T. DOUGLAS GURLEY MD, LLC

@ studioplex

659 Auburn Avenue NE, Suite 156, Atlanta, GA 30312 PHONE (404) 888-0228 FAX (404) 888-0552

www.tdouglasgurleymd.com

Personal/Contact Information

Patient Name: _____M ____ F ____ Date of Birth: ____/____/_____

SS#_____-_____-_____ Status: Single___ Partnered ____M ____W ____D ____

Address: _____ City: _____State: _____ Zip: _____

Home Phone # _____ OK to leave messages? Y or N

Cell # _____ OK to leave messages? Y or N

Email Address: _____ @_____ OK to send email? Y or N

Emergency Contact: Name: _____ Phone: _____Relation:_____

Employment Information

Employment Status: Employed _____Retired _____Disabled _____Student _____

Employer: _____Work # _____ Ext: _____

Payment Information

Relationship to Insured: _____ Form of payment: _____

Primary Insurance: _____ Policy/ Group # _____

Policyholders Name: _____ Policyholders D/O/B: ____/____/_____

Member ID# _____ Customer Service Phone # _____

Billing Address:_____

Secondary Insurance: _____ Policy/ Group # _____

Policyholders Name:_____ Policyholders D/O/B: _____/_____/_____

Member ID# _____ Customer Service Phone #_____

Billing Address: _____

Referral Information

How did you hear about us? Phone Book_____ Website/ Search Engine_____ Printed Ad _____

Insurance network list_____ Referred by Patient_____ Referred by Physician _____ Other _____

Established Patient: _____ Other Referral Source: _____

Referring Physician Name & Phone: _____

Patient Demographics

RACE: American Indian or Alaska Native _____ Asian _____

Native Hawaiian or Other Pacific _____

Black or African American_____

White_____Hispanic_____Other Race_____

ETHNICITY: Hispanic or Latin_____

Not Hispanic or Latin_____

PRIMARY LANGUAGE SPOKEN: English_____ Indian_____

Spanish_____ Russian_____

Other_____

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Receipt of Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by mail or in person at our office.

By signing below, you acknowledge that you have read, received or declined a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name (Please Print): _____ Date of Birth: ____/____/____

Patient/ Responsible Party Signature: _____ Date: ____/____/____

Disclosure of Private Medical Information

I authorize T. Douglas Gurley, M.D., L.L.C. to disclose medical information pertaining to my personal health to the following persons:

Name	Relationship	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above will stay in effect until voided by you.

Patient Name (Please Print): _____ Date of Birth: ____/____/____

Patient/ Responsible Party Signature: _____ Date: ____/____/____

Missed Appointment Policy

If you are unable to keep an appointment, please let us know no less than 24 hours in advance. Please be advised that your account will be charged a $50 missed appointment fee for office or aesthetician visits, and a $150 missed appointment fee for physical examinations if 24 hour cancellation is not given.

Patient/ Responsible Party Signature: _____ Date: ____/____/____

Insurance Assignment/Release of Information

I authorize payment of insurance benefits to be made directly to T. Douglas Gurley, M.D., L.L.C. for medical services or supplies rendered to me by their practice. I authorize T. Douglas Gurley, M.D., L.L.C. to release medical information for claim processing.

I understand my insurance company may not pay the entire amount of my bill and I am responsible for the balance that the insurance company does not pay.

Patient/ Responsible Party Signature: _____ Date: ____/____/____

Out of Network Benefit Acknowledgement

(Only applicable if your insurance plan is out of network.)

T. Douglas Gurley, M.D., L.L.C. may not be a participating physician with your insurance plan, and if not, benefits may be reduced as such. We can help you determine if T. Douglas Gurley, M.D., L.L.C. is a network provider with your insurance plan and the in and out of network benefits of your plan. Should you choose T. Douglas Gurley, M.D., L.L.C. as your provider and your insurance plan is out of network, you may have a higher deductible and co-insurance dependant upon your specific out of network benefits.

I acknowledge that T. Douglas Gurley, M.D., L.L.C. is not in network with my insurance plan and I am responsible for any costs in accordance with my individual insurance policy.

Patient/ Responsible Party Signature: _____ Date: ____/____/____

Confidential