OBSTETRICS & GYNECOLOGY ASSOCIATES OF AUGUSTA, P.C.

1430 Harper St., Bldg. A • Augusta, GA 30901-3699 • Phone (706) 724-2261 • Fax (706) 724-2523
www.ogaaugusta.com

In order to be ready for your first appointment we need the following information. All information will be strictly confidential.

PERSONAL INFORMATION Please print Date: ____________________________

Patient's full name: ____ Nickname: _________________________

SSN: ______________________________ Date of birth: _____________________ Age: __________ Race: ________________

Home address: ____
Street City State Zip

Home phone: ___________________________ Cell: ___________________________ Work: ____________________________

E-mail address: ____

Employer (include address): ____

Spouse's name: ____ Spouse's date of birth: ______________________________

Spouse's social security number: __________________________________

Emergency contact name: ____ Phone: ________________________________

Relationship to you: _________________________________ Referred by: ____

INSURANCE INFORMATION

Do you have health insurance? ______ Yes _____ No _____ Medicare More than one? ______ Yes ______ No

Primary insurance: ___________________________________

Policy holder: _______________________________________

Insured d/o/b: _______________________________________

Relation to insured: ___________________________________

Secondary insurance: ___________________________________

Policy holder: ____

Insured d/o/b: ____

Relation to insured: ____________________________________

OUR FINANCIAL POLICY: We are dedicated to provide you with the best possible care and service, and regard your understanding of our financial policy as an essential element of your care and treatment. If you have any questions, please feel free to discuss them with our staff. Unless other arrangements have been made in advance, payment is due at the time of service. Co-payments are always due at the time of your visit. If you fail to pay your co-payment at the time of your visit, a surcharge of $3 will be added to cover the expense of sending a statement. For your convenience, we accept personal checks, cash, Visa and MasterCard. If you do not have active insurance coverage or do not have documentation of your coverage, we will ask that you pay for services at the time of your visit. We require our staff to check your insurance card at each visit, so please have it ready at the time of check-in. We participate with most major carriers and will bill those plans with which we have an agreement. All co-payments or deductibles are due at the time of service. In the event your health plan determines a service to be not covered, you will be responsible for the charges. If you have insurance coverage through a plan with which we do not have an agreement, we will prepare and send the claim for you as a courtesy; however, payment is still your responsibility at the time of service. We will submit claims to your health care plan for services provided in the hospital. However, your portion of the deductible and coinsurance must be paid in advance of your planned surgery or estimated delivery. Our office typically uses Mullins or University Hospital for laboratory services unless otherwise specified by you. If your insurance carrier requires another laboratory please let us know so that you will not be responsible for the charge. We use the services of an outside collection agency for past due accounts. In the event that attorney and/or court fees are required to collect your account balance you will be responsible for those charges in addition to your charges from our practice. Patients with accounts in bad debt will not be allowed to schedule further appointments until the balance is paid in full. MINORS: all services rendered to minors will be the financial responsibility of the adult accompanying the minor. I have read and understand the financial policy of Obstetrics & Gynecology Associates of Augusta, P.C. and I agree to be bound by its terms. By entering my name below I agree to the above statements:

____
Signature

OGA NOTICE OF PRIVACY PRACTICES EFFECTIVE NOVEMBER 8, 2007

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances. A charge will be made for copies of these records.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Administrator, Linda Saunders, at (706)724-2261. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I have read this Notice of Privacy Practices and have been offered a copy for my records.

______________________________	______________________________
Name	Date