DOUGLAS WOMEN'S CENTER

Lisa Ortenzi, MD, FACOG
Holly Burman, MSN, WHNP
Suzanne Csorna, MSN, ANP-BC, WHNP-BC

Dear _____,

We appreciate the opportunity to serve you again, and look forward to seeing you.

Your appointment has been scheduled for: _____

Enclosed you will find our patient registration forms, which our providers request you update annually.

Please complete the forms in advance and fax or mail them to our office along with a copy of the **front & back of your insurance card**. **IMPORTANT:** If you plan to mail the forms, please **allow at least 7 days** prior to your appointment to allow time for delivery. If you do not have access to a fax machine and time does not allow you to mail them, please bring all forms with you to the appointment. Our fax number is 770-739-6006.

Please arrive 20 minutes prior to your scheduled appointment time so that we may check you in and prepare your medical chart.

Payment is expected at the time of service unless prior arrangements are made. WE DO FILE INSURANCE CLAIMS FOR YOU AS A COURTESY. HOWEVER, IT IS IMPORTANT FOR YOU TO BECOME FAMILIAR WITH YOUR PARTICULAR INSURANCE BENEFITS, AS ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY.

IF YOU ARE COVERED BY INSURANCE, YOU MUST BRING YOUR CARD WITH YOU. WITHOUT YOUR INSURANCE CARD, YOU WILL BE RESPONSIBLE FOR CHARGES OR HAVE THE OPTION TO RESCHEDULE YOUR APPOINTMENT.

If for some reason you must cancel your appointment, please notify us at least ***24 HOURS*** prior to your appointment to avoid a **$35.00 cancellation fee**. This will help us utilize your time slot for other patients who may need to be seen.

We are looking forward to seeing you and we welcome any questions you may have.

Sincerely,

Lisa Ortenzi, MD, FACOG Holly Burman, MSN, WHNP

Suzanne Csorna, MSN, ANP-BC, WHNP-BC

PLEASE NOTE:

We use an automated appointment reminder system. This is an automated system which will call to remind you of your appointment between the hours of 5:00 p.m. and 9:00 p.m. **When you receive the call, please listen carefully to the message.** The automated recording will notify you of the day and time of your scheduled appointment with Douglas Women's Center. **It will not indicate who your appointment is with, nor will it indicate the type of appointment scheduled.**

If you have more than one appointment scheduled for the same day, the automated recording will give you the time of the first appointment only. For example, if you are scheduled to have a mammogram at 9:00, and an appointment with the provider at 9:30, the message will only indicate that you have an appointment with Douglas Women's Center at 9:00 a.m. on the specified date.

Please listen to the message in full and at the end, press "1" to confirm your appointment, or "2" to cancel your appointment. If you do not respond to the recording, our scheduling team will attempt to contact you a second time by phone. If you decide to cancel your appointment, our scheduling team will follow-up to see if you would like to re-schedule for a more convenient time.

IMPORTANT: If you have voice mail, the system may hang up without leaving a message and it will appear as a "missed call" from Douglas Women's Center.

Revised 07/24/2015

DOUGLAS WOMEN'S CENTER PATIENT REGISTRATION FORM

PLEASE **PRINT** CLEARLY!

Patient's Full Name: _____
FIRST MIDDLE MAIDEN LAST

Nickname or Name Patient Prefers To Be Called: _____

Street Address:_____**Lot # or Apt #**_____

City _____**State** _____ **Zip Code**_____

VERY IMPORTANT! PLEASE PROVIDE ALL CURRENT CONTACT NUMBERS WHERE YOU CAN BE REACHED:

Home Phone#: _____**Work Phone**#: _____

Cell Phone#: _____ **Any Other #'s**: _____

Social Security#: _____**Date of Birth**: _____**Marital Status** _____

Employer: _____**Employer Address:** _____

Primary Physician or Personal Physician (other than Douglas Women's Center): _____

Referred By: _____ **Allergies:** _____

INFORMATION FOR SPOUSE:

Spouse Name: _____ **Spouse Date of Birth**:_____

Employer_____ **Employer Address**: _____

Spouse Work Phone#:_____ **Spouse Cell #:** _____ **Spouse Social Security #:**_____

PLEASE PROVIDE TWO EMERGENCY CONTACTS:

1) Name:_____ Relationship To Pt. _____ Home# _____ Work# _____ Cell#_____

2) Name:_____ Relationship To Pt. _____ Home# _____ Work#_____ Cell#_____

INSURANCE INFORMATION:

Primary Insurance Co _____

Name of Primary Card Holder: _____DOB: _____Relationship to Patient: _____

Claim Mailing Address: _____

ID#_____Group#: _____

Secondary Insurance Co: _____

Name of Primary Card Holder: _____DOB: _____Relationship to Patient: _____

Claim Mailing Address: _____

ID#_____Group#: _____

PLEASE READ THE FOLLOWING STATEMENTS AND WRITE YOUR INITIALS IN THE SPACE PROVIDED:

(INITIAL) _____I authorize Douglas Women's Center, P.C., to release to my insurance company information required in the course of my treatment.

(INITIAL) _____I hereby assign payment directly to Douglas Women's Center, P.C. for medical benefits payable for these services. I understand that I am responsible for any charges not paid under this assignment and/or for any non-covered service.

_____ _____
Signature of Patient Date

_____ _____
Signature of Responsible Person if Patient is a Minor Date

Revised 02/17/12 ***(Office Use Only) Acct. #*** _____***Emp. Init.*** _____

DOUGLAS WOMEN'S CENTER
Method of Contact &
Permission To Leave Health Information With Persons Other Than Patient
Authorization Form

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please note, the referring physician or referral source may be sent a copy of records to ensure continuity of care.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Home Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Work Telephone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

Written Communication

- O.K. to mail to my home address ____
- O.K. to mail to my work/office address ____
- O.K. to fax to this number _____ ____
-

Cell Phone

- O.K. to leave message with detailed information ____
- Leave message with a call back number only ____
- Do not leave message ____

I AUTHORIZE DOUGLAS WOMEN'S CENTER TO LEAVE INFORMATION WITH THE FOLLOWING PEOPLE:

Name: Relationship:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature **Date:**

Print Name: **Social Security #:** **Birth Date:**

DIRECTIONS TO DOUGLAS WOMEN'S CENTER

880 Crestmark Drive, Suite 200
Lithia Springs GA 30122

From Atlanta:

I-20 West to Thornton Road exit #44 – turn right off ramp.
Go to second traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

Toward Atlanta:

I-20 east to Thornton Rd exit #44 – turn left off ramp
Go to third traffic light turn left onto Skyview Drive
Turn left at first street onto Crestmark Drive
Go around curve to last building on left, 880 Crestmark Dr., Suite 200 (upstairs)
(second light gray building with blue roof behind Shoney's Inn & McDonalds)

If you have any problems locating our office, please call 770-941-8662