associates, P.C.**

**Medical History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

(If there is insufficient space under a heading please finish the answer on the blank lines at the bottom of the page)

**CHIEF COMPLAINT** (reason for coming in) \_\_\_\_\_

**MEDICAL PROBLEMS:**

Please circle any other following that you suffer from: High Blood Pressure Heart Disease Diabetes Kidney Disease Liver Disease Lung Disease

Please list any **SURGICAL PROCEDURES** that have been performed on you: \_\_\_\_\_

What **x-rays, mammograms, ultrasounds, lab work** or other tests have you had recently for this problem? \_\_\_\_\_

Please list all **ALLERGIES**(drug, food, tape, latex, etc) and your reaction \_\_\_\_\_

Please list all **MEDICATIONS** and/or supplements you are presently taking including the dosage and reason:

Are you taking Plavix, Coumadin or any other blood thinner? \_\_\_\_\_ Do you have any cardiac stents? \_\_\_\_\_

Do you use **tobacco**? \_\_\_\_\_ If yes, type, how much and how long? \_\_\_\_\_

Do you drink **alcoholic beverages**? \_\_\_\_\_ If yes, how much and how long? \_\_\_\_\_

Is there a **FAMILY HISTORY** of any significant illnesses or diseases? \_\_\_\_\_

Is there any history of contact with any hazardous chemicals or radiation? \_\_\_\_\_

(Use the space below to complete any answers in which there was not enough space on the form)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please make a check in the box next to the symptoms you have experienced in the past or present:

**General**

- Fever/Chills
- Weight Loss

**Eyes/Ears/Nose/  
Mouth**

- Vision Loss
- Hearing Loss
- Ringing in the Ears
- Nosebleeds
- Hoarseness/Voice Change
- Difficulty Swallowing

**Cardiovascular**

- Irregular Heartbeat
- Chest Pain
- Shortness of Breath
- Swollen Ankles

- Fainting Spells
- Heart Failure

**Endocrine**

- Thyroid Disease/Goiter
- Diabetes

**Respiratory**

- Chronic Bronchitis
- Emphysema
- Chronic Cough
- Asthma
- Wheezing

**Gastrointestinal**

- Nausea/Vomiting
- Abdominal Pain
- Diarrhea
- Constipation

- Bloody Stools
- Black Tarry Stools
- Indigestion

**Musculoskeletal**

- Arthritis
- Joint Pain

**Integumentary**

- Rashes
- Hives

**Neurological**

- Muscle Weakness
- Numbness/Tingling
- Sensation

**Psychiatric**

- Depression
- Nervous Breakdown

**Genitourinary**

- Kidney Infection
- Frequent Overnight Urination
- Blood in Urine

**Hematological/Lymphatic**

- Anemia
- Easy Bruising
- Blood Transfusions/ Reactions
- Bleeds Easily/ Hemophilia

Do you have any other symptoms that seem important or abnormal? \_\_\_\_\_

Please list all physicians that you are currently seeing: \_\_\_\_\_

FOR BREAST PATIENTS ONLY: Any family history of breast cancer: \_\_\_\_\_

Previous breast surgery or biopsy: \_\_\_\_\_

Any nipple discharge or bleeding? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Did you nurse? \_\_\_\_\_ Last menstrual period: \_\_\_\_\_

Hormone history: \_\_\_\_\_

Have you undergone a Hysterectomy? \_\_\_\_\_ Oophorectomy? \_\_\_\_\_

I believe this is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient or Guardian Signature

# NASA Patient Identification Policies

## Important Information For New Patients

NASA policy requires all healthcare staff to obtain, verify, and record information that identifies each new patient.

This policy is for your protection. Identity thieves use people's identifying information to request health care services. This misuse of your information may result in declined healthcare coverage or financial responsibility for services not rendered to you.

**What this means for you:** When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents. We may request that you allow us to take a digital photo of you for our records and your protection.

North Atlanta Surgical Associates will obtain, verify, and record the following information on new patients.

- Name
- Address
- Drivers License # and State
- Other Photo ID
- Date of Birth
- Social Security/TIN
- Insurance ID
- Other supporting documentation if needed

If identification is not possible during an emergency situation you will not be denied medical care. It will be the responsibility of the patient to provide North Atlanta Surgical Associates appropriate identification as required by our Policy.

**I certify I am who I claim to be. I have provided documentation supporting claims and my information was verified by North Atlanta Surgical Staff. It will be my responsibility to inform NASA of any changes in my personal information upon future visits.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### For Internal Office Use Only

**I have followed NASA Policy in obtaining, verifying, and recording this patient's identification.**

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Updated 1/2011

**NORTH ATLANTA SURGICAL ASSOCIATES, P.C.  
PATIENT ACKNOWLEDGMENT RECEIPT OF NOPP,  
FINANCIAL POLICY, PATIENT RIGHTS, & ADMINISTRATIVE FEES**

I have been offered a copy of the following NASA, P.C. policies

Notice of Privacy Practices

Financial Policy

Patient Rights & Responsibilities

Administrative Fees

By signing below, I acknowledge that I have read and have been offered all of the policies listed above for North Atlanta Surgical Associates, P.C.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship of Representative to Patient

\_\_\_\_\_  
Description of Representative's authority to act on behalf of Patient

\_\_\_\_\_  
Date

## Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____
North Atlanta Surgical Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the Patient or others in keeping with the patient's instructions.

<b>Entity to receive information</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____
<input type="checkbox"/> Other (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows _____

<p><b>Patient Information</b></p> <p>I understand that I have the right to revoke this authorization at any time and I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</p> <p>I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.</p> <p>I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. <u>This authorization shall be in effect until I revoked by the patient</u></p>
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\_\_\_\_\_  
Signature or Patient or Personal Representative  
Description of Personal representative's Authority (attach necessary documentation)

\_\_\_\_\_  
Date:

Created April 2009

**NORTH ATLANTA SURGICAL ASSOCIATES, P.C.**  
**NOTICE OF PRIVACY PRACTICES**

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE  
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS  
INFORMATION.  
PLEASE REVIEW IT CAREFULLY**

Effective Date: March 31, 2003

If you have any questions about this notice, please contact the office's Privacy Officer.

**WHO WILL FOLLOW THIS NOTICE**

This notice describes our office practices and those of:

- Any healthcare professional authorized to enter information into your medical record.
- All employees, staff and other personnel.

**OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive here. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by us, whether made by office personnel or by the physician.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about; and
- Follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical assistants or medical office personnel who are involved in taking care of you here in our office. For example, the doctor may need to schedule you for a colonoscopy. The medical staff will need to review any and all of your indications for this test in order to properly orient you for the procedure. The staffer will then need to schedule you with the facility and may also need to pre-cert the test with your insurance company. In both instances, she would need to have full access to your medical information. We also may disclose medical information about you to people outside our office who may be involved in your medical care, such as referring physicians, your primary care physician or others we use to provide services that are a part of your care.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may disclose information about you to another health care provider, such as another physician, for their payment activities concerning you.
- **For Healthcare Operations.** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to your prior approval.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

## **SPECIAL SITUATIONS**

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Dept. Of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation.** We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  1. To prevent or control disease, injury, or disability;
  2. To report deaths;
  3. To report reactions to medications or problems with products; to notify people of recalls of products they may be using;
  4. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  5. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  1. In response to a court order, subpoena, warrant, summons, or similar process;
  2. To identify or locate a suspect, fugitive, material witness, or missing person;
  3. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  4. About a death we believe may be the result of criminal conduct;
  5. About criminal conduct on the office premises; and
  6. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

- **Coroners, Medical Examiners, and Funeral Directors.** We May release medical information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release medical information about deceased patients to funeral directors as necessary to carry out their duties upon the request of the patient's family.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution; or (4) to obtain payment for services provided to you.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you.

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay the fees, if any, for preparing the summary or explanation.

We may deny your request to inspect and copy your medical information in certain very limited circumstances, such as when we, as your physician, would determine that for medical reasons this is not advisable. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by NASA, PC will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this person decides.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for NASA, PC.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  2. Is not part of the medical information kept by or for NASA, PC;
  3. Is not part of the information which you would be permitted to inspect and copy; or
  4. Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of some of the disclosures we made of medical information about you that were not specifically authorized by you in advance.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Confidential Communications.** You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, besides your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. Contact our Privacy Officer if you require such confidential communications.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, request a copy from the front desk.

## **CHANGES TO THIS NOTICE**

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. {In addition, each time you visit the office, we will offer you a copy of the current notice in effect.}

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact the Office Manager. If you feel this has not been resolved you can contact our Business Office at 678-336-5951.

All formal complaints must be submitted in writing to:

North Atlanta Surgical Associates, PC  
5115 New Peachtree Road  
Suite 202  
Chamblee, GA 30341

***You will not be penalized for filing a complaint.***

## **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

# North Atlanta Surgical Associates, P.C.

## Financial Policy

We are committed to provide the patient with the best medical service available. Your clear understanding of our Financial Policy is important to us. **Please read carefully.** If you have any questions or concerns regarding the Financial Policy, please contact the Central Billing Office at (678) 336-5951.

NASA DOES NOT ACCEPT MEDICAID.  
BY LAW DEDUCTIBLES/CO-PAYS CANNOT BE WAIVED.

### All Patients:

- I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at North Atlanta Surgical Associates, P.C. ("NASA").
- NASA accepts Cash, Checks, Money Orders, and Visa/Master Card.
- If my check is returned for non-payment due to insufficient funds or a closed account, NASA will charge me a \$25.00 fee. This fee is in addition to any fees that may be assessed by my bank for returned checks.
- If I do not speak English, it is my responsibility to obtain an interpreter to assist in completing and understanding these documents.
- In the event of default on this account with NASA, this account will be submitted to an outside source for collections. Any unpaid balance will accrue 1.5% per month or 18% per year interest. If this account is collected by or through an attorney at law that is not our salaried employee, I will be liable for accrued interest, all costs of collection and 15% attorney's fees.

### Uninsured Patients:

- If I do not have insurance, I am expected to pay for services rendered in advance unless prior arrangements are made.

### Surgical Patients:

- All procedures which are cancelled/rescheduled within 5 days of the surgery date will be charged a \$150.00 non-refundable administration fee. (unless cancelled by Physician)

### Medicare Patients:

- NASA participates in Medicare. NASA will collect my 20% co-pay and any deductible at the time service is rendered. If there is a Medigap/Supplemental policy in place we will submit claims to both carriers.
- If I am a Medicare/Medicaid patient, I am responsible for the balance Medicare does not pay.

### Insured Patients:

- NASA allows 60 days from the date a claim is filed for my insurance plan to pay.
- It is my responsibility to know and understand my insurance plan. This includes my financial responsibility for services rendered such as co-pay's, deductibles, co-insurance and anything else that my insurance plan determines is my responsibility.

- It is my responsibility to provide NASA with any information necessary to process my claim. Any information requested by my insurance is necessary for processing. If I do not provide the requested information I will be billed for the balance.
- I am required to provide NASA with my most current insurance information. (This would include a copy of my current insurance card, any changes in insurance plan coverage, co-pay, deductible, coinsurance).
- I am responsible for any services and/or procedures not covered by my insurance plan. If I am seen without a referral I am responsible for the charges. It is also my responsibility to ensure my insurance plan pays my bill in a timely manner. If no payment has been received after the sixty (60) day grace period I will be billed for the balance.
- NASA expects payment of my account in full within 30 days. If I cannot pay the entire balance, a payment plan can be arranged.
- It is my responsibility to inform NASA of any changes in my contact information.

### **Managed Care Patients:**

- I UNDERSTAND THAT I AM REQUIRED TO OBTAIN PROPER REFERRAL AND/OR AUTHORIZATION AS REQUIRED BY MY INSURANCE PLAN PRIOR TO MY APPOINTMENT WITH ANY OF THE NASA PHYSICIANS.
- IF AUTHORIZATION IS NOT OBTAINED FOR MY VISIT, MY INSURANCE PLAN MAY NOT PAY FOR MY TREATMENT. IN THIS CASE, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED. I UNDERSTAND THAT NASA IS NOT OBLIGATED TO SEE PATIENTS WITHOUT A VALID REFERRAL/AUTHORIZATION.
- CO-PAYMENTS/DEDUCTIBLES WILL BE COLLECTED AT THE TIME SERVICES ARE RENDERED.
- I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to me directly to NASA. I hereby authorize NASA to release any information necessary to process my claim. I understand that I am legally and financially responsible for all charges not covered by my insurance plan. I hereby authorize payment directly to NASA for services rendered.
- I understand that if my insurance plan sends me a check for payment of the medical services provided by NASA, the check belongs to NASA and I must immediately deliver the check to NASA for payment on my account.
- I understand and agree that I will be responsible for any co-pays, deductibles, and co-insurance amounts, as well as any services not covered by my insurance. After payment by my insurance plan and negotiated adjustments are made, any balance becomes my legal and financial responsibility.
- In the event that my insurance plan denies my claim and I choose to appeal their decision, this form and my signature authorizes my physician at NASA to submit an appeal along with any necessary medical information to my insurance plan.

## Notice of Office Administrative Fees

North Atlanta Surgical Associates, P.C. charges administrative fees for the following forms:

Annual Fee \$75.00 (optional-waives all other fees for one year)

Disability forms \$25.00 (per form)

Account history \$15.00 (per form)

**Medical Records –Charges per Georgia Law:**  
**GEORGIA STATE COPY LAW**  
**SECTION 2:CODE SECTION:31-33-3**

The party requesting the patient's records shall be responsible to the provider for the reasonable costs of copying and mailing the patient's record. The actual cost of postage incurred in mailing the requested records may also be charged, in addition copying costs for a record which is in paper form shall not exceed\$.97 per page for the first 20 pages of the patient's record which are copied. \$.83 per page for pages 21 through 100 and \$.66 for each page copied in excess of 100 pages. All of the fees allowed by this code section may be adjusted annually in accordance with the medical component of the consumer price index. A charge of \$25.88 may be collected for search retrieval and other direct administrative costs related to the request under this chapter.

Administrative Costs \$25.88  
(e.g., search, retrieval and other labor costs)

Certifying the Copies up to \$9.70 per record

Cost of Postage Actual Charges

First 20 pages of patient's record up to \$.97 per page

Pages 21 through 100 of record up to \$.83 per page

Each page over 100 pages up to \$.66 per page

# North Atlanta Surgical Associates, PC

## Patient Rights and Responsibilities

### You Have A Right:

- To be treated with respect, consideration, and dignity at all times.
- To receive assistance in a responsible manner.
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternatives and likely consequences of your decision.
- To express a complaint to the office manager, physician or staff.

### You Have A Responsibility:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions, and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each office visit. Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment. (24 hour notice)
- To pay all charges for co-payments, deductibles, non-covered benefits of services at the time of your visit unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.