

Peachtree Surgical Specialists, P.C.
Clarence R. Hixon M.D., FACS

PATIENT INFORMATION

DATE: _____ SS#: _____
Name: _____ DOB: _____ AGE: _____ SEX: **F M**
Parent/Gardian (if patient is a minor): _____
Address: _____
City: _____ **State:** _____ **Zip:** _____ **County:** _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Marital Status: **S M D W** Spouse Name: _____
Patient Employer: _____ Occupation: _____
Nearest Relative(Not Living with You): _____ Relationship: _____ Phone: _____
EMERGENCY CONTACT: _____ Relationship: _____ Phone: _____
E-MAIL: _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN: _____
Address: _____
Phone #: _____ Fax #: _____

REASON FOR VISIT: _____
Have you previously been seen by Dr. Clarence R. Hixon ? **Yes** **No** *If yes, when:* _____
If yes, please list reason below

ALLERGIES? Yes No *If yes, please list:* _____

MEDICATIONS? Yes No *If yes, please list:* _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____
Policy Holder Name: _____ Relationship to Insured: _____
Birth Date: _____ Place of Employment: _____ Phone: _____
Address of Insurance Company: _____
Policy # / ID#: _____ Group #: _____
Benefits Phone #: _____ Precert Phone #: _____

SECONDARY INSURANCE CARRIER: _____
Policy Holder Name: _____ Relationship to Insured: _____
Birth Date: _____ Place of Employment: _____ Phone: _____
Address of Insurance Company: _____
Policy # / ID#: _____ Group #: _____
Benefits Phone #: _____ Precert Phone #: _____

INSURANCE AUTHORIZATION

I understand that this release includes all confidential information in my medical record, including information related to psychiatric care, drug and/or alcohol abuse and HIV/AIDS. I authorize medical information to be released via Mail, Fax, Electronic Data, or by Telephone as requested. I understand that this authorization shall remain in effect until revoked by me in writing. I understand that I have the right to receive a copy of this authorization. I authorize all insurance benefits for services rendered by Peachtree Surgical Specialists, P.C. to be paid directly to Clarence R. Hixon, M.D. P.C.

Signature: _____ **Date:** _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for all fees not paid by their insurance carrier. It is also customary to pay for services when rendered, unless other arrangements have been made in advance with the office patient accounts representative.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of services be made to **Clarence R. Hixon, MD, P.C.** for any services furnished to me by said physician. Regulations pertaining to insurance assignment of benefits apply.

I authorize any holder of medical, or other information about me, to be released to the social security administration and health care financing administration or its intermediaries of any carrier or any other insurance company claim.

I understand my signature requests that payment be made and, authorizes release of medical information necessary to pay the claim. My signature authorizes releasing or information to the insurer or agency shown. In medicare/other insurance companies assigned pre-contracted cases, the physician or supplier agrees to accept the charge and the patients is responsible only for the deductible, coinsurance AND non-covered services. Coinsurance and the deductible are based upon the charge determination of the medicare/other insurance company.

I further understand that by signing this document I acknowledge that I am responsible for payment of studies that my insurance company may deem medically unnecessary of non-covered. If **Clarence R. Hixon, MD** has not received payment from my insurance company within 60 days, I will begin making payment on the bill and will assume responsibility for any further correspondence with my insurance carrier. If I receive payment from my insurance carrier, I agree to make payment to **Clarence R. Hixon, MD** for the entire amount I received within one week from receipt of the payment.

Signature: _____ **Date:** _____

Peachtree Surgical Specialists, P.C.

Clarence R. Hixon M.D., FACS

285 Boulevard, Suite 440

Atlanta, GA 30312

Phone: (404) 265-3333 Fax: (404) 265-3334

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand this Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care procedures. I also understand Dr. Hixon is not required to agree to my requested restrictions.

Patient Name and/or Responsible Party: _____

Relationship to Patients: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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