WELCOME TO ALPHA INTERNAL MEDICINE!

Please fill out the following *New Patient Forms* completely. Please do not skip over or leave anything blank. Missing information will cause a delay in getting your visit started.

On the form "Release of Records", sign your name but do not date it. This way it can be kept in your file and used again if you need records from other providers.

Feel free to ask if you have any questions. We are here to assist you.

FINANCIAL POLICY

PLEASE NOTE THAT ALL INSURANCE PROVIDERS HAVE DIFFERENT COVERAGE AND BENEFIT LEVELS DEPENDING ON WHAT YOU HAVE CHOSEN TO PURCHASE OR WHAT YOUR EMPLOYER HAS CHOSEN FOR YOU. SOME PLANS REQUIRE THAT YOU PAY A DEDUCTIBLE FOR LABS AND DIAGNOSTIC TESTS IN ADDITION TO YOUR VISIT COPAY. YOU SHOULD CHECK WITH YOUR INSURANCE PROVIDER TO SEE WHAT YOUR PLAN COVERS AND WHAT YOU WILL BE RESPONSIBLE TO PAY FOR LABS, X-RAYS AND OTHER DIAGNOSTIC TESTS. WE USE AN OUTSIDE REFERENCE LAB (LABCORP) FOR LABS THAT WE DO NOT PERFORM HERE IN OUR OFFICE. THEY ARE PARTICIPATING ON MOST PLANS, HOWEVER YOU MAY BE BILLED BY THEM FOR ANY BALANCE NOT COVERED BY YOUR INSURANCE. THE OUTSIDE LAB DOES NOT BILL SECONDARY INSURANCE.

WE ARE PARTICIPATING ON MOST INSURANCE PLANS. IF YOU ARE AN HMO PATIENT, YOU MUST CHOOSE ONE OF OUR DOCTORS FOR YOUR PRIMARY CARE PHYSICIAN. THIS CAN BE DONE BY CALLING YOUR PLAN AND HAVING THEM LIST OUR PHYSICIAN AS THE PCP. YOU WILL BE RESPONSIBLE FOR THE VISIT IF WE ARE NOT LISTED AS PCP WITH YOUR PLAN.

ALL BALANCES INCLUDING DEDUCTIBLES AND COPAYS ARE DUE AT THE TIME OF SERVICE. WE FILE WITH YOUR INSURANCE (UP TO 2 PLANS) AND THEN ANY BALANCES THAT ARE DUE BY YOU MUST BE PAID WITHIN 30 DAYS UNLESS PRIOR ARRANGEMENTS ARE MADE WITH THE BILLING OFFICE. IF YOU HAVE A BILLING OR INSURANCE QUESTION, PLEASE CONTACT OUR BILLING OFFICE AND THEY WILL BE HAPPY TO ASSIST YOU. WE ASK THAT PATIENTS REFRAIN FROM DISCUSSING BILLING QUESTIONS WITH THE PHYSICIANS, AS THEY DEVOTE THEIR TIME AND EXPERTISE TO YOUR HEALTH CARE AND CANNOT ANSWER BILLING QUESTIONS.

I HAVE READ THE FINANCIAL POLICY:

SIGNATURE:________________________________ DATE:__________

ALPHA INTERNAL MEDICINE

Betsy S. Horton-Pawlowski, M.D.
Diliana Panova, M.D.
Carrie Madej Collins, D.O.
Coral Benge, P.A.

Dear

Enclosed are your new patient information forms. Please read and complete all forms, making sure they are all signed, and bring them with you to your appointment. Please arrive, for your appointment, at least 15 minutes before the scheduled time and be sure to bring your new patient forms with you; please do **NOT** mail them. Should you have any questions please contact our office at: (770)719-5490.

Please remember to bring all prescription medication in the bottles they were prescribed in.

We look forward to seeing you at your appointment on
_________________ at _______:________am/pm.

Thank you,

Betsy Horton, M.D.
Diliana Panova, M.D.
Carrie Madej Collins, D.O.
Coral Benge, PA-C
Office Staff

(770)719-5490 745 S. Glynn Street Fayetteville, GA 30214 (770)719-3113 (fax)

ALPHA INTERNAL MEDICINE

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____ PCP____________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single /Mar /Div/ Sep/ Widow

Is this your legal name? ❑Yes❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑M ❑F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	Zip	Cell Phone No. ( )

Occupation	Employer	Employer Phone No.

Chose Clinic Because/Referred to Clinic by (Please check one box)

❑ Family❑ Dr.__________ ❑Hosp❑ Close to Home/Work❑ Yellow Pages❑InsurancePlan

EMAIL ADDRESS: OTHER FAMILY MEMBERS SEEN HERE:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Indicate primary insurance ❑ United Healthcare ❑ Blue Cross ❑ Cigna ❑Medicaid ❑PHCS ❑ Champus ❑ Aetna

****please provide us with your card so we can make copy.***

Subscriber's Name	Subscriber's S.S. #	Birth /	Group #	Policy #	Co-pymt $

Patient's Relationship to Subscriber ❑ Self ❑Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Betsy Susan Horton, M.D., P.C. or insurance company to release any information required to process my claims.

X

PATIENT/GUARDIAN SIGNATURE DATE

*****please turn over to complete**

ALPHA INTERNAL MEDICINE

PATIENT HISTORY FORM

PATIENT LEGAL NAME	DATE OF BIRTH

FAMILY HISTORY: Has any blood relative had any of the following(please indicate which relative):

Allergies	Diabetes	High Blood Pressure	Stroke
Anemia	Drug/Alchoholism	High Cholesterol	Thyroid Disease
Arthritis	Epilepsy	Kidney Disease	Tuberculosis
Asthma	Glaucoma	Mental illness	Other
Bleeds easily	Gout	Migraine	Other
Cancer	HIV/AIDS	Obesity	Other
Depression	Heart Disease	Osteoporosis	Other

SIGNIFICANT HOSPITALIZATIONS/SURGERIES/INJURIES: (attach additional page if needed)	DATE

CURRENT MEDICATIONS: (attach page if needed)	DOSE	FREQUENCY

DRUG ALLERGIES	REACTION

ALPHA INTERNAL MEDICINE

PATIENT HISTORY FORM(cont'd)

TOBACCO USE:

_________Never smoked _________Less than ½ pack/day _________1/2 pack/ day

_________1 pack/day _________2 packs/day _________More than 2 packs/day

_________Chewing tobacco _________Dip Snuff _________Smokers in home?

Stopped Smoking _________/_________/_________

ALCOHOL USE:

_______Never drink _________Rarely drink __________Alcoholics in home?

Average: _______Beers(per day) ________Glasses of wine(per day) _________Mixed drinks(per day)

Stopped Drinking ________/________/_________

REVIEW OF SYSTEM: Do you now or have you had any of the following symptoms/diseases?

_____High Blood Pressure _____Heart Attack/Failure _____Arthritis

_____Stomach Ulcer _____Asthma _____Chronic Lung Disease

_____Stroke _____Diabetes _____Cancer

_____Blood Disorder _____Glaucoma _____Internal Blood Clots

_____Thyroid Disease _____Mental Illness _____Depression

_____Kidney Stones _____Hepatitis _____Chest Pain

_____HIV/AIDS _____Veneral Disease _____Emphysema

Other significant medical history:____

I affirm that the information I have given is correct and complete to the best of my knowledge.
I understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient /Legal Guardian	Date

PATIENT POLICIES

WE WELCOME YOU TO OUR PRACTICE. TO BETTER SERVE YOU, WE ASK THAT YOU REVIEW THE FOLLOWING PRACTICE POLICIES AND PROCEDURES. PLEASE SIGN THIS FORM AND RETURN TO THE RECEPTIONIST FOR YOUR CHART. YOU MAY RECEIVE A COPY OF THIS AT YOUR REQUEST.

WE ASK THAT YOU...

1. PRESENT YOUR INSURANCE INFORMATION AND VALID PICTURE ID UPON YOUR FIRST VISIT. IT IS YOUR RESPONSIBILITY TO UPDATE THIS INFORMATION SHOULD CHANGES OCCUR.
2. PROVIDE US WITH INSURANCE REQUIREMENTS REGARDING PRE-CERTIFICATION AND REFERRAL FOR DIAGNOSTIC TESTS, HOSPITALIZATION AND VISITS TO SPECIALISTS.
3. NOTIFY US OF CANCELLATIONS OF SCHEDULED APPOINTMENTS WITH 24 HOUR NOTICE OR YOU WILL BE BILLED A $25 NO-SHOW FEE.
4. BRING A COMPLETE LIST OF ALL CURRENT MEDICATIONS WITH DOSAGES AND INSTRUCTIONS TO EACH OFFICE VISIT FOR YOUR DOCTOR TO REVIEW.
5. NOTIFY US OF RECENT VISITS TO OTHER DOCTORS/HOSPITALS AND ANY NEW ALLERGIES TO MEDICATIONS SINCE YOUR LAST VISIT.
6. CALL OUR OFFICE APPROXIMATELY ONE WEEK AFTER BLOOD OR OTHER LABORATORY WORK IS ORDERED, IF YOU WOULD LIKE TO KNOW THE RESULTS. WE WILL CALL YOU ONLY IF LAB/BLOOD WORK RESULTS RETURN WITH AN ABNORMAL RESULT AND/OR NECESSITATE TIMELY FOLLOW-UP.
7. UNDERSTAND THAT ALL CO-PAYS, DEDUCTIBLES AND PATIENT BALANCES ARE DUE AT THE TIME OF SERVICE. IF YOU ARE UNABLE TO PAY, YOU MUST MAKE ARRANGEMENTS WITH OUR OFFICE PRIOR TO YOUR OFFICE VISIT.
8. PROVIDE 72 HOURS ADVANCE NOTICE FOR PRESCRIPTION REFILLS.

I HAVE READ THE PATIENT POLICIES:

______________________________ _______________

SIGNATURE **DATE**

ALPHA INTERNAL MEDICINE

745 S. Glynn Street (770)719-5490 FAYETTEVILLE, GA 30214

This office has a policy to keep patient information confidential. You may Designate below if you want someone other than yourself to have access to Your private health information.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PATIENT NAME:____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices Of **ALPHA INTERNAL MEDICINE.**

______________________________ ______________________________
Signature of Patient Date

RELEASE OF INFORMATION TO PERSONS OTHER THAN MYSELF

I allow the people listed below to receive medical information about my condition at any time:

______________________________ Relationship__________________

______________________________ Relationship__________________

______________________________ Relationship__________________

______________________________ ______________________________
Signature of Patient Date

ALPHA INTERNAL MEDICINE
BETSY S. HORTON-PAWLOWSKI, M.D.
DILIANA PANOVA, M.D.
CARRIE MADEJ COLLINS, D.O.
CORAL BENGE, PA-C

RELEASE OF INFORMATION

I, ______________________ON THIS DATE, ___________________,

PERMIT THE OFFICE OF ____________________________TO RELEASE

MY MEDICAL RECORDS, EITHER IN PART OR IN WHOLE, TO THE

OFFICE OF ALPHA INTERNAL MEDICINE AND RELEASE THE OFFICE

OF ______________________FROM ANY LIABILITY IN DOING SO.

PATIENT NAME/GUARDIAN____________________________________
PRINT NAME

PATIENT NAME/GUARDIAN____________________________________
SIGNATURE

DATE____________________

(770)719-5490
745 S. GLYNN STREET
FAYETTEVILLE, GA 30214
(770)719-3113 FAX