PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

PATIENT INFORMATION:

NAME: _____ GENDER: ❑ Male ❑ Female

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____ E-MAIL: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS:

_____
Street / P.O. Box / Apt. No. City / State / Zip Code

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

DOMESTIC INFORMATION:

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

SPOUSE/OTHER NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian
❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

SECONDARY INSURANCE: _____ INS ID#: _____

RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____

SUBSCRIBER'S ADDRESS: _____

SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET

IF SERVICES ARE BEING PROVIDED TO YOUR DEPENDENT, PLEASE COMPLETE THE FOLLOWING:

MOTHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

FATHER/GUARDIAN: _____ DOB: _____ SS#: _____

ADDRESS: _____
Street / P.O. Box / Suite # City / State / Zip Code

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

I hereby authorize Galen Medical Group, its physicians and staff, to render appropriate medical care to my dependent listed under the patient information section on the front of this form.

_____ _____
Signature of Responsible Party ***Date***

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, grant permission for the person(s) listed below to have access to any and all of my medical information that pertains to my care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, my physician's plans for health care, etc.

Signature: _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED

ADVANCED DIRECTIVES:

It is the right of every adult citizen in Tennessee and Georgia (18 years and over) to sign a Living Will, as well as a Durable Power of Attorney for Health Care that empowers an Individual of your choosing to see that your wishes are carried out. It is important to decide whether or not you wish to sign a Living Will now when you are fully competent to make your own decision. The choices you make in your Living Will will be binding on doctors, hospitals, and other healthcare providers in the event you become incapable of telling them your wishes. If you have signed either document, please make sure your provider has a copy for your file.

AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I request that payment of Medicare, MediGap, Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial, Workers' Compensation, Liability, and/or any other insurance benefits be made on my behalf to Galen Medical Group for services furnished to me or on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____ _____
Signature of Patient ***Date*** ***Signature of Responsible Party/Insured***

THANK YOU

Gastroenterology Evaluation Form

Name: _____ **DOB:** _____ **Sex: M F Date:** _____

Referring Doctor: _____ **Primary Care Provider:** _____

Cardiologist: _____ **Other Providers:** _____

Vaccination/ Immunization

Vaccination/ Immunization	Date of vaccination/ immunization (MM/YYYY)	Did not receive immunization (Mark X here)
Last Influenza- flu shot		
Pneumococcal- pneumonia shot		

Allergy List

Medication, Environmental, and/or Food	Reaction
Reaction to Anesthesia: ☐ Yes ☐ No If yes, what type of reaction: _____	

Medical History (Please check all that apply)

☐ High Blood Pressure ☐ Emphysema ☐ Heart Attack ☐ Shortness of Breath
☐ Kidney Disease ☐ Abnormal Heart Rhythm ☐ Diabetes ☐ Arthritis
☐ Chest Pain ☐ Stroke ☐ Migraines ☐ Asthma
☐ Kidney Stones ☐ Seizures ☐ Tuberculosis ☐ COPD
☐ Depression ☐ Sleep Apnea ☐ Blood Clots ☐ Blood Disorder
☐ Glaucoma ☐ HIV/AIDS ☐ Cancer(s): _____
☐ Other: _____

Surgeries

☐ Tonsils and Adenoids ☐ Hysterectomy (Year: ___) ☐ Hernia Repair ☐ Appendix
☐ Joint Replacement ☐ Hemorrhoid ☐ Gallbladder ☐ Heart
☐ Pancreas ☐ Thyroid ☐ Colon Resection (Year:___) ☐ Breast (Year:____)
☐ Nissen Fundoplication ☐ Pacemaker (Year:____) ☐ Defibrillator (Year:____) ☐ Organ Transplant
☐ Cardiac Stent (Year:____) ☐ Abdominal Surgeries: _____
☐ Other: _____

Procedure History (Please check all that you have had in the past)

☐ Colonoscopy, year was it done? _____ By whom? _____
☐ EGD (Upper Endoscopy) ☐ ERCP ☐ EUS (Endoscopic Ultrasound)

Preventive

Last Mammogram **(month & year):** _____ Last Pap-smear **(month & year):** _____

Medication List

☐ **I am on a blood thinner** (if so, please list below) Who Prescribes? ______________________________

Name of Medication	**Dose (mg, mcg, units)**	**Times Taken Per Day, Week, Month, or Year**

My Pharmacy: ____

Patient Name: ____ **DOB:** ____________________

Social History

Tobacco

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Cigarettes ☐ Chew ☐ Cigars Packs per day _____ How many years _____ Year quit _____

Alcohol Use

☐ No ☐ Never ☐ Previous ☐ Current ☐ History of alcoholism

How often? ☐ Rare ☐ Socially ☐ Regularly ☐ Heavy Type: ☐ Beer ☐ Liquor ☐ Wine

Illicit Drug Use

☐ Never ☐ Current ☐ Previous Years Sober: _____

☐Marijuana ☐ Cocaine ☐ Heroin ☐ Methamphetamine ☐ Other: _____

Work History

☐ Full-time ☐ Part-time ☐ Homemaker ☐ Disabled ☐ Retired ☐ Student

Living Situation

☐ Alone ☐ Lives with family ☐ Spouse ☐ Other: _____

Exercise

☐ Never ☐ Rarely ☐ Occasionally ☐ Regularly- timer per week: _____

Exposures

☐ Tattoos, if so how many? _____ ☐ Blood Transfusion, if so how many? _____

Diet

☐ High Fiber ☐ Low Fiber ☐ Vegetarian ☐ Vegan ☐ Caffeine Use, if yes how much _____

Use of NSAIDS

☐ Aspirin ☐ Advil ☐ Aleve ☐ Goody's ☐ Ibuprofen ☐ Naproxen ☐ Excedrin

Family Medical History

(Please enter one of the following in the blank space: F= Father, M=Mother, B=Brother, S=Sister, C=Child)

____ Colon Polyps	____ Esophageal Cancer	____ Irritable Bowel Syndrome	____ Colon Cancer
____ Stomach Cancer	____ Esophageal Reflux	____ Colitis	____ Gallbladder Disease
____ Pancreatitis	____ Crohn's Disease	____ Breast Cancer	____ Pancreatic Cancer
____ Liver Disease	____ Stomach Ulcers	____ Prostate Cancer	____ Blood Disorders

Other: _____

Review of Systems (current symptoms)

General: ☐ Fever ☐ Chills ☐ Fatigue ☐ Decreased Appetite ☐ Weight Loss ☐ Weight Gain

Psychiatric: ☐ Depression ☐ Anxiety ☐ Stress

Skin: ☐ Rash ☐ Skin Change ☐ Itchiness ☐ Jaundice

Eyes: ☐ Jaundice ☐ Glaucoma

Ears: ☐ Ear Pain ☐ Hearing Loss ☐ Ringing of Ears ☐ Ear Fullness ☐ Ear Drainage

Nose: ☐ Nasal Congestion ☐ Nose Bleeds

Mouth/Throat: ☐ Dentures ☐ Dry Mouth ☐ Mouth Ulcers ☐ Hoarseness ☐ Trouble Swallowing ☐ Painful Swallowing

Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ Home Oxygen ☐ Trouble Breathing ☐ Sleep Apnea

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Congestive Heart Failure ☐ Murmur ☐ Heart Attack ☐ Angina

Gastrointestinal: ☐ Seen other GI Doctor(s) ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Abdominal pain ☐ Heartburn ☐ Reflux ☐ Belching ☐ Gas ☐ Bloating ☐ Nausea ☐ Vomiting ☐ Difficulty Swallowing ☐ Painful Swallowing ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Black Stools ☐ Change in bowel habits ☐ Mucus in Stool ☐ Pain with Bowel Movement ☐ Straining During Bowel Movement ☐ Urgency with Stools ☐ Stooling Accidents ☐ Rectal Pain ☐ Hemorrhoids ☐ Colon Polyps ☐ Diverticulitis ☐ Change in Stool Caliber

Genitourinary: ☐ Frequent Urination ☐ Incontinence ☐ Blood in Urine ☐ Heavy Periods ☐ History of Bladder/Kidney Infections ☐ History of Kidney Stones

Neurological: ☐ Dizziness ☐ Headaches ☐ Fainting ☐ History of Stroke ☐ Seizures

Musculoskeletal: ☐ Arthritis ☐ Osteoporosis ☐ Fractures ☐ Joint Pain ☐ Muscle Pain

Endocrine: ☐ Thyroid Problems ☐ Diabetes ☐ Hormone Imbalance ☐ Heat Intolerance ☐ Cold Intolerance

Hematologic/Lymph: ☐ Excessive Bruising ☐ Excessive Bleeding ☐ History of Blood Transfusion ☐ History of Anemia

Immunologic: ☐ Food Allergies ☐ Frequent Infections ☐ Frequent Steroid Use ☐ Problems with Immunity

Patient Name: _____ **DOB:** _____

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

This Authorization is intended to comply with the HIPAA Privacy Rule for the release, use and disclosure of medical information, and if applicable, the release, use and disclosure of medical information with respect to minors, incapacitated patients, and deceased persons. The undersigned acknowledges that Galen cannot guarantee information disclosed pursuant to this Authorization may not be re-disclosed by the recipient and/or no longer protected by privacy regulations:

The undersigned, _____
[print name of person signing below]

[and designate one power by which the undersigned authorizes this release]:

- ☐ for Himself/Herself
- ☐ as Legal Guardian
- ☐ as Authorized Personal Representative
- ☐ as Custodial Parent
- ☐ with Health Care Power of Attorney
- ☐ as Executor of Patient's Estate
- ☐ as Spouse of Deceased Patient [only if no other known authority listed above]

hereby authorizes Galen Medical Group, P.C. ("Galen") to disclose the medical record for:

_____, born _____
[*print name of patient*] [*date of birth*]

To:_____ [*party to whom records will be released*]	From:_____ [*party releasing records*]
Address:_____ _____	Address:_____ _____
Phone: _____ [*required only for fax or secure email verification*] Fax:_____	Phone:_____ Fax:_____
E-mail: _____ [only *for verification and encrypted records*]	E-mail:_____

by the following means [choose one]:

- ☐ mail
- ☐ fax
- ☐ pick up in person

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Information to be Released

- ☐ Entire Medical Record
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-Ray
- ☐ Clinic Visits
- ☐ ER Records
- ☐ Discharge Summary
- ☐ EKG
- ☐ Laboratory
- ☐ Physician Orders
- ☐ Other: _____

Purpose of Release

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of Care
- ☐ Worker's Compensation
- ☐ Disability
- ☐ Insurance
- ☐ Disposition
- ☐ Billing

by the following means [choose one]:

☐ mail ☐ fax

☐ pick up in person

GALEN HAS NOT DETERMINED WHETHER OR NOT INFORMATION CONCERNING THE DIAGNOSIS OR TREATMENT OF SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV OR AIDS, MENTAL HEALTH, AND/OR THE USE OF ALCOHOL, DRUGS, OR TOBACCO MAY BE PRESENT IN THIS MEDICAL RECORD. IF SUCH INFORMATION MAY BE PRESENT IN THE MEDICAL RECORD, THE UNDERSIGNED AUTHORIZES THE RELEASE OF SUCH INFORMATION.

☐

Initials Required for this Authorization to be effective for any portion of the Medical Record

The undersigned acknowledges that any prior agreements to restrict protected health information ("PHI") do not apply to this authorization and that Galen is hereby authorized to release and disclose the patient's entire medical record without restriction, except as set forth in this authorization.

The undersigned further understands that:

- -The undersigned is not required to sign this authorization for treatment, payment, enrollment, or eligibility for benefits.
- -This authorization is effective for one year, but may be revoked in writing at any time, except for any actions Galen may have already taken at the time of the revocation.
- -If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others.

_____ _____

signature of patient or patient representative pursuant to the designated authority above [date signed]

accepted and verified by _____ on _____

[Galen Representative] [*date*]

I understand and agree that Galen is relying on my status as the personal representative of the patient. Under penalties of perjury, I hereby certify that to the best of my information and belief I am a personal representative.

GALEN

Notice of Personal Health Information Practices

Revised effective October 17, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

We are required by federal law to give you this notice.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Galen Medical Group, P.C. will post a copy of this Notice as amended in a prominent place in our offices and on our web site.

This notice becomes effective September 1, 2013 and amends our previous form of notice. We do not deem any current amendment to constitute a material change notice. No amendment relates to any substantive right of a Galen patient or any duty of Galen. If you have any questions about the Notice of Personal Health Information Practices, please contact our Privacy Officer at 423-308-0280 ext. 133 or by e-mail at privacy@galenmedical.com.

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Galen Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Health Oversight Activities. We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Family Members. We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates. We have contracted with other entities to provide services to Galen Medical Group. When these "associates" require your personal health information in order to accomplish tasks asked of them by Galen Medical Group it will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training. Your personal health information may be used for the purpose of research, teaching and/or training.

Appointment Reminders. Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation. We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illnesses. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Special circumstances requiring your authorization. Most uses and disclosures of psychotherapy notes, health information for marketing purposes, and as part of a sale of protected health information require your authorization. Galen does not maintain psychotherapy notes, nor sell your health information. Your receipt of this notice authorizes Galen to use your health information for marketing purposes. Galen does not receive financial remuneration in exchange for communicating information to you for marketing purposes.

Individual Rights

You have certain rights under the federal privacy standards.

These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment by alternative means or at alternative locations if you request, your request is reasonable, and you acknowledge that such alternative means or locations could risk the disclosure of all or part of your protected health information
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice, even if you have an electronic copy

Galen Medical Group's Duties We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and privacy practices regarding protected health information, to notify you of a breach of any unsecured protected health information as defined by applicable regulations, and to abide by the terms of this notice then currently in effect.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit and on our website, unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department of the Galen Medical Group office which you are a patient.

Requests for Restrictions on Protected Health Information You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to agree with your request in certain situations, including emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, disclosures to your health plan unless you pay out of pocket in full for the item or service, and any uses and disclosures described on the front page of the Notice. However, if we decide to grant your request, we are bound by our agreement.

Nondiscrimination Galen Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Galen Medical Group will make available language assistance services free of charge.

Complaints If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: HIPAA Privacy Officer, Galen Medical Group, P.C., 5600 Brainerd Road H-100, Chattanooga, TN 37411

If you believe that your privacy rights have been violated, you should call the matter to our attention by calling the Privacy Officer at 423-308-0280 and press option 8, or by sending an e-mail to privacy@galenmedical.com or a letter describing the cause of your concern to the address provided. You may also address any complaint to the United States Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices. I understand Galen Medical Group, P.C. has the right to change this Notice at any time, subject to Galen's obligation to inform me of material changes.

_____ Date:_____

Signature of Patient or Legal Representative

_____ _____

Print Name of Person Signing

Relationship to Patient, *if signed by legal representative*

GALEN
MEDICAL GROUP

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Eastgate Mall	www.galenmedical.com
P.O. Box 1030	5600 Brainerd Rd. Suite H-100	
Chattanooga, TN 37401	Chattanooga, TN 37411	

If you have any questions regarding our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

NOTE:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____ _____

Patient Signature Date

_____

Printed Patient Name