THE MULTIPLE SCLEROSIS CENTER OF ATLANTA

2010 Patient Registration Form

ACCOUNT NO. ______________
DOCTOR NO. ______________

WELCOME TO OUR OFFICE

PATIENT INFORMATION

NAME: FIRST | M.I. | LAST

STREET ADDRESS		APT./ UNIT #
CITY	STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )
EMAIL ADDRESS		SOCIAL SECURITY# - -
DATE OF BIRTH / AGE	SEX: ☐ MALE ☐ FEMALE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
SPOUSE'S NAME	SPOUSE HOME PH. ( )	SPOUSE WORK PH. ( )
PATIENT'S EMPLOYER	OCCUPATION	
LOCAL RELATIVE OR FRIEND		FRIEND'S PHONE ( )

INSURANCE INFORMATION

PRIMARY INS. CARRIER	ID #	GROUP #
INSURED'S NAME		DATE OF BIRTH
SECONDARY INS. CARRIER	ID #	GROUP #
INSURED'S NAME		DATE OF BIRTH
MEDICAID ID NUMBER	MEDICARE ID NUMBER	DATE OF SOC. SEC. DISABILITY ELIGIBILITY

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: FIRST | M.I. | LAST

ADDRESS	CITY	STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )	SOCIAL SECURITY # - -	
EMPLOYER NAME			
EMPLOYER ADDRESS	CITY	STATE	ZIP

IF REFERRED BY PHYSICIAN

PHYSICIAN ADDRESS	CITY	STATE	ZIP
PHYSICIAN NAME	SPECIALTY	PHONE	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be made on my behalf to The MS Center of Georgia d.b.a. The Multiple Sclerosis Center of Atlanta. Regulations pertaining to medical assignments of benefits apply. I understand that I am financially responsible to the physician for charges not covered by this assignment or that which is above the usual and customary determined by my insurance company.

Signed ______________________________ Date ______________________

OPTIONAL - FOR MS STATISTICAL RESEARCH PURPOSES ONLY

ETHNICITY: ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ OTHER ☐ ASIAN ☐ HISPANIC/LATINO ☐ WHITE

COMBINED ANNUAL INCOME FOR FAMILY LIVING IN PRIMARY DOMICILE: ☐ LESS THAN $25,000 ☐ $25,001 TO $50,000 ☐ $50,001 TO $75,000 ☐ $75,001 TO $100,000 ☐ $100,001 TO $150,000 ☐ MORE THAN $150,000

AUTHORIZATION FOR TREATMENT

I ___________________________________, knowing that in a rare occurrence I could require emergency medical care, do voluntarily consent to care encompassing diagnostic procedures and medical treatment, as may be ordered by physicians. I further consent to treatment by authorized employees or agents of MS CENTER OF GEORGIA, d.b.a. THE MULTIPLE SCLEROSIS CENTER OF ATLANTA who are assigned to my care.

____________________________ ________________ __________________
Patient Full Name (Please print clearly) DOB SS#

____________________________ __________________
Patient Signature Date Signed

____
Witness Name (Please print clearly)

____________________________ __________________
Witness Signature Date Signed

MSCA
THE MULTIPLE SCLEROSIS CENTER OF ATLANTA

Payment Policy Form

The Multiple Sclerosis Center of Atlanta is very concerned about the cost of your healthcare and the cost of medical services. Considerable care has been taken in setting our fees. Most physicians' fees are above the rate at which most insurance companies choose to pay. We use many sources to determine the appropriateness of our fees. We want to assure you that our charges accurately reflect the skill and expertise required for the complex care of patients with Multiple Sclerosis. We cannot and do not allow the payment or allowances of insurance companies to set the amount that we charge for services.

PAYMENT POLICY

To assist you, we will file claims with your insurance carrier. Our policy requires payment of all co-payments, co-insurance and deductibles at the time of service. All remaining balances are to be paid within 30 days of receiving your statement.

If your insurance plan requires a referral (HMO/POS) to be seen by a specialist, you are responsible for seeing that we have an ***active referral*** on file. An active referral indicates that your date of service is both (1) within the dates listed and (2) within the number of visits listed on the referral. If we do not have an active referral at the time of your visit and you still wish to be seen, you will be required to either pay for your visit in full at check-in or reschedule your appointment until such time as you are able to obtain an active referral.

It is your responsibility to verify with your insurance carrier that our physicians are considered ***in network*** with your plan. If your carrier processes your claim as ***out of network***, you are responsible for the balance of the charges. Please be aware that our agreement is with you and not your insurance company. Although we will assist you by submitting your claim to your carrier, ***you are ultimately financially responsible for the services you receive***. Payment to our office is neither contingent nor dependent upon your insurance company.

For your convenience, we are pleased to accept cash, checks, MasterCard and Visa for your charges. Returned checks will incur an additional $25.00 charge. If any account is placed in collections, future appointments may be delayed.

If you have questions concerning our financial policy, your insurance reimbursement or your account balance, please discuss them with our billing department.

POLICY ACKNOWLEDGEMENT

I have read and understand my financial responsibilities under this policy.

Patient Name (Please print clearly)	Patient Signature	Date

MSCA
THE MULTIPLE SCLEROSIS CENTER OF ATLANTA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for The Multiple Sclerosis Center of Atlanta to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The Multiple Sclerosis Center of Atlanta's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices, which is available upon request or on The Multiple Sclerosis Center of Atlanta's website at www.mscatl.org, prior to signing this consent. The Multiple Sclerosis Center of Atlanta reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Multiple Sclerosis Center of Atlanta Medical Records Department at 3200 Downwood Cir. NW, Suite 550, Atlanta, GA 30327.

With this consent, The Multiple Sclerosis Center of Atlanta may call my home or other alternative location as I might designate, and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, The Multiple Sclerosis Center of Atlanta may mail to my home or other alternative location as I might designate, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Multiple Sclerosis Center of Atlanta may e-mail to my home or other alternative location as I might designate, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that The Multiple Sclerosis Center of Atlanta restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Multiple Sclerosis Center of Atlanta may decline to provide treatment to me.

By signing this form, I am consenting to The Multiple Sclerosis Center of Atlanta's use and disclosure of my PHI to carry out TPO.

______________________________ ________________________
Print Patient's Name Date

______________________________ ________________________
Signature of Patient or Legal Guardian Print Name of Legal Guardian

I give my consent for my physician and his staff with The Multiple Sclerosis Center of Atlanta to discuss my medical condition, treatment, test results or any other pertinent information regarding my care with the following person(s):

	First Person	Second Person
Print name of person to whom PHI can be given:		
Relationship to patient:		
Patient Signature:		
Date of Signature:		

(List additional person(s) on reverse side)

REVISED 12.30.2009

MSCOA
THE MULTIPLE SCLEROSIS CENTER OF ATLANTA

Clinical Department
New Patient Complaint/Background Form

Patient Information

Name: ______________________ DOB: ______________ Date: ______________

Chief Complaint

Please list main problem: ______________________

____

Please list any other active problems: ______________________

____

____

Background Information

Please list past medical problems and/or surgeries: ______________________

____

____

____

Family History (Indicate any significant illnesses or cause of death, if applicable)

Mother ______________
Father ______________
Sisters ______________
Brothers ______________
Children ______________
Other ______________

Social History

Use of Tobacco? ______________
Use of Alcohol? ______________

List Current Medications (include doses): ______________________

____

____

____

Allergies: ______________________

____

____

Please check the appropriate box to indicate whether you presently have or experienced in the past any of the following conditions:

- ☐ Headaches
- ☐ Visual Problems
- ☐ Speech Problems
- ☐ Hearing Problems
- ☐ Dizziness
- ☐ Stroke
- ☐ Seizures
- ☐ Fever
- ☐ Weight Loss
- ☐ Breathing Problems
- ☐ Heart Problems
- ☐ Sleep Problems
- ☐ Loss of Consciousness
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Numbness
- ☐ Weakness
- ☐ Walking Problems
- ☐ Incontinence
- ☐ Memory Problems
- ☐ Depression
- ☐ Anxiety
- ☐ Cancer
- ☐ Other ______________

THE MULTIPLE SCLEROSIS CENTER OF ATLANTA

Clinical Department
Annual Current Medication Form

Patient Name: ______________________ **Date of Birth** _______________ **Date of Service** _______________

Please list ALL of your current medications, including prescriptions, injections, infusions, over-the-counter medications, supplements, vitamins, and herbal remedies.

	Name of Medication		Dosage		Frequency
1		/		/	
2		/		/	
3		/		/	
4		/		/	
5		/		/	
6		/		/	
7		/		/	
8		/		/	
9		/		/	
10		/		/	
11		/		/	
12		/		/	
13		/		/	
14		/		/	
15		/		/	

Medical Records **Release** Form

Date: ______________________

Patient Name: ______________________ Patient Phone: ______________________

Date of Birth: ______________________ SSN: ______________________

Acct #:______________________ Physician: ______________________

Medical Records Needed:
All: ______ Dr. Notes: ________ Labs: _________ Tests: ________
From Date: ______________ To Date: ______________________

Billing Records Needed:
All: ______
From Date: ______________ To Date: ______________________

MRI Images Needed:
All: ______ Film: ____________ Disc: _________ Report: _______
From Date: ______________ To Date: ______________________

I, the undersigned patient/guardian hereby authorize the **release** of medical information to:

The Multiple Sclerosis Center of Atlanta
ATTN: Medical Records
3200 Downwood Circle NW, Suite 550
Atlanta, GA 30327

I understand this authorization includes release of all medical records including HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization and consent will expire in ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time to the extent that action has previously been taken in reliance hereof.

______________________________ ______________________________
Signature of Patient/Guardian Date of Signature

______________________________ ______________________________
Relationship to Patient Signature of Witness

REVISED 12/2008

Medical Records **Request** Form

Date: ________________________

Patient Name: ____________________________ Patient Phone: ______________________

Date of Birth: ____________________________ SSN: _____________________________

Acct #:___________________________________ Physician: _________________________

Medical Records Needed:
All: ______ Dr. Notes: ________ Labs: _________ Tests: _______
From Date: _______________ To Date: ______________________

Billing Records Needed:
All: ______
From Date: _______________ To Date: ______________________

MRI Images Needed:
All: ______ Film: ____________ Disc: _________ Report: _______
From Date: _______________ To Date: ______________________

I, the undersigned patient/guardian hereby request and authorize MS Center of Georgia d.b.a. The Multiple Sclerosis Center of Atlanta to **send** the information listed above to:

Name: ____

Address: ____

Phone: __________________________ Fax: __________________________

I understand this authorization includes release of all medical records including HIV records, psychiatric mental illness, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. This authorization and consent will expire in ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time to the extent that action has previously been taken in reliance hereof.

______________________________ ______________________________
Signature of Patient/Guardian Date of Signature

______________________________ ______________________________
Relationship to Patient Signature of Witness

REVISED 10/2008