

Carroll County Nephrology, PC

Phone: 770-832-0429

Fax: 770-838-9108

WELCOME TO CARROLL COUNTY NEPHROLOGY

****Please bring the completed enclosed paper work with you to your appointment along with your medications and insurance card(s). Do not mail this information to the office. Please arrive 15 minutes prior to your scheduled appointment time.****

We have three office locations for your convenience:

CARROLLTON :

157 Clinic Ave, Suite 203 Carrollton, GA 30117

Located between Tanner Hospital and Walgreens Pharmacy

BREMEN :

108 Redding Dr. Bremen, GA 30110

Located behind the Piggy Wiggly shopping center on Hwy 78

VILLA RICA :

403 Permian Way #B Villa Rica, GA 30180

Exit I-20 onto Mirror Lake Blvd. and travel north to the first light (intersection at Conners Rd). Turn right onto Conners Rd and travel past the Publix shopping center on your left. Take first right turn onto Permian Way (at the Dollar General store sign) and continue straight to the office.

IMPORTANT: *Please bring the following information with you to your appointment:*

- Enclosed paperwork
- Photo identification and insurance card(s)
- All current medications

Thank you,

Maria J. Orig, M.D., FASN

Bryan D. Quinn, M. D.

**Authorization for Disclosure of Protected Health Information
Carroll County Nephrology, PC**

To the following person or class of persons: To any and all physicians health care providers, health care facilities, or healthcare entities that provide or have provided health care services to the patient named below.

Patient name _____ **Date of birth:** _____

Note: "You" refers to the person(s) to whom this authorization is directed. "I", "me" refers to patient.

Authorization

You are hereby authorized to disclose my protected health information, whether oral, written or electronic healthcare information pertaining to my complete medical record, including but not limited to HIV and AIDS confidential information.

You are hereby authorized to disclose my protected health information specifically pertaining to my mental health, including but not limited to psychiatric and psychological information, drug and alcohol abuse treatment information.

You are hereby authorized to disclose my protected health information to any physician health care provider or healthcare facility that has provided health care services to me. Additionally, you are hereby authorized to disclose such protected health information to any attorney at law representing such physician, healthcare provider or healthcare facility. Discussion related to my care. You are hereby authorized to discuss my care and treatment with any attorney or representative of an insurance provider if I assert a claim against another physician, health care provider, health care facility or health care entity.

This authorization expires in three (3) years after the date of execution shown below.

I hereby authorize and direct payment to Carroll County Nephrology, PC for medical benefits under the terms of my insurance. I hereby authorize the release of medical records to the indicated insurance company(ies) for the purpose of proof of treatment, verification of coverage and pre-certification.

Patient's Rights

I understand I do not have to sign this authorization to receive healthcare benefits (treatment, payment or enrollment) from the person (s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I wish to revoke this authorization, I shall do so by sending a letter to the person (s) to whom this authorization is directed. Once the health care provider discloses information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I must sign an authorization form to take part in a research study, or to receive healthcare when the purpose is to create health information for a third party.

Patient or legally authorized individual signature

Date

Printed Name (if signed on behalf of patient)

Relationship (parent, guardian)

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Our Pledge Regarding Medical Information

We understand that medical information about you and your health is very personal. As such, our staff is committed to protect your medical information. We are required by law to insure that all medical information that identifies you is kept private. To comply with the proper use and disclosure of your medical information, please provide us below with the names of the individuals involved in your care and/or with the payment of your care.

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Signature of Patient: _____

Date: _____

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Financial Policy

All co-pays are due at the time of visit. This includes the 20% coinsurance allowed by Medicare if you do not have a secondary insurance. If you have deductibles under your plan that applies to our visits, you are responsible for paying this in a timely matter. Please contact our billing department if payment arrangements are required.

Carroll County Nephrology requires a **24 hour notice for all cancellations**. If no one is available when you call, please leave a detailed voice message with your name and date/time of appointment. If appropriate notice is not given, **there will be a \$25.00 charge**.

Carroll County Nephrology PC accepts cash, check, money order, VISA and MasterCard as forms of payment. Please be aware there will be a **\$30.00 charge for non-sufficient funds** for returned checks marked with non-sufficient funds. This is an automatic debit done by our bank.

Carroll County Nephrology PC will charge an **administrative fee of \$15.00 to patients requesting forms** (examples: medical records copies, disability, family medical leave, medical equipment forms, etc.), to be completed by staff. The patient is responsible for this fee.

Please sign below to indicate that you have read and understand all of the above statements.

Signature of Patient

Date

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Please provide us with your preferred Pharmacy information.

Pharmacy: _____

Phone: _____

Signature: _____

Date: _____