Apollo Family Medicine
Dr. Asmita Joshi, M.D.
3990 Old Milton Pkwy, Ste. 200
Alpharetta, GA 30005
TEL#: (470) 875-1560
FAX#: (470) 781-2710

Patient Information

PERSONAL INFORMATION

Patient Name (first, middle, last): _____

Address: _____,
Street Name

_____, _____ _____
City State Zip Code

Date of Birth: _____/_____/_____

SSN: _____

Sex (please circle one): M/F

Phone: _____

Email: _____

Race: _____

Marital Status: _____

Patient's Employer: _____

Occupation: _____

Spouse or Parent Name (first and last): _____

Spouse or Parent Phone: _____

Pharmacy Name: _____

Pharmacy Address:_____,
Street Name

_____, _____ _____
City State Zip Code

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CONTINUED

INSURANCE INFORMATION

Person Insured (please circle one): Self Spouse Parent

Other (please specify): _____

Insured Person's Name: _____ Relationship: _____

Date of Birth: ____/____/_____ SSN: _____ Phone: _____

INSURANCE COVERAGE

Primary Insurance: _____ Policy Holder: _____

Member ID: _____ Group Number: _____

Secondary Insurance: _____ Policy Holder: _____

Member ID: _____ Group Number: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship: _____ Do you have a living will? (please circle) Yes No

PAYMENT RESPONSIBILITY

All professional services rendered are charged to the patient. We will file insurance claims for the patient if the patient is covered by an insurance plan with which our office has a negotiated contract. If the patient is not covered by an insurance plan that our office has a negotiated contract with, it is the responsibility of the patient to pay for services when rendered, regardless of insurance coverage.

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INSURANCE AUTHORIZATIONS: RELEASE OF INFORMATION/ELECTRONIC PRESCRIBING

I authorize the release of any medical or other information necessary to process my insurance claims for my child or for myself. I authorize the release of my information to other providers of service needed for continuation of my medical care such as specialists, hospitals, etc. I request that payment of authorized benefits is made on my behalf to Apollo Family Medicine, LLC for any services furnished to me by that party who accepts assignment. I understand that it is mandatory to notify the health care provider of any party who may be responsible for my treatment. I authorize my provider to electronically prescribe medication directly to my pharmacy.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name of Patient or Legally Authorized Representative

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I authorize Apollo Family Medicine and its providers to obtain and view my prescription history via all prescription services. This includes other unaffiliated medical providers, insurance companies, and pharmacy benefit managers, and it may include prescriptions from several years ago. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan. By signing below, I certify that I have read and understand the scope of my consent and that I authorize this access.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name of Patient or Legally Authorized Representative

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CONTINUED

NOTICE OF PRIVACY PRACTICES:

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices (HIPAA) for Apollo Family Medicine and understand that I can request a copy of that notice from the front office.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____

Name of Patient or Legally Authorized Representative