The Wiregrass Medical and Surgical Group

Please Fill Out Completely:

Patient's Name: _____ SSN: _____

Date of Birth: _____ Age: _____

Patient's Address: _____
Address City State Zip

Patient's Phone: Home: _____ Work: _____ Cell: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced Sex: _____
M. F.

Employer: _____ Employer Phone: _____

Responsible Party: _____ Date of Birth: _____

Resp. Party Address: _____
Address City State Zip

Resp. Party Phone: Home: _____ Work: _____ Cell: _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Phone: _____ Email: _____

FOR OFFICE USE ONLY

_____ _____
Verified by Initials Date

The Wiregrass Medical & Surgical Group, Inc.

MAILING ADDRESS:
804 N. WILEY AVENUE
DONALSONVILLE, GEORGIA 39845
PH. (229) 524-2706
OR (229) 524-2808
FAX (229) 524-1272
OR (229) 524-2738
wmsg@windstream.net

ANDREA G. ALEXANDER, MD
DERMATOLOGY

HOMER E. BRECKENRIDGE, III, MD, ACS
GENERAL SURGERY AND FAMILY MEDICINE

HEATHER CASTLEBERRY, MD
FAMILY MEDICINE

GREGORY L. HALL, MD
FAMILY MEDICINE

SARAH W. HAMPTON, MD
INTERNAL MEDICINE

RYAN S. SHINGLER, DO
FAMILY MEDICINE

GARY W. SMITH, PHD
LICENSED PROFESSIONAL COUNSELOR

JOSEPH L. WALKER, MD
GENERAL SURGERY

PATIENT INFORMATION RELEASE FORM

Patient Name:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: HM:_____ WK:_____ Cell:_____

Email:_____

- **Medical information and/or test results can be given over the phone to:**

  _____ NO ONE except myself

  _____The following person (s):

Name:_____ Relationship to patient:_____

HM:_____ WK:_____ Cell:_____

Name:_____ Relationship to patient:_____

HM:_____ WK:_____ Cell:_____

Name:_____ Relationship to patient:_____

HM:_____ WK:_____ Cell:_____

Patient Comments:_____

_____

_____

_____ _____

Patient Signature Date

The Wiregrass Medical & Surgical Group, Inc.

Homer E. Breckenridge, III, MD Gregory L. Hall, MD Sarah W. Hampton, MD Charles O. Walker, MD
Joseph L. Walker, MD Andrea G. Alexander, MD Gary W. Smith, PhD, Geary D. Bush, MD
804 N. Wiley Ave.
Donalsonville, GA 39845

Patient Release of Information and Benefit Assignment

In consideration of services rendered or to be rendered, the undersigned agrees to pay the physicians rendering services, the reasonable charge thereof, insurance not withstanding and for the collection of said charges, undersigned hereby waives all claims or right of exemption allowed by the constitution and laws of the State of GA or any other state of the United States, and further agrees to pay all cost of collections of said charges, including reasonable attorney's fees where collection is turned over to an attorney to enforce collection of said charges. Undersigned further understands that physicians' do not accept any insurance policy assignment as a guarantee of full payment.

Assignment of Insurance Benefits

In consideration of care and services rendered to me by physicians during this office visit and/or hospital stay, I assign the benefits payable under my insurance policies for physician services to the physician furnishing the services, or to their authorized billing agent insofar as necessary to cover their charges. I authorize such physician (or their authorized billing agent) to submit a claim to my insurance carrier for payment to me and authorize payment directly to said physician's billing agent or organization.

Assignment of claims against third parties

In consideration of the office care and/or hospital care and services rendered, or to be rendered to me by physicians' during my confinement, I hereby assign to the physician furnishing the services all claims I may have against third parties, including tort-feasors insurance companies who may be liable for any of my medical expenses, to the extent necessary to cover my expenses for physicians care and service. I also assign to said physician all rights in any settlement made by me and arising out of my claim of which this office care and/or hospitalization is a part to the extent necessary to cover my expenses for physicians' care and service, whether or not a portion of said settlement is designed as being for medical expenses. Any funds received by me in connection with such claims against third parties, or settlement of such claims, shall be paid to the said physician or organization insofar as necessary to pay expenses. I hereby authorize payment directly to said physician or their authorized billing agent of any of the above mentioned funds which are otherwise payable to me, but not to exceed the regular reasonable charges for this service.

Statement to permit payment of Medicare benefits to physicians

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf for any services furnished me by physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Medicaid Authorization and Assignment

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Georgia Medicaid agency, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign th the Georgia Medicaid Agencies all claims against third parties, including tort-feasors and insurance companies, who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid, I also assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of any such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the GA Medicaid Agencies. I permit a copy of this authorization and assignment to be used in place of the original.

Authorization to Release Insurance Information

I hereby authorize physicians rendering services to release to my insurers billing certain medical information including final diagnosis and operative procedures relative to this or related hospital claim (s) and/or office claim(s) for the purpose of determining eligibility for a payment of charges for services rendered in connection with this hospitalization and/or office care.

GUARANTOR: (Please print clearly)

Name:_____ **Signature:**_____

Date of Birth: _____

The Wiregrass Medical & Surgical Group, INC.

804 N Wiley Avenue Donalsonville, GA 39845

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. We are required by law to provide individuals with this notice of our privacy practices and our legal duties with respect to protected health information.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at the office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity, and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

Although patient medical records are the "property" of The Wiregrass Medical & Surgical Group, Inc., you have the right to access to the information contained in your personal medical record. You have the right to inspect and receive a copy of your protected

health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Practice Administrator of your complaint. We will not retaliate against you for filing a complaint. If you have any objections to this form, please ask to speak with our Practice Administrator, who is our HIPAA Compliance Officer.

This notice was published and became effective in 2003, and has been updated pursuant to The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

Recent Changes in HIPAA Privacy Requirements

Changes in HIPAA privacy regulations allow us to disclose certain protected health information to family members, caregivers, close friends, and others who are involved in your care, unless you specifically object or unless another state or federal law require such privacy protection. When you are in our office, we will discuss your condition openly with whoever accompanies you, unless you expressly request to exclude specific persons.

In telephone communications, we will continue to require you to designate who we may speak with regarding your care; therefore, it is important that you designate any and all persons you might wish us to speak with on your behalf on our Patient Information Release Form. We will not speak with anyone over the telephone that is not designated on this form.

By my signature below, I acknowledge that I have received The Wiregrass Medical & Surgical Group, Inc. Notice of Privacy Practices.

Signature _____ Date_____

Printed Name_____ Date of Birth_____

PRACTICE FINANCIAL POLICY

Homer E. Breckenridge, III, MD
Gregory L. Hall, MD
Sarah W. Hampton, MD

Andrea G. Alexander, MD
Joseph L. Walker, MD
Gary W. Smith, PhD

Thank you for choosing The Wiregrass Medical & Surgical Group, Inc. We are committed to your health. Listed below are our financial policies. If you have any questions, please discuss them with someone from our financial team.

1. Insurance co-payments are due at the time of service.
2. If your insurance requires a referral, it is your responsibility to ensure the office has received it prior to the scheduled appointment.
3. It is your responsibility to ensure that our physicians are in your insurance network.
4. You are ultimately responsible for payment of charges for service you receive in our office.
5. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your ID card at the time of service. If you do not have an insurance card, you will be responsible for payment at the time of service.
6. As a courtesy, we will process and file your insurance claims for services at no cost to you. We will file workers compensation claims. We no longer submit claims to auto insurance companies for services or injuries related to auto accidents. Payment in full will be due at the time of service for appointments related to an auto accident.
7. All co-pays, deductibles, co-insurance, or non-covered services are to be paid in a timely manner according to office policy. If we are unable to verify or if your insurance coverage is in question, you may be asked to sign an "advanced beneficiary notice" as a condition of service.
8. Payment of co-insurance and/or unmet deductibles may be required prior to scheduled procedures.
9. Payment is due upon receipt of your billing statement for all patient responsible balances; hospital and office rendered services. Unpaid previous balances must be paid in fell prior to any additional visit unless specific arrangements have been made with our Business Office. Billing statements may be delayed until your insurance company responds to all claims. This delay does not alter our policy of patient financial responsibility.
10. Accounts more than one-hundred and twenty (120) days old are subject to an outside collection agency. The patient is responsible for all fees related to a collection agency, such as collection expense, legal fees, and court costs.
11. A minimum fee of thirty dollars ($30.00) will be assessed to your account for checks that do not clear or cannot be cashed.
12. There is a fee for patient administrative services such as forms completion. A fee of fifteen (15.00) is charged for letters, disability forms, wheelchair, assisted living, and other single page forms. Twenty-five ($25.00) is charged for multiple page forms. Payment is due prior to the completion of paperwork/forms. In the event other administrative services are required, any associated fee will be disclosed to you prior to completion of the service.

By my signature below. I acknowledge that I have read, understand, and accept the terms of this Financial Policy.

_____	_____	_____
Signature of patient or responsible party	Please print the name of the patient	Date