

**Capstone Medical Group, P.C.**  
**5900 Hillandale Drive, Suite 200**  
**Lithonia, Georgia 30058**  
**404-446-3870(p)**  
**404-446-3875(f)**

## **Patient Information Registration Form**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ SS#: \_\_\_\_\_

**May we call or leave a voice mail message regarding your lab results? Yes or No (please circle)**

Employer: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

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**ASSIGNMENT OF INSURANCE BENEFITS**

**I hereby authorize direct payment of surgical/ medical benefits to Dr. Clyde Watkins, Jr. /Capstone Medical Group, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.**

**AUTHORIZATION TO RELEASE INFORMATION**

**I hereby authorize Dr. Clyde Watkins, Jr. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.**

**MEDICARE - MEDICAID**

**I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.**

**Patient (please print) \_\_\_\_\_ Date \_\_\_\_\_**

**Signature \_\_\_\_\_**

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### **Payment of Services Agreement**

- Please be aware that if you have medical insurance, we will accept assignment on the portion of you charges which are covered by insurance.
- Please understand that you will be responsible, before services are rendered, for deductible(s) and any co-insurance(s) not covered by your insurance company.
- We will allow you 90 days to pay any balance remaining after insurance payment. If we have not received your payment your account will be turned over to a collections agency and you may possibly be dismissed from the practice.
- For services that **are not** covered by insurance, the practice requires payment of 100% of the total charges.
- Returned checks are subject to a handling fee of \$35.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.**

### **Cancellation Policy**

**There is a \$30.00 charge for appointments not cancelled 24 hours prior to the scheduled appointment. The patient will be required to pay this fee on or before the next appointment.**

**PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING.** By signing below, I acknowledge that I have read and understand this policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient and/or Responsible Party)

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## HIPPA Health Insurance Portability and Accountability Act

### Dr. Watkins and his Staff Want You to Know How We Will Protect Your Private Health Information

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Given patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after August 2005 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep for you records. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer.

Thank you for your cooperation.

**I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.**

**Patient Name:** \_\_\_\_\_  
(Please Print)

**Signature of Patient or Personal Representative:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**If Personal Representative, give relationship to patient:**

\_\_\_\_\_