SFP Patient Registration Form

Patients Last Name: _____ First: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone No. _____ Home Phone No. _____

Date of Birth: ____/____/____ Sex: ☐Male ☐Female Marital Status: S, M, D, W

» Ok To Leave Phone Voice Mail Message Regarding Results? ☐Yes ☐No

Social Security No. _____ Email Address: _____

Patient's Occupation: _____ Employer's Name: _____

In case of an Emergency Name, Number (relationship) of Person to Notify: _____

If we are filing with your insurance company please complete the following:

Policy/Guarantor Name: _____ DOB: _____

Relationship to patient: ☐ Self ☐Father ☐Mother ☐Spouse ☐Other _____

Phone No. _____ SSN. _____

↓↓↓↓↓ **Please Initial the following stating that you did read, review, agree and are aware of the following**

_____ I consent to treatment for the above named patient.

_____ I understand it is my responsibility to call the office for test results if I have not received a communication.

_____ *For HMO INS patients only* that require a physician, Dr. John Y. Shih must be listed as your Primary Care Physician.

_____ ***Co-Pay's and Deductibles are due at the time of service.***

_____ Payment for services considered 'non-covered" are your responsibility payable within 30 days.

_____ An office visit charge for non-insured patients will be collected before services are rendered.

_____ Suwanee Family Physicians is unable to extend credit or set up payment plans.

_____ *Accounts with balances over 60 days will be assessed a* $25 fee, 6.5% interest and sent to collections.

_____ There is a $25.00 fee for bounced checks. We Do Not accept checks over $40.00

_____ Your benefits are an agreement between you and your insurance company. If your services are not covered by your Insurance company, you are responsible for the balance.

(PLEASE LIST FIRST AND LAST NAME OF PERSON(S) WE MAY SPEAK TO IN REGUARDS TO PATIENT ABOVE)

Privacy Policy:

☐ **I AUTHORIZE** Suwanee Family Physicians to discuss my treatment, care, or financial responsibilities with the following persons:

_____

Designate someone other than yourself

Signature: _____ Date: _____

OR

☐ **I DO NOT AUTHORIZE** Suwanee Family Physicians to discuss my treatment, care, or financial responsibilities with anyone other than myself.

Signature: _____ Date: _____

Billing and Collection Information

Our board certified physicians treat patients and order tests based on the standards of care in the scientific medical community. They do not decide to treat or test patients based on insurance coverage or limitations. Your benefits are an agreement between you and your insurance company. We are unable to verify all benefits prior to services. *We strongly suggest you contact your insurance company prior to your visit and ask them what they will pay for and what they will exclude.* You will be held responsible for any outstanding balances on your account should your insurance plan deny payment for services, regardless of their reason for denial.

Office Visit Charges- For Your Reminder

- If your insurance company does not pay your claim in 30 days, payment becomes your responsibility. We will apply the balance towards your credit card or you can pay with cash or a check.
- We kindly request cash or credit cards for visits; **We Do Not accept check over $40.00**.
- There is a $25 service fee for resubmitting claims on your behalf.
- There is a $150 deposit collected before any Dermatological procedure applied to the service.

X-Ray Services

Some insurance plans require that x-rays be performed in a hospital radiology center. If that is your plan's requirement, your x-ray cannot be performed at this office. Please check with your insurance company.

Lab Services

Some lab tests are performed in this office, others must be sent out to an outside lab. You may receive a bill directly from the lab if your services are not covered by your insurance. Check with your insurance company to verify your lab benefits and confirm which lab is in there network.

Services Not Paid By Insurance

Cryotherapy of Skin- $125	Smoking Cessation RX (Chantix)- $100 office visit
EKG with Physical-$68	Physical Requested by 3rd Party (Not the patient)
Nursing Home Evaluation for Admission- $150	FAA Exam $125 to $150 plus other services.
Skin Tag Removal-$125 for 1-5 skin tags - over 6- $175	FMLA forms $50 with Office Visit
3231 Form And Evaluation (if they chose not to do physical)- $100	Physical Evaluation requested by your Attorney.

We Do Accept Medicare; However Medicare will NOT COVER following. Patient will have to pay

$250 General Physical if you have had one within the last 365 days.
$150- PAP or GYN Exam within 2 years- Unless they are at high risk
$39 Cholesterol Screen- 5 Year limitation
$68- TdaP
$29- Vision Test
$57- Hearing Test

No Show / Late Cancellation Policy

Please call us 24 hours prior if you are unable to make your appointment.

We make every effort to accommodate your busy schedule and strive to be flexible with your day. However, other patients also have busy schedules. That is why we charge patients a **$50.00** fee for missed or appointments cancelled less than 24 hours prior. This allows other patients access to the care they need and helps us manage the flow of visits and reduce wait times.

***Patient Signature/Guardian:** _____ **Date**_____

Prescription Policy

We cannot call in pharmacy requests for refills or for medications for which you have not been evaluated.

Please make your follow up appointment for your prescription refill 2 weeks to 10 days prior to running out of your medications.
In "some" circumstances **Prior Authorizations** are required by your insurance company and may delay your prescription. **There is a $20.00 charge for managing the Prior Authorization Request.** Mail orders take up to 10 days to be delivered, so please allow sufficient time so you do not run out of your medication.

Also, we cannot call in prescriptions simply because your pharmacy faxes in a refill request. If our providers require a follow up visit this allows them to evaluate the appropriateness of the medication as well as examine you for any adverse side effects. These visits may or may not require bloodwork; please keep that follow up appointment so you can fill your prescription before running out.

Required Urine testing for "certain" Prescription Drugs

If you are receiving any of the following medications today including;
Opioids, Benzodiazepine, Muscle Relaxers, Sleep Medications, Anabolic Steroids, Pain Medications, Adderall, Vyvanse, Ambien, Paxil, or Zoloft.

In order to provide you with the best care it is important that I know if you have been taking or not been taking any controlled substance that may interfere with the medication you are requesting today. It is important that I ask for a urine sample to test for Amphetamines, Cocaine, THC, Opiates and Methamphetamines.

Agree to provide a urine sample for this test and I understand this test is $85.00 and is not payable by my insurance company.

By signing, you are stating that, "I have read and agree to the Prescription Policy."

***Patient Signature/Guardian: _____ Date_____**

SUWANEE FAMILY PHYSICIANS

PATIENT HISTORY

Fill out this Section:

Patient Name: _____ **Allergies:** _____

DOB: _____

Social History:

Single / Married / Divorced / Widowed #of Children:_____ Occupation: _____

Tobacco Use: Never / Quit / Current smoker. How long:_____ How Much:_____ When Quit:_____
Alcohol Use: Never / Quit / YES. How much per week: _____
Street Drugs: Never/ Quit / Yes. Explain:_____

Female: No. of Pregnancies #_____. Gynecological problems? _____Male:_____

Family History: NONE

_____

_____

Surgical History: NONE

_____

_____

_____

Patient Signature: _____
Date:_____

OFFICE USE ONLY:

Physical		Hepatitis A	1) 2)
Physical		Hepatitis B	1) 2) 3)
		Tdap	
GYN Exam		MCV	
		Pneumonia	13) 23)
Mammogram		Shingles	
		Flu Shot	
Colon Cancer Screening		Other Immunizations:	
Prostate Cancer Screen			
EST			
Microalbumin			
Monofilament			

Suwanee Family Physicians- Master Sheet Part B

Patient Name _____ DOB_____ Allergies _____

Dx	Tx		Dx	Tx