MADISON MEDICAL ASSOCIATES
1550 Eatonton Rd.
MADISON, GA 30650
706-752-0322 p
706-752-0325 f

PATIENT INFORMATION:

Last Name:_____ First Name:_____ MI:___ Preferred Name:_____

SS#: _____ Date of Birth_____ Age: _____ M / F Race:_____ Language:_____

P.O. Box_____ ____ Single ____ Married ____Widowed ____Divorced Ethnicity: Hispanic / Latin / Non Hispanic or Latin

Street Address:_____ City:_____ State:_____ Zip:_____

Home #: ( )_____ Cell #: ( )_____ Work #: ( )_____

Employer: _____ Employed: Part time/ Full time Full Time Student? Y / N

Emergency Contact:_____ Relationship_____ Emergency Contact Phone _____

SPOUSE INFORMATION:

Name: _____ SS #: _____ D.O.B._____

Employer: _____ Work#: _____ Cell#:_____

INSURANCE:

Primary Insurance:_____ Secondary Insurance: _____

ID#_____ Group#_____ ID#_____ Group#_____

Policy Holder Name & DOB_____ Policy Holder Name & DOB_____

Insurance Phone #:_____ Insurance Phone #:_____

Insurance Address:_____ Insurance Address:_____

_____ _____

MUST COMPLETE IF UNDER 18 YEARS OLD:

Father's Name:_____

Address: _____

SS #:_____

Date of Birth: _____

Work #: ( ) _____

Mother's Name: _____

Address: _____

SS #:_____

Date of Birth: _____

Work #: ( )_____

Employer: _____ *Employer:* _____

AUTHORIZATIONS:

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by MADISON MEDICAL ASSOCIATES, P.C. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of MADISON MEDICAL ASSOCIATES, P.C. as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to MADISON MEDICAL ASSOCIATES, P.C., for services rendered, I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Patient / Parent or Guardian (Please Print) Patient / Parent or Guardian Signature Date

MADISON MEDICAL ASSOCIATES
1075 S. MAIN ST. SUITE 100
MADISON, GA 30650
706-752-0322
706-752-0325 FAX

Patient Name:_____ **Patient Date of Birth:**_____

Authorization for Treatment

I consent to the administration of medical treatment at Madison Medical Associates, PC. I consent to x-rays, medical procedures, examination, and any other service rendered to me under the general and specific instruction of my physician(s).

X_____ X _____ X_____
Signature of Patient or Legal Representative | Relationship to Patient | Date

Authorization to Release Medical Information

I consent to allow Madison Medical Associates, PC to carry out my treatment, obtain payment and to carry out health care operations. My protected health information may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My protected health information may be disclosed to outside health agencies or institutions involved in my continuing care when I am transferred to another facility and/or for emergency care purposes. My physician(s) may also share my information with referring physicians for continuing care. My protected health information may include medical information or any information pertaining to the examination, treatment, history, which may include psychiatric, HIV/AIDS, sickle cell, alcohol and or drug information and medical information, changes to my health plan and/or their acting intermediaries and/or agents.

X_____ X _____ X_____
Signature of Patient or Legal Representative | Relationship to Patient | Date

Assignment of Benefits

I authorize my health plan to pay benefits directly to Madison Medical Associates, PC. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to payment of those fees and charges not directly reimbursed to Madison Medical Associates, PC by any insurance policy, self-insurance program or other benefit plan. I further agree to accept full financial responsibility for payment of charges rendered to_____.
Name of minor or dependent adult if appropriate

This authorization shall remain in effect until revoked by me in writing except to the extent that action has been taken in reliance on treatment payment and health care operations. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

X_____ X _____ X_____
Signature of Patient or Legal Representative | Relationship to Patient | Date

Acknowledgement of Privacy Notice

I understand that specific information regarding the use and disclosures of my medical information can be found in Madison Medical Associates, PC Notice of Privacy Practice which was made available to me and which I have a right to review before I sign. I further understand that Madison Medical Associates, PC has the right to change its Notice of Privacy Practices and that I may obtain a revised copy at Madison Medical Associates PC, office. I understand that I have the right to request that Madison Medical Associates, PC restrict how my protected health information is used and disclosed for treatment, payment, and health care operations. I further understand that Madison Medical Associates, PC is not required to agree to my requested restrictions. However, if Madison Medical Associates, PC agrees to a requested restriction, Madison Medical Associates, PC is bound by the restriction.

X_____ X _____ X_____
Signature of Patient or Legal Representative | Relationship to Patient | Date

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Patient/legal representative refused to sign this section through good faith efforts by staff were made. Explanation by staff._____
Restrictions_____
_____Approved_____Not Approved

_____ _____
Signature of Privacy Officer and or Practice Manager | Date

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Records to be used for the intent of continuation and/or transfer of medical care.

Patient Name:_____ Date of Birth:_____

I, the above named patient, authorize the disclosure of protected health information about me to the recipients listed below. I understand what information will be disclosed, who may disclose the information, and who will receive the information. I understand that when the information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Information to be disclosed:

( ) My Entire Record ( ) Demographic information only ( ) Other Information (specify below)

_____
_____
_____

I understand that I have the right to revoke this authorization in writing, except anything already disclosed, or during any contestability period. For the revocation to be effective, Madison Medical Associates must receive a written revocation. It must include:
*Patients name, date of birth, and address.
*The effective date of this authorization, and the recipient of the protected health information shown on this authorization.
*Patients desire to revoke this authorization with current date & patient's signature.
Madison Medical Associates will accept written revocation of this authorization via mail, fax, or in person.

These records are to be released to: Madison Medical Associates, David T. Fletcher, M.D.

I hereby release Madison Medical Associates and its employees from any and all liabilities, damages, and claims which might arise from the release of information authorized above.

WITNESS SIGNATURE _____ Date_____

PATIENT SIGNATURE _____ Date_____

If additional consent is necessary from a person authorized to give consent other than the patient, please sign below.

_____	_____	_____
Signature of Patient Representative	**Relation To Patient**	**Date**

MADISON MEDICAL ASSOCIATES
1075 S. MAIN ST. SUITE 100
MADISON, GA 30650
706-752-0322

Patients Name: _____ **DOB**: _____

If we should need to contact you regarding appointments, lab results, X-ray results, prescriptions or any other matters not covered herein, and you are not available to take the call, is there someone you authorize us to give this information to.

Yes__ NO__

Name of Authorized Individual_____ **Relationship**_____

Telephone Number_____

Name of Authorized Individual_____ **Relationship**_____

Telephone Number_____

What phone number do you prefer for us to contact you by? (Please Check One)

____ Home ____ Cell Preferred Phone # _____

May we leave appointment reminders, lab results and etc on your answering machine or voice mail?

YES___ NO___

May we leave appointment reminders, lab results and etc by E-mail or Text Message?

____Yes ____ No

Email: _____

Cell #: _____

In case of an emergency whom should we contact?

Name _____ **Telephone No.**_____

I have verified the information above.

Signature:_____ Date:_____

Print Name:_____ Relationship if not Patient:_____