Georgia Arrhythmia
Consultants and Research Institute

We would like to take this opportunity to welcome you to Georgia Arrhythmia Consultants. We appreciate your trust in us, to create a partnership that will support you in accomplishing your heart-related health care goals. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner. Our practice will offer you a safe healthcare environment that emphasizes the importance of being proactive about your heart health. Your satisfaction is our goal.

Please have all your identification and documentation available at your scheduled appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms **annually** so we may update your information.

As we will strive to stay on time, we ask that you allow ample time to get to the office for your appointment. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will do our best keep you informed of how long of a delay you may experience.

Please bring an accurate list of, or all your prescription and over-the-counter medications with you at each visit.

All forms require a fee for processing and can take 2-4 weeks to process. Please plan accordingly. Pre-op clearances require an office visit with one of our providers.

Providing the highest quality of professional care to our patients is very important to us.

Welcome to our practice and thank you for choosing
Georgia Arrhythmia Consultants
for your electrophysiological needs.

Macon Electrophysiology Associates dba Georgia Arrhythmia Consultants
639 Hemlock Street Suite 100 Macon, GA 31201 Office: 478-755-1560 Fax: 478-755-1562

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REGISTRATION FORM (Please Print)

Today's date:	Primary MD:		
PATIENT INFORMATION			
Patient's Legal Last Name:	First Name:	Middle Initial:	Birth Date: / /
Street address:		Permission to obtain records: Yes No	
City:	State:	ZIP Code:	Sex: ❑ M ❑ F
PO Box:	**Email:** (for access to **YOUR Patient Portal** and Online Account/Statements/Payments)		
Pharmacy Name and Location:			
Marital status (circle one): Single / Married / Divorced / Separated / Widowed			
Social Security #:	Cell phone #: ( )	Home phone #: ( )	
Occupation:	Employer:	Employer phone #: ( )	
Race: American Indian / Alaska Native / Asian / Hawaiian / Black or African American / White / Hispanic			

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Name of **Primary** Insurance:	Policy / ID #:	Group #:
Subscribers Name (if different from patient):	Subscriber's SSN (if different from patient):	Subscribers DOB:
Name of **Secondary** Insurance (if applicable):	Policy / ID #:	Group #:
Subscribers Name (if different from patient):	Subscriber's SSN (if different from patient):	Subscribers DOB:
Name of **Tertiary** Insurance (if applicable):	Policy / ID #:	Group #:
Subscribers Name (if different from patient):	Subscriber's SSN (if different from patient):	Subscribers DOB:

HEALTH INFORMATION DISCLOSURE:

Name:	**Relationship to patient:**	**Contact no.:**	**Emergency Contact?** ☐
1.			**Emergency Contact?** ☐
2.			**Emergency Contact?** ☐
3.			**Emergency Contact?** ☐
4.			**Emergency Contact?** ☐

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 Macon Electrophysiology Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

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PATIENT NAME _____

CONSENT FOR MEDICAL TREATMENT

The undersigned user hereby authorizes Macon Electrophysiology Associates d/b/a Georgia Arrhythmia Consultants and Research Institute (GACRI) to furnish the necessary treatments: Laboratory tests, drugs and supplies as may be ordered by the Physician in charge to the above-named patient. I may be seen by a Nurse Practitioner under the supervision of Physician. GACRI participants in training local students and you may have a student observe your care. You may request not to have student. I authorize access to my external prescription history via EHR records. I acknowledge that no guarantee or assurance has been made to me as the result of treatment or examinations in the Physician's office.

Authorization to access past medical history

Authorization is hereby granted to GACRI to access my external prescription history.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization is hereby granted to Georgia Arrhythmia Consultants and treating Healthcare Professionals to release to my insurance company or companies, their agents, or other third party payers, confidential information (including copies of records) as may be requested or necessary for the completion of claim processing relative to my office visits.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned, and if more than one, jointly and severally, hereby authorize payment directly to Macon Electrophysiology Associates d/b/a Georgia Arrhythmia Consultants, of the insurance benefits otherwise payable to him/her or due to become payable to him/her, but not to exceed the balance due of the charges. I understand and agree that I am financially responsible for any charges not covered by the assignment of insurance benefits. I authorize Georgia Arrhythmia Consultants to file appeals on my behalf if required.

GUARANTEE OF ACCOUNT

For and in consideration of the goods and services rendered and to be rendered by or through Macon Electrophysiology Associates d/b/a Georgia Arrhythmia Consultants and treating Healthcare Providers, the undersigned guarantees payment of all fees and charges incurred by and for the above-named patient. Final billing will be rendered upon confirmed determination of all charges incurred, less insurance payments, if any, received. The undersigned agrees to make such payment in full immediately upon receipt of such billing. If the undersigned is unable to make full payment, satisfactory payment arrangements can be made.

ACKNOWLEDGED PRIVACY ACT (HIPPA) Copy available upon request
Initials _____

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, THAT IT HAS BEEN FULLY EXPLAINED, AND THAT HE/SHE UNDERSTANDS ITS CONTENTS AND AGREES TO ALL TERMS AND CONDITIONS SET FORTH ABOVE.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
GUARANTOR SIGNATURE DATE

_____ _____
WITNESS (MEP/GAC REPRESENATIVE) DATE

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FELIX O. SOGADE, MD, FACC, FHRS JOSEPH W. POKU, MD, FACC, FHRS
DANIEL B. HAITHCOCK, MD, FACC KATHY S. FRAZIER, NP-C
AMY S. GROOVER, NP-C BRIDGET J. LEARY, NP-C
ROBBI S. BRETT, NP-C JACEY M. COFFEY, NP-C

Board Certified in Clinical Cardiac Electrophysiology, Cardiovascular Diseases, and Internal Medicine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

TO: _____
PHYSICIAN'S NAME

_____
ADDRESS

_____
CITY STATE ZIP

I hereby request my medical records be released to:

_____

_____

_____

Patient's Name:

_____ _____
First Middle Last Date of Birth

_____
Patient's Signature

_____
Patient's Authorized Representative Relationship

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Name _____ Date of Birth _____

Reason for today's visit: _____

How long have you had this problem? _____

LIST ALL DRUG AND FOOD ALLERGIES: _____

Please list all your current medications:

Medication Name	Mg	Frequency	Medication Name	Mg	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Please indicate of you have (of have had) any of the following medical conditions by placing an **"X"** next to the condition.

	Heart Disease		Previous Stroke		Diabetes		Lung Problems
	High Blood Pressure		Digestive Problems		Seasonal Allergies		Kidney Problems
	Seizures		Hepatitis		Arthritis		Depression
	Cancer		Thyroid Problems		Asthma		Tuberculosis

If you have ever had surgery, please list the year and type of surgery.

Year	Surgery

Have you or anyone in your family ever had a reaction to anesthesia? Yes ____ No ____
If yes, please describe what happened: _____

Please indicate with an **"X"** if anyone in your family has had any of the following health problems:

	Heart Disease		High Blood Pressure		Diabetes		Sudden Cardiac Arrest
	Stroke		Cancer		Seizures		Congestive Heart Failure

Have you ever smoked cigarettes or used tobacco? Yes ____ No ____
If YES, do you still use tobacco products? Yes ____ No ____
If YES, how much/how often do you use these products? _____

Do you drink alcohol? Yes ____ No ____
If YES, how would you describe your drinking? Social ____ Moderate ____ Heavy ____

Do you now or have you ever used illegal drugs? Yes ____ No ____
If yes please describe your drug use: _____

Have you had a recent: Stress Test? ____ Ultrasound of heart? ____ Heart Cath? ____Worn a heart monitor? ____

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PATIENT INFORMATION/FINANCIAL POLICY

1. Please bring a picture ID and you current insurance cards to your appointment.

2. Macon Electrophysiology Associates, P.C. d/b/a Georgia Arrhythmia Consultants accepts most forms of private insurance, as well as Medicare and Medicaid. It is the policy of MEP/GAC to submit claims to third-party payers in a timely manner as a courtesy to patients; however, you are responsible for any outstanding balances not covered by your plan.

3. **Your Co-Pay is due upon arrival**. We accept cash, personal checks, Visa, Master Card, AMEX & Discover Card. **You are responsible for payment of any co-payment or outstanding balance at the time services are rendered. If you are not able to provide payment at time of service, you will be rescheduled to a new service date.** If you are unable to make a payment today, we will arrange to see you **this visit only**.

4. If checks are returned for non-payment, you will be charged a $30 returned check fee.

5. If it becomes necessary to transfer unpaid balances to a collection agency, any legal fees associated with those collections will be your full responsibility.

6. Effective October 15, 2014, Macon Electrophysiology Associates, P.C. d/b/a **Georgia Arrhythmia Consultants will charge a $25 fee for forms. Forms can take 2-4 weeks to process, please plan accordingly. Forms will not be returned without payment.**

7. Prior to your appointment, please confirm we have received your records from your referring physician/primary care physician. If we have not received your records, **you will be responsible** for obtaining your records and bringing them with you to your scheduled appointment.

8. We ask that you please give a 24-hour notice if you cannot make your scheduled appointment.

9. **Please note** we will do our best to get you in and out of the office in a timely manner; however, sometimes emergencies arise, we greatly appreciate your understanding. After 30 minutes of wait time, you do have the option to reschedule your appointment. If you are late arriving for your appointment, we will make every attempt to serve your needs, as time allows.

10. Due to limited space in our waiting room, we would appreciate only essential people accompanying you to your visit.

Patient Signature _____ Date _____

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CENTRAL GEORGIA HEALTH EXCHANGE
The next generation of patient information

PERMISSION TO CREATE A HEALTH EXCHANGE RECORD AND SHARE MY MEDICAL INFORMATION WITH MY HEALTHCARE PROVIDERS

We are taking part in an exciting program to improve you healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to chare you Health Information (as defined below) through the Central Georgia Health Exchange electronic medical record program (Health Exchange). This will authorize your CGHN-participating doctors to disclose your health information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the Health Exchange and this permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

Printed Name of Patient/Representative	Signature of Patient/Representative	Date

AUTHORITY OF REPRESENATIVE:

I, _____ , do hereby state that I am authorized to sign this permission on behalf of

the patient on the following basis (Relationship to Patient): _____
[A signed copy of this form will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the Health Exchange electronic medical records system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, and monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The Health Exchange will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the Health Exchange to other healthcare providers who need access to my Health Information for purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides, or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis, or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the Health Exchange system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the Health Exchange will be limited to only those users who have agreed to use the Health Exchange consistent with your permission. Information shared through the Health Exchange will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the Health Exchange and CGHN.

You can learn more about Central Georgia Health Exchange by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 777 Hemlock Street, Hospital box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the Central Georgia Health Exchange program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the Central Georgia Health Exchange.