Ocmulgee Physicians, LLC

446 Poplar Street Suite B

Macon, GA 31204

Phone: (478) 746-0097 Fax: (478) 742-4051

Thank you for choosing to become a patient of Ocmulgee Physicians. We are committed to providing exceptional service and assistance to each and every patient in our practice with the utmost diligence.

Please bring the following items to your appointment:

- Insurance Card(s), Picture ID and Co-pay
- COMPLETED NEW PATIENT PAPERWORK
- All medications you are currently taking in their correct bottles
- The name(s), address, phone/fax numbers to your previous doctors to obtain your medical records

We would like to take this opportunity to familiarize you with our practice policies.

- It is your responsibility to know the benefits that you receive from your insurance company. This includes wellness/physical coverage, deductible amounts and co-pay requirements.
- For your convenience, we provide onsite lab services. If your insurance requires you to use a specific reference laboratory, it is your responsibility to tell us before labs are drawn so that you may be given an order sheet to go to an outside lab that your insurance covers.
- In compliance with HIPAA laws, no information will be given to anyone, including family, without prior written consent.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for the providers will be directed to the nurses.
- If you need to reschedule or cancel your appointment, we ask that you give at least a 24 hour notice.

While our address is on Poplar Street, the office entrance with parking is accessible on the backside of the building off of Poplar Street Lane. You will see a sign for “Poplar Medical Complex”.

Please do not hesitate to call us if you have any questions. We look forward seeing you soon!

Sincerely,

Dr. Alan Justice and Ocmulgee Physicians Staff

At Ocmulgee Physicians, we are committed to providing quality and affordable primary health care. Because some of our patients have questions regarding general practice guidelines and patient financial responsibility for services rendered, we have developed these policies for your information and future reference. Please read them, ask any questions you may have and sign in the space provided.

GENERAL PRACTICE POLICIES:

Telephone Calls: If you have a medical emergency, please call 911.

Due to heavy call volumes, some calls will be transferred to a voice mail box. The voicemails are monitored continuously throughout the day. All calls received before 4pm will be returned within the same business day.

Medication Refills: All refills and prescription renewals should be initiated through your pharmacy. Please notify your pharmacy when you need a refill, and they will contact our office for approval. **If you have no future appointments scheduled, you will need to contact our office to make an appointment for evaluation to ensure there are no issues with your medications before we can send any refills to your pharmacy.**

Missed Appointments: To ensure the best outcome for every patient, we feel strongly that every appointment is medically necessary. Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Our system is set to call and/or text reminders of your scheduled appointments. Please ensure that your preferred method of contact and contact information are up to date in our system and respond to these calls accordingly. Although we understand that emergency situations may arise, a quick call to cancel your appointment would be appreciated. Due to high demand and limited availability of same day appointments we have instituted a "missed appointment" fee. You must give at least a 24hr advance notice to cancel or reschedule appointments. Failure to do so will result in a missed appointment fee charge of $25.00-$50.00 to your account, depending on the service scheduled. These fees are patient responsibility, will be billed directly to you and must be paid before scheduling another appointment.

FINANCIAL POLICIES:

Identification and Proof of Insurance: At each visit you will be asked to provide driver's license/picture ID and current insurance card. Please be sure to bring these to each appointment so we can ensure accurate information in your patient account. We have made prior arrangements with many insurers and health plans to accept assignment of benefits and participate in most insurance plans, including Medicare and Medicare Advantage plans. We are happy to file insurance to your primary and secondary insurance as a courtesy. Your insurance will be verified prior to each visit or procedure. If we are unable to verify your coverage prior to your visit, you will be considered a self-pay patient and payment in full will be expected until your coverage can be re-established.

Dismissal: As a last resort, repeated failure to keep your scheduled appointments or failure to comply with practice treatment polices may result in dismissal from the practice. Dismissal may also occur if your account has carried an unpaid balance after the 3rd billing statement without making payment arrangements. If for any reason you have been dismissed from Ocmulgee Physicians, you will be notified by regular and/or certified mail.

Self-Pay Patients: For all services rendered to patients without insurance or proper proof of insurance, a self-pay discount will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Should any test performed result with any abnormalities, additional testing may be required and will fall under the patient's responsibility for those charges.

Insurance Coverage: If your insurance changes, please notify our office prior to your visit so that the necessary updates can be made to ensure you receive the maximum benefits. We will submit your primary and secondary insurance claims; however, resolving any claims issues that require additional information from you are your responsibility. If additional information is requested, failure to respond to Ocmulgee Physicians or your insurance company will result in the unpaid balance being moved to your financial responsibility. If your insurance company does not respond to our claim with payment or denial within 45 days,

unpaid charges may be billed directly to you. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any specific questions you may have regarding your benefits, deductible, and coverage limitations.

Co-payments, Co-Insurance and Deductibles: Payment of co-pays, co-insurance and deductibles are part of your contract with your insurance company and are required per our agreement to accept your plan. Please help us in upholding the terms of these contracts by paying your co-payment at each visit. We will attempt to verify your out-of-pocket expense prior to any procedures being performed but pre-certification does not guarantee payment by your insurance company and therefore could become patient responsibility after the claim has paid. If we cannot determine this amount at the time of your visit, patient responsibility will be assigned after your insurance company has processed the claim and submitted payment to Ocmulgee Physicians. This balance is due upon receipt of your statement.

Non-covered services: Some recommended services may be ordered by your provider but may be deemed as not reasonably necessary by Medicare or your insurance company based on plan limitations and/or your benefit structure. When possible, you will be advised in advance if we believe the service may not be covered, the reason it may not be covered and the anticipated charges for these services. Services that exceed your limits of coverage will be billed directly to you. For traditional insurance, annual physicals are typically scheduled at least 366 days apart. We will try our best to notify you of these circumstances; however, understanding the benefits of your insurance is ultimately your responsibility.

Preventive Services/Sick Visit on the Same Day: Preventive services are traditionally scheduled at regular intervals to collect or update basic patient information related to history, physical status, and to make plans for additional services that may be required to ensure patient wellness. In some cases, a patient may request or require additional services outside of what is traditionally provided in a preventive/wellness visit.

Multiple Statements: Ocmulgee Physicians bills for services provided by the physicians and providers in the practice. Ancillary services such as laboratory, pathology, or radiology services, etc., may be billed by an outside medical vendor. Therefore, you may receive separate statements from those offices. Please pay each statement separately.

Non-payment: If any balance is over 90 days past due, your final statement will notify you that you have 20 days to pay your account in full to avoid being turned over to an outside collection agency. Partial payments will not be accepted unless a payment agreement has been established and followed as scheduled. If at any point a payment is missed, the collection process will pick up where it left off and the account will be referred immediately to an outside agency. In the event your account balance is referred to a collection agency, your account will be made inactive and you will be dismissed from Ocmulgee Physicians. Additionally, because of the high expense related to using an outside collection agency, additional fees will be added to your account.

Credit Balances: In the event that a credit balance is created for any service date, we will verify that there are no outstanding balances on any other date of service and no upcoming appointments before initiating a refund. Because of the administrative expense of processing a refund, any credit balance of $20.00 or less will remain on the account for use at a future visit unless the refund is specifically requested by the patient or guarantor.

I HAVE READ, UNDERSTAND, AND ACCEPT THE ABOVE STATEMENTS.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Patient Information:

bame (Last, First): _____ M.I. _____ Date of Birth: _____

Sex: (M)☐ (F)☐ Race: _____ SSN: _____ Marital Status: _____

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: Home: _____ Cell: _____

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

I authorize Ocmulgee Physicians, LLC to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes (check all that apply):

☐ Home Phone Voicemail ☐ Cell Phone Text Message/Voicemail ☐ Work Phone Voicemail

I authorize any holder of medical or other information about me to be released to my insurance company or the Social Security Administration needed for this or any related medical claim. I request payment of medical insurance benefits to Ocmulgee Physicians, LLC. I understand that the charges are my responsibility. I understand that it is my responsibility to know if my physician is in network with my plan. If my insurance company fails to make payment in a timely manner, I am responsible for this bill. **_____ (Initials)**

Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners and/or physician assistants of Ocmulgee Physicians, who may attend me, their assistants, including those employed by Ocmulgee Physicians, to provide the medical care, tests, procedures, drugs, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services, and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personal assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. **_____ (Initials)**

I consent and give permission to Ocmulgee Physicians, to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes. **_____ (Initials)**

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my MEDICAL CARE. I realize the authorization allows Ocmulgee Physicians to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Ocmulgee Physicians and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to which I am entitled, with respect to the Health Care Service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Ocmulgee Physicians LLC and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. **_____ (Initials)**

HIPAA-Privacy Policy

It is the policy of our practice that all physicians and staff members preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our entire practice has the necessary medical and PHI to provide our patients the highest quality of medical care possible. Patients should not hesitate to provide information to our practice, physicians, or staff members for purpose of treatment, payment, and healthcare procedures. Our HIPAA policy in its entirety can be obtained through out office at any time. Let us know if you would like to receive a copy prior to signing this consent.

I understand HIPAA and its policies. **_____ (Initials)**

I authorize the release of medical information necessary to process insurance claims and to healthcare providers for treatment or care. **_____ (Initials)**

I hereby acknowledge that Ocmulgee Physicians LLC will share my medical information, as permitted under federal law (HIPAA) and Georgia State law, with my healthcare providers through a health information exchange. **_____ (Initials)**

Prescription History Authorization:

I authorize the review of my prescription history for reasons of evaluation and treatments. **_____ (Initials)**

Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

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Consent to Disclose Protected Health Information

I, _____, am granting permission for Ocmulgee Physicians, LLC to allow the following people to have access to my:

☐ Medical Records

☐ Account Information

I understand I may revoke this permission by completing a new form.

Name:	Relationship:	Phone Number:

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to Ocmulgee Physicians, LLC.

Patient Name: _____ DOB: _____

I understand that my medical records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment.

☐ I give my specific authorization for these records to be released to Ocmulgee Physicians, LLC.

☐ **IF NOT**, initial the information that you **DO NOT** want released:

____ Drug/Alcohol Abuse/Treatment ____ Sexually Transmitted Diseases

____ HIV/AIDS Diagnosis/Treatment ____ Psychiatric Diagnosis/Treatment

This authorization will automatically expire one year from date signed. You may revoke this consent at any time, except to the extent that action has already been taken. You do not have to sign this authorization in order to obtain treatment, payment or enrollment. You may revoke or terminate this authorization by submitting a written revocation to Ocmulgee Physicians, LLC. Information disclosed under this authorization may be disclosed again by the person/organization to which it was sent. It may not be possible to ensure your right to protection of the privacy of this information once Ocmulgee Physicians, LLC discloses it to another party.

Signature: _____ Date: _____

Patient Portal Agreement

We are pleased to provide a Patient Portal in partnership with our electronic medical records provider, eClinicalWorks, for the exclusive use of established patients. The Patient Portal is designed to enhance patient-provider communication. All users must be established by a previous office visit. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services:

- Request Prescription Refills
- View Your Medical Records
- Send Messages to Clinical Staff

The Patient Portal is not intended to provide internet based diagnostic medical services. The following limitations also apply:

- No internet based triage and treatment requests. Diagnosis can only be made and treatment rendered after the patient is seen by the doctor or nurse practitioner.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic, emergency room, or by calling 911 should the emergency be life threatening.
- No requests for new prescriptions or refills for conditions in which you are not being treated by our providers will be accepted.
- It may take up to 48 hours to receive a response to an email request. If you do not receive a response within 48 hours you should contact the office at (478) 746-0097.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to log out and close your browser when you are finished accessing your password protected Patient Portal services. This prevents someone else from accessing your personal information.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between Ocmulgee Physicians, LLC and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein as well as any instructions or guidelines that my medical provider may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all of my questions have been answered.

Do you wish to sign up for the Patient Portal?

☐ No, I do not want to sign up.

☐ Yes, I want to sign up.

Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____