Betty V. Koukis, PC for Women

1405 South Main St
Moultrie, GA 31768
229-785-2335 phn
229-785-2336 fax

Be prepared with your insurance card(s), ID, and medication list

First Name | Middle Name | Last Name | Date of Birth (/ /)

Social Security Number | Race | Single Married Separated Divorce Widow

Mailing Address | City, St | Zip

Home Ph | Cell Ph | Work Ph

Email | Is it okay to leave messages at the above phone numbers? Yes No

Employer | Occupation

Spouse/Partner Name | Cell Ph | Work Ph

Emergency Contact | Relationship | Cell Ph

Guarantor Information *(a guarantor is the person who is financially responsible)*

Name | Date of Birth | Social Security Number

Employer | Relationship | Cell Ph

My medical information may be given to the following:

☐ Primary Care Physician _____ ☐ Patient ONLY

Name | Name | Name

I authorize the release of any medical information necessary to process this claim. Additionally, I authorize payment of medical benefits (Medicare, Medicaid, and/or personal insurance) to Betty V. Koukis, PC for Women for all services performed. All copays are due at the time of service. I understand that I am responsible for payment regardless of insurance coverage. We use the services of an outside collection agency for past due accounts in the event your account is not paid on time. Patients with accounts in bad debt will not be allowed to schedule further appointments until the balance is paid in full. For your convenience, we accept cash, personal checks, Visa, and MasterCard. Our office typically uses Colquitt Regional Medical Center Lab for Lab services unless otherwise specified by the you. If your insurance carrier requires another lab, please let us know so that you will not be responsible for the charges.

I have read and understand the financial policy of this offices and I agree to be bound by its terms.

I have received a copy of the HIPAA Privacy Notice and by entering my name below, I agree to the above statements.

Patient Signature | Date (/ /)

Betty V. Koukis, PC for Women

1405 South Main St
Moultrie, GA 31768
229-785-2335 phn
229-785-2336 fax

Consent for Treatment

I authorize Betty V. Koukis, PC for Women and physician(s) assigned to furnish the medical and/or surgical treatment or tests that are deemed appropriate by the physician for the patient whose name appears on this form.

Release of Information

☐ Yes ☐ No

I authorize Betty V. Koukis, PC for Women and all physician(s) to release any information, repots, copies of records necessary to process insurance, etc., to other referral physicians, my primary care physician or attending physician, Blue Cross Blue Shield, Medicare, Medicaid, or other health insurance companies to complete the patient's claim(s), and the appropriate governmental agency of the United States as such information may be required by Federal Law.

Assignment of Insurance Benefits

☐ Yes ☐ No

I hereby authorize and direct payment to Betty V. Koukis, PC for Women and to all physician(s) of the benefits herein specified and otherwise payable to me. I understand I am financially responsible for the charges to all parties not covered by this assignment and/or third parties, etc.

Health Insurance Information

Primary Carrier _____ Policy Number _____

Insured Name _____ Date of Birth ___/___/___ Relationship to Patient _____

Secondary Carrier _____ Policy Number _____

Insured Name _____ Date of Birth ___/___/___ Relationship to Patient _____

Patient Name (printed) _____ Patient or Representative Signature _____ Date ___/___/___

Witness Signature _____ Date ___/___/___

Betty V. Koukis, PC for Women

1405 South Main St
Moultrie, GA 31768
229-785-2335 phn
229-785-2336 fax

Medical Release

I, _____ hereby authorize _____ to disclose the following protected health information to Betty V. Koukis, PC for Women.

Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.

This protected healthcare information is being used or disclosed to carry out treatment, payment and/or health care operations of Betty V. Koukis, PC for Women in the following manner :

This authorization shall be in force and effect UNTIL RECEIVED at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Betty V. Koukis, PC for Women. I understand that a revocation is not effective to the extent of Betty V. Koukis, PC for Women relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and may no longer be protected by federal or state law.

Betty V. Koukis, PC for Women will not condition treatment, payment, or enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Patient Name (printed)	Patient or Representative Signature	Date
		/ /

Betty V. Koukis, PC for Women

1405 South Main St
Moultrie, GA 31768
229-785-2335 phn
229-785-2336 fax

HIPAA Acknowledgement

I acknowledge that I have read the Notice of Privacy Practices.

Patient Name (printed)	Patient or Representative Signature	Date
		/ /

Informed Consent for Routine Procedures

I voluntarily request and consent to the performance of the procedures or treatments described or referred to on the Routine Procedure Notice or Betty V. Koukis, PC for Women provider who may be involved in the course of my treatment. By signing this form, I acknowledge that I have read and/or had the Routine Procedure Notice explained to me; that I fully understand its content; and that I have been given ample opportunity to ask questions and that any and all questions have been answered satisfactorily.

Patient Name (printed)	Patient or Representative Signature	Date
		/ /

Payment Policy

Payment is due at the time services are rendered. There is no exception. If you are unable to make payment at the time of your appointment, please let us know 24 hours in advance and we will be happy to reschedule you for a later date.

Self Pay/Uninsured patients : payment in full is due at the time of service.

Insured Patents: We are in-network with most insurance plans and will happily accept insurance as a portion of payment. However, any co-pays,. Co-insurance, and required deductibles are your responsibility and are due at the time of service. We will verify your insurance at the time of your visit to determine any cost which will not be paid by insurance. You will be responsible at the time of service for paying any amount insurance will not pay.

Missed Appointment / Cancellation Policy

If you are unable to keep your scheduled appointment time, please call our office at least 24 hours in advance in order to avoid a missed appointment fee. This charge is not covered by your insurance. If you fail to give us 24 hour notice you will be charged a $25.00 missed appointment fee per missed appointment. Three missed appointments could result in dismissal from the practice.

My signature below indicates that I understand and agree to Betty V. Koukis, PC for Women payment policy.

Patient Name (printed)	Patient or Representative Signature	Date
		/ /

Witness Signature	Date
	/ /