

# McDaniel & Durrett, PC

***This form must be filled out completely in order for us to file your insurance***

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_ Chart: \_\_\_\_\_

Status: S M D W DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Name: \_\_\_\_\_ Pref. Name: \_\_\_\_\_  
Last First M.

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

Hm.#: \_\_\_\_\_ Wrk#: \_\_\_\_\_ City State Zip  
Cell#: \_\_\_\_\_

E-mail: \_\_\_\_\_ Religion: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse/Sig.Other: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouse/Sig.Other SS#: \_\_\_\_\_ Wrk.#: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Primary Insurance: \_\_\_\_\_ Cust.Service #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member/Subscriber ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Cust.Service#: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member/Subscriber ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

*I understand that it is my responsibility to provide a valid insurance card at the time of my exam. Should my insurance deny coverage on any service(s) rendered, I realize I am responsible for payment. I understand that if I do not have insurance, I am responsible for payment at the time of service. I understand that if I am seventeen years of age or younger, I must be accompanied by a parent or legal guardian.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or legal Guardian Signature



# ***McDaniel & Durrett, P.C.***

*105 Collier Road, N.W., Suite 1080*

*Atlanta, GA 30309*

## **Cervical Cancer Screening**

There has been an exciting development in cervical cancer screening, which McDaniel & Durrett, P.C. are pleased to offer our patients. If you are 30 years or older, adding the test for Human Papilloma Virus (HPV) greatly improves the accuracy of cervical cancer screening, allows your provider to better determine your risk of cervical cancer or it's precursors, and provides guidance on how often you should be screened.

Most insurance companies cover the HPV test when used with a Pap test for cervical cancer screening of women 30 years of age & older. However, the elected health benefit plan you or your employer chose, may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. **You may call 1-866-895-1478 to obtain coverage & benefit information for your plan specifically.**

**Cervical cancer screening guidelines recommend that every woman 30 years of age and older receive the HPV test along with her Pap test. McDaniel & Durrett, P.C. recommend this as well.**

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\_\_\_\_\_ I would like to add the HPV test to my pap smear.

\_\_\_\_\_ I would not like to add the HPV test to my pap smear.

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Patient Signature

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Date

**KNOWING YOUR INSURANCE & YOUR PAYMENT RESPONSIBILITIES**

As the patient, it is your responsibility to provide us with accurate and up to date insurance information. As a courtesy, we will gladly file claims to your insurance company on your behalf, based upon the information you have provided. If for some reason your insurance company does not pay for all of your visit, a portion of your visit, and/or does not pay in a timely fashion; you, as the patient, are ultimately responsible for the services rendered.

**CANCELLATION POLICY**

**A CERTAIN AMOUNT OF TIME IS HELD SPECIFICALLY FOR YOU WHEN YOU SCHEDULE AN APPOINTMENT. AS A COURTESY TO OUR PROVIDERS & OTHER PATIENTS ALSO IN NEED OF MEDICAL ATTENTION; WE REQUIRE A 24 HOUR NOTICE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT FOR ANY REASON. OTHERWISE, A \$50.00 FEE WILL BE ASSESSED TO YOUR ACCOUNT.**

\_\_\_\_\_ I have read & understand the above guidelines. I understand that I am  
(initial) responsible for knowing my insurance company's guidelines & informing  
McDaniel & Durrett, P.C. of those guidelines. I understand that if I do not  
adhere to the cancellation policy, I will be charged a \$50.00 fee that must be  
paid before any future appointments can be scheduled.

**PREFERRED METHOD(S) OF CONTACT**

Primary Contact Phone Number \_\_\_\_\_

Secondary Contact Phone Number \_\_\_\_\_

\_\_\_\_\_ I give my consent to leave messages with DETAILED information.  
\_\_\_\_\_ I DO NOT give my consent to leave messages with DETAILED information.

I authorize McDaniel & Durrett, P.C. to discuss my Private Healthcare Information with the following person(s): \_\_\_\_\_.

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

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

## **PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for the office of McDaniel & Durrett, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please see the office's Notice of Privacy Practice booklets located in the lobby for a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of McDaniel & Durrett reserves the right to revise its Notice of Privacy Practices at any time. A copy of these Practice revisions will be available in our lobby as an addendum to the original version.

With this consent, the office of McDaniel & Durrett may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of McDaniel & Durrett may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results, and patient statements.

I have the right to request that the office of McDaniel & Durrett, P.C. restrict how it uses or discloses my PHI to carry out TPO. These requests must be presented in writing to the Practice Manager. The practice of McDaniel & Durrett, P.C. is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to the office McDaniel & Durrett, P.C. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent ,or later revoke it, the office of McDaniel & Durrett, P.C. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient's Name

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Print Name of Patient or Legal Guardian

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Date