MERCER Medicine
Feel better. Live better.

PERSONAL INFORMATION

Patient Name: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell: _____

Date of Birth: _____ Sex: Male / Female Social Security Number: _____

Email Address: _____ Married / Widowed / Divorced / Separated / Single

Spouse's Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Primary Care Physician: _____ Pharmacy: _____

****Mercer Medicine has a contract with Quest Lab Partners. Please inform us if your insurance requires you to use a specific lab.**

**Health Insurance Provider In-Network Lab: _____

EMPLOYMENT

Employer: _____ Phone: _____

Occupation: _____

Spouse's Employer: _____ Phone: _____

Spouse Occupation: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____

Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION: *Please present your insurance card and driver's license on check-in.*

Primary Insurance: _____ Member Name: _____

Member Number: _____ Group Number: _____

Primary Insurance Phone: _____

Secondary Insurance: _____ Member Name: _____

Member Number: _____ Group Number: _____

Secondary Insurance Phone: _____

_____ _____

Signature of Patient or Patient Representative *Date*

PATIENT FINANCIAL AGREEMENT

Thank you for choosing Mercer Medicine for your healthcare needs. We are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2. **COPAYMENTS: ALL COPAYMENTS ARE TO BE PAID AT THE TIME OF SERVICE. THIS ARRANGEMENT IS PART OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY.**
3. **Registration:** All patients must complete our patient information form, which will be entered into our electronic health records (EHR) to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have timely filing restrictions; if a claim is not received within the required timeframe, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
4. **Patient Forms:** There will be a $25 fee for completion of various forms that require documentation and/or the provider's signature. This fee must be paid before the forms are completed. These forms require a minimum of 7 days for completion.
5. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.
6. **Collections:** Patient accounts with a balance due will receive monthly statements from our office. Please be aware that if a balance has remained unpaid for 120 days, it may be sent to our outside collection agency. If an account is sent to collections, it is the policy of this office to discharge the patient from the practice. You will be notified by mail that you will have 30 days to find alternative medical care. During that 30-day period our providers will be able to treat you only on an emergency basis.

AUTHORIZATION

- I authorize the release of any medical or other information necessary to process claims and/or appeals.
- I authorize Mercer Medicine to submit claims for benefits without obtaining my signature on each claim.
- I authorize payment of medical benefits to the providers of Mercer Medicine for services rendered.
- I have read, understand and agree to the provisions of this Patient Financial Agreement form.

_____ _____

Signature of Patient or Patient Representative *Date*

Section I Acknowledgement of Mercer Medicine Notice of Privacy Practices (updated August 2018)

I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding the Mercer Medicine Notice of Privacy Practices (NPP) and to request a copy, if desired.

_____ **Initial**

Section II Acknowledgement of Mercer Medicine Prescription Policy

I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding Mercer Medicine's prescription policy and to request a copy, if desired. I understand that I must allow my physician **3 business days** to write or send my prescription to the pharmacy.

_____ **Initial**

Section III Georgia Registry of Immunization Transactions & Services (GRITS)

I, the patient, hereby accept or deny consent for my immunization data to be submitted to the Georgia Registry of Immunization Transactions and Services, which has been established to collect and maintain accurate, complete and current vaccination records to promote effective, and cost-efficient disease prevention and control.

_____ **Accept** _____ **Deny**

Section IV MEDICARE PATIENTS ONLY: Georgia Physicians for Accountable Care (GPAC)

Mercer Medicine is a participating member of the Georgia Physicians for Accountable Care Organization, a group of Georgia health care providers who voluntarily work together to coordinate care for Medicare beneficiaries like yourself. Because your physician is a member of GPAC, Medicare may share your health information with other physicians who are participating members of GPAC in order to provide you with the highest quality of care. If you do not wish to share your health information as part of GPAC, please ask a Mercer Medicine front desk staff member for a form to opt out of this program.

_____ **N/A** _____ **Accept** _____ **Deny**

Section V Healthcare Formulary

I, the patient, acknowledge that I am aware that Mercer Medicine could review my insurance provider's prescription formulary in order to prevent potential adverse medication effects.

_____ **Initial**

Section VI Research

To protect you and your privacy, your health information may be released by Mercer Medicine for research purposes only when you give your permission.

_____ **Accept** _____ **Deny**

Section VII Access to Protected Health Information

The people listed below may access my health records:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Section VIII Labs

****I, the patient, hereby acknowledge that I have been given the opportunity to ask any questions I may have regarding Mercer Medicine's partnership with Quest Diagnostics/Solstas. I understand that I may be financially responsible for services I receive from an out of network lab provider.**

_____ **Initial**

Section X Patient Acknowledgement

I have read and understand all information provided on these forms.

_____ _____

Signature of Patient or Patient Representative *Date*