WELLSTAR THORACIC SURGERY ASSOCIATES LLC

WILLIAM R. MAYFIELD, M.D. WARD V. HOUCK, M.D. THERESA LUU, M.D.

Patient's Name:__________ **Nick Name:**__________

Address:__________ **Gender:** __________

City:__________ **State:**_____ **Zip:**_____ **SSN:**__________

Date of Birth:__________ **Home Phone:**__________ **Cell:**__________

Marital Status: **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Age:**__________

Patient's Employer/School:__________ **Fulltime** ☐ **Parttime** ☐ **Retired** ☐

Employer/Student Address:__________ **Phone:**__________

Spouses Name:__________ **DOB:**__________

Referring Physician:__________ **Phone:**__________

Primary Care Physician:__________ **Phone:**__________

In case of emergency contact:__________ **Phone:**__________

Email Address__________

Please present picture ID and all insurance cards at front desk.

If you don't have medical insurance please tell our front desk person so she can set up a meeting with our financial dept.

PRIMARY INSURANCE:__________ **Phone:**__________

Policy Holder's Name:__________ **SSN:**__________ **DOB:**__________

Policy#:__________ **Group#:**__________

SECONDARY INSURANCE:__________ **Phone:**__________

Policy Holders Name:__________ **SSN:**__________ **DOB:**__________

Policy#:__________ **Group#:**__________

Are you currently or have you ever been enrolled in Hospice Care?_____ ***If yes, when?***_____

I hereby authorize benefits to be assigned to Wellstar Thoracic Surgery Associates (TSA), for healthcare services provided to me by TSA. I hereby certify that the insurance information that I have provided above is true and accurate as of the date of service and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize TSA to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided TSA, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

Signature__________ **Date**__________

61 WHITCHER STREET, SUITE 4120
MARIETTA, GEORGIA 30060

TELEPHONE: (770) 424-9732
FAX: (770) 421-0228

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I hereby irrevocably designate, authorize and appoint TSA as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as TSA has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any applicable ERISA plan benefits and rights to TSA including the right to receive any applicable plan documents/remedies, pursue appeals and litigation on my behalf. This authorization includes any other rights due me permissible under state and federal laws.

I hereby instruct and direct my Insurance Company to pay TSA directly. I understand under ERISA that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERISA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assignability clause to myself and TSA. Upon proof of non-assignability documentation I instruct the insurer to make out the check to me and mail it directly to Thoracic Surgery Associates, P.C., 61 Whitcher Street Suite 4120 Marietta, GA 30060 for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

I agree and understand that any funds I receive by my insurance company due for services rendered by TSA will be immediately signed over and sent directly to TSA.

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize TSA to endorse them for deposit only, and to deposit and apply all proceeds toward payment on my account.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize TSA to be my personal representative, which allows TSA to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to TSA for acting as my personal representative.

I authorize TSA and its associates to provide medical care reasonable by today's standards.

A photocopy of this Assignment shall be considered as effective and valid as the original.

______________________________ ________________
Signature of Patient/Guarantor Date

______________________________ ________________
Signature of Policy Holder Date

____
Witness

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FINANCIAL POLICY

Office hours: Monday thru Friday 9:00 am to 4:30 pm Office telephone #770-424-9732
Office fax #770-421-0228

We recognize the need for a definite understanding between the patient, the office and the doctor concerning health care and the financial arrangements for medical care. The following is a statement of our Financial and Office Policies. Please read and sign that you understand your responsibilities regarding all services rendered.

OFFICE FORMS

All forms must be completed and signed prior to seeing the doctor.

We understand that some people may have concerns providing specific information requested, but all information is required for payment, treatment or operations. Should this be of concern and you do not wish to submit required information, please ask to speak to the office manager.

FEES

ALL COPAYS AND CO-INSURANCE FEES ARE DUE PRIOR TO SERVICES RENDERED.

****For your convenience, we accept Cash, Checks, Visa, Discover, Mastercard or American Express****

Return check or charge back fee is $30.00 plus any court cost and legal fees.

OTHER MEDICAL FORMS

The completion of disability forms, FMLA, attending physician statements or other supplemental insurance forms all require office supplies, physician and/or staff time to complete. Therefore, a $10 fee per form will be charged and prepaid. *Note: There will be a 14-day turn around time for completion, so make arrangements accordingly. Non-standard or multiple page forms may be higher.*

REFERRALS

If your insurance plan is one that requires a referral to be seen by a specialist, it is the patient's responsibility to obtain that referral and bring it in at the time of your appointment. This will prevent any appointment delay or reschedule.

PATIENT INITIALS:__________

INSURANCE

In order to obtain accurate billing information, we require a copy of your insurance card at the time of service. If you do not have your insurance card at the time of your visit, you will be listed as self pay – uninsured (SEE UNINSURED). If your insurance has changed since last visit, please tell the front desk during check-in. Note: We cannot file or accept assignment of your insurance unless all insurance information is provided. Patients are responsible for balances due upon notification from your insurance company (EOB explanation of benefits).

Medicare Patients: **We accept Medicare assignment on covered Medicare charges. Twenty percent (20% of Medicare Co-insurance payments are expected at the time of service unless you have supplemental insurance.**

Secondary Insurance: **We will file claims on secondary insurance as a courtesy to the patient. If the secondary insurance has not paid within 60 days after filing, the patient will receive a statement and be responsible for the balance.**

Balance Due: **After insurance has paid their portion, you will receive a statement for your outstanding patient balance. Payment will be due in full unless you have made prior payment arrangements with the Reimbursement Dept. Past due balances that are turned over for collections will assessed a collection fee determined by our cost of outside collection services (between 20% - 30% plus court cost).**

SELF PAY / UNINSURED

All un-insured patients must register *prior* to office visit with our Reimbursement Dept. The patient will be expected to make payment in full for services rendered the day of the visit.

APPOINTMENTS

Patients are seen by appointment only. This allows for quality of care as well as a improved convenience to our patients. We make a sincere attempt to adhere to the appointment schedule, but when emergencies and other circumstances arise beyond our control, they must take precedence and some delays may therefore occur. When you arrive at the office for your appointment, please check-in with the front desk and provide any updated information since your last visit.

PRESCRIPTIONS AND REFILLS

It is not our policy to prescribe new medications over the telephone. Please try to handle refill medications during your follow-up appointment and only during *regular* office hours. Please call your pharmacist before 3pm with refill requests in order to ensure completion of the refill approval process. *We do not refill long term medications from previous doctors.*

EMERGENCIES

Thoracic Surgery Associates or a covering physician will be on call and available for emergencies at all times. During office hours, please call our office at (770-424-9732), identify yourself and relay your information to staff.

______________________________ ______________

Signature of Patient or Responsible Party **Date**