Lifetime MEDICAL CENTER P.C.

14244 Highway 515 North, Suite 100
Ellijay, GA 30540
(706) 698-5433

PATIENT INFORMATION

PATIENT'S NAME (PLEASE PRINT)	SS# MARITAL STATUS Single Married Widowed Divorced Separated DATE OF BIRTH	AGE SEX- Male / Female

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME TELEPHONE NUMBER

PATIENT DRUG ALLERGIES	SPOUSE OR PARENT'S NAME	SPOUSE DATE OF BIRTH

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN BEFORE? INCLUDE PHYSICIAN AND FAMILY MEMBER	PREVIOUS PHYSICIAN	PERMISSION TO RELEASE INFORMATION TO:

HOW DID YOU HEAR ABOUT OUR PRACTICE? ❑ NEWSPAPER ❑ INSURANCE COMPANY ❑ YELLOW PAGES ❑ FRIEND (NAME) ❑ OTHER

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

NAME OF POLICY HOLDER _____ POLICY HOLDER DATE OF BIRTH _____

INSURANCE ID _____ POLICY NUMBER _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO **LIFETIME MEDICAL CENTER P.C**. FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNEMENT. I UNDERSTAND THAT IT IS MANDATORY TO NOTIFY THE HEALTH CARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

X _____ _____

SIGNATURE OF POLICY HOLDER DATE

NOTICE OF PRIVACY PRACTICES

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received / read a copy of LIFETIME MEDICAL CENTER PC's Notice of Privacy Practices.

YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE **PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE**. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING DEPARTMENT. ALL CHARGES ARE DUE AT THE TIME SERVICES ARE RENDERED. **I AGREE TO PAY ALL COLLECTION COSTS, COURT COSTS, AND REASONABLE ATTORNEY FEES IF I FAIL TO PROMPTLY PAY THIS ACCOUNT WHEN DUE AND ANY UNPAID BALANCE IS PLACED WITH A COLLECTION SERVICE.**

Insurance is billed as a courtesy for our patients- you are ultimately responsible for any and all charges incurred at this office.
We will make (3) three attempts to bill your insurance. If after that, the charges are not paid, you will be required to pay the charges in full and then you may file with your insurance for reimbursement.

X _____

PATIENT / GUARANTOR (for minors) SIGNATURE
ACKNOWLEDGEMENT OF INSURANCE AUTHORIZATION, NOTICE OF PRIVICY PRACTICES, RESPONSIBILITY FOR BILL
By signing on the above line, I acknowledge consent to all (3) three sections listed above.