Madison Medical Associates, PC
1550 Eatonton Road
PO Box 209
Madison, GA 30650-0209
(706)752-0322 phone
(978)327-7921 fax

"Caring Community Healthcare"
www.mma-pc.com

David T. Fletcher, MD
Elaine S. Hodges, MD
Amelia Malcom, DNP, FNP-BC
Christy Shaw, FNP-C
Allison Welch, FNP-C
Natasha Osborne, FNP-C

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:* _______________________________________

Policy, Member or ID#: ____________________________________ *Policy, Member, or ID#:* ____________________________________

Policy Holder Name & Date of Birth: ___________________________ *Policy Holder Name & Date of Birth:* ____________________________

MUST COMPLETE IF UNDER 18 YEARS OLD:

Father's Name: ____________________________________

Address: ____

*SS #:*____

Date of Birth: ____________________________________

*Work #: ( )*____

Employer: _______________________________________

Mother's Name: ____

Address: ____

*SS #:*____

Date of Birth: ____

*Work #: ( )*____

Employer: ____

______________________________ ______________________________ ______________ ____________
Patient / Parent or Guardian (Please Print) Patient / Parent or Guardian Signature Relationship Date

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Patient Name: ____ **Patient Date of Birth:** _______________________

I. 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).

II. 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. I allow the fax transmittal of my medical records if necessary. 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. I authorize Madison Medical Associates to perform an external prescription history search.

III. 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.

IV. 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

- 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 deductible and co-insurance fees.

- I understand that insurance companies have made 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.

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.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

X____ X __________________________________ X________________

Signature of Patient or Legal Representative — Relationship to Patient — Date

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Patients Name: ____ **DOB**: ____________________

*If you should need anyone other than yourself to pick up prescriptions, paperwork, or If we should need to contact you regarding appointments, clinical results, prescriptions, billing information, or any other matters not covered herein, and you are not available to take the call or if individual listed below is requesting any matters listed above, is there someone you authorize us to give this information to? **Yes___ (if Yes, please list these person(s) names below No ___**

1. **Name of Authorized Individual**____ **Relationship**_________________

   Phone Number________________________________ **Information to be given:** ____________________________________

2. **Name of Authorized Individual**____ **Relationship**_________________

   Phone Number________________________________ **Information to be given:** ____________________________________

3. **Name of Authorized Individual**____ **Relationship**_________________

   Phone Number________________________________ **Information to be given:** ____________________________________

4. **Name of Authorized Individual**____ **Relationship**_________________

   Phone Number________________________________ **Information to be given:** ____________________________________

*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: ___________________________________ **Cellphone number:** ___________________________________

I have verified the information above and know it to be and correct.

___________________________________ _________________________________ ____________ ____________

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

Patients Name: ____ **DOB**: _____________________

PLEASE READ AND INTIAL THESE POLICIES:

________ All phoned, faxed, or web encounter medication refills take up to 3 TO 5 BUSINESS DAYS from the day the request is put into our system. The office will notify you when the medication has been sent to your pharmacy. If you find yourself in urgent need of a medication refill, please schedule a same day appointment and we can get a refill for you the same day.

________ All paperwork that is not filled out at your appointment will require a $30.00 charge per occurrence and will take 5 TO 7 BUSINESS DAYS turn around. When it is completed, you will be notified by the office when it is ready to be picked up.

________ A $25.00 No Show fee will be added to your account if you do not call and cancel 24 hours prior to your appointment. This fee must be paid before you can be seen at your next appointment.

________ A $50.00 No Show fee will be added to your account if you do not call and cancel 24 hours prior to your appointment for a procedure or ultrasound. This fee must be paid before you can be seen at your next appointment.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH RECORD INFORMATION

Fax to: 978-327-7921

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 Health 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.

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

___________________________	___________________________	__________	__________
Patient / Parent or Guardian (Please Print)	**Patient / Parent or Guardian Signature**	**Relationship**	**Date**

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