HARSCH, OSBORNE & CARR, M.D., P.C.
SOUTHEASTERN PRIMARY CARE PROVIDERS

John A. Harsch, M.D.
Board Certified
Internal Medicine

William R. Osborne, M.D.
Board Certified
Internal Medicine

Roger G. Carr, M.D.
Board Certified
Internal Medicine

Larry Bergere, M.D.
Board Certified
Internal Medicine

Richard B. Goodjoin, M.D.
Board Certified
Internal Medicine

Joanne Talley, L.D., R.D.
Certified Diabetic Educator

Laura Dean, PA-C
Physician Assistant

Tamra Casper, ANP-C
Adult Nurse Practitioner

Pamela Stoneburner
Practice Manager

Welcome to our Practice!

We are pleased to welcome you to the SE Primary Care Providers healthcare family.

We Believe:
All people are created equal. They need to have the opportunity to maximize their lives based on their priorities and abilities.
Health fundamentally impacts people's lives and therefore:

Our Mission:
Our mission is to improve our patients' lives by providing the highest quality healthcare to our community. We believe in educating our patients in order that they will be able to care for themselves and participate in their healthcare decisions. We will use a highly motivated and trained staff combined with innovative techniques to deliver care in an efficient manner.
Our commitment is not only to our patients, but also to their families and the communities we serve.

We Believe:
All people deserve respectful, accessible, cost efficient, quality care and the opportunity to care for themselves and to participate in their healthcare decisions to maximize their quality and quantity of life.

We Strive to Improve Our Patients' Lives By Providing:
The best and most satisfying care.
Education to enable them to care for themselves and participate in their healthcare.
Respect and compassion.
The utilization of a motivated and dynamic staff to provide traditional personalized care combined with innovative techniques to most efficiently conserve resources.
A partnership with our patients…it is important to us. If you have not heard from our office in two weeks after having labs or x-rays, please contact our office for your results. We do not have a '*no news is good news*' policy. If you are unclear or confused about anything regarding your care, please contact our office so your providers nurse can answer your concerns.

SOUTHEASTERN PRIMARY CARE PROVIDERS
HARSCH & OSBORNE, M.D., P.C.
PLEASE PRINT

PATIENT NAME: _____PREFERRED NAME:_____

STREET ADDRESS: _____

STATE: _____ZIP CODE: _____HOME PHONE: _____

WORK PHONE: _____ CELL PHONE:_____

RACE: □ BLACK □ AMERICAN INDIAN/ALASKAN NATIVE □ CAUCASIAN □ PACIFIC ISLANDER □ ASIAN □ OTHER □ PREFER NOT TO ANSWER

ETHNICITY: □ HISPANIC □ NON HISPANIC □ PREFER NOT TO ANSWER

LANGUAGE OTHER THAN ENGLISH:_____

D.O.B.: _____ MALE / FEMALE SOCIAL SECURITY #: _____

MARITAL STATUS: □MARRIED □SINGLE □DIVORCED □WIDOWED □ SEPARATED □LIFE PARTNER □OTHER

EMAIL:_____

EMPLOYER'S NAME: _____EMPLOYER'S PHONE:_____

SPOUSE'S NAME:_____D.O.B.: _____

SOCIAL SECURITY #:_____ CELL#:_____

EMAIL: _____

SPOUSE'S EMPLOYER: _____ WORK NUMBER: _____

IN CASE OF AN EMERGENCY, (OTHER THAN SPOUSE), PLEASE CONTACT: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ID #: _____ GROUP #: _____

POLICY HOLDER: _____

DOB: _____SOCIAL SECURITY #:_____

PHONE #:_____RELATIONSHIIP TO PATIENT:_____

I authorize Harsch & Osborne, M.D., P.C. to release, to my insurance company, any information required in the course of my examination or treatment. I also authorize any physician, hospital or clinic to provide details of my medical history to Harsch & Osborne, M.D., P.C.

Patient's Signature **Date**

OFFICE POLICIES

Hours of Operation:

We are pleased to provide service to our patients in our Fayetteville office, Monday through Thursday 7:30am to 7:00pm, Friday 9:00am to 3:50pm, and Saturday 9:00am to 1:00pm. Walk-ins are welcome Monday through Friday and Saturday mornings. (Including Lab hours) Our Stockbridge office hours are Monday 7:30am to 7:00pm, Tues-Thurs 7:30-3:50 and Fri 9:00am-3:50pm.

Payment is required at the time of service. We accept cash, check, Visa, MasterCard, Discover Card, American Express or your check/debit card. Should you choose to write a check, all checks will be processed through Telecheck. Should you have insurance, your insurance card must be presented at check-in in order for verification of coverage. *We cannot bill co-payments.* Should your insurance company require that you choose a Primary Care Physician, one of our physicians must appear on your card. Please contact your carrier prior to your visit to verify that our provider is listed as your PCP.

As a courtesy, we will file your primary insurance. However, you are required to obtain specific benefit coverage from your insurance carrier. Filing your insurance is not a means of payment and does not preclude you from paying your co-payment, deductible or coinsurance at the time of your appointment. *We do not file secondary insurance- unless traditional Medicare is primary or secondary.* Should your insurance company deem all or part of your charges for your care non-payable, you will be responsible for those charges. You are responsible for knowing your insurance coverage. To avoid misunderstandings, our insurance specialists are available to answer questions regarding fees or payments from insurance carriers *before your visit.* If you need assistance, we will put you in touch with your carrier *before being seen.* You are responsible for the percentage of the charges that your insurance company will not cover and will be required to pay when you check-in.

You are responsible for payment of your medical care within a reasonable time, regardless of the status of your claim. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. If you prefer to file your insurance, fees are payable at the time services are rendered.

FMLA/ Disability (School/ Physical Forms):

This additional paperwork is requested by your employer, NOT our office. All of our staff's time is dedicated to direct patient care, and we spend time and effort in completing all paperwork. It takes 10-14 business days for forms to be completed with a $40- $75 charge, depending on which forms are needed. If paperwork needs to be expedited for same day completion, there is a fee of $125 payable in advance.

Medical Records:

The cost of medical records is determined by your medical history. The minimum charge is $10 and there may be additional charges based on the number of pages in your records. There is no charge for records to be requested and sent to another provider.

Prior Authorization from Insurance:

We realize that your insurance may request prior authorizations for medication/procedures/testing prescribed or ordered for you by the provider. Please be aware that there is a 48 to 72 hour turn around for prior authorization for any medication/procedure/test.

Regarding Cancellation:

In an effort to better accommodate all patients, we require 48 hours notice for cancellation of a scheduled appointment. Failure to give proper notice will result in a $30.00 fee for an office visit/ $50.00 fee for any test/procedure which must be paid before your next appointment.

I have read and understand the policy of the practice.

Authorization for Treatment:

By signing this document, I authorize Harsch and Osborne, M.D., P.C. to treat me.

Please print your name_____

Signature_____Date_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for *Southeastern Primary Care Specialist* to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Southeastern Primary Care Specialist Notice of Privacy Practices provides 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. *Southeastern Primary Care Specialist* reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy may be obtained by forwarding a copy to Harsch and Osborne, MD., P.C. Privacy Officer at *105 Carnegie Place, Suite 103, Fayetteville, Georgia 30214.*

With this consent, *Southeastern Primary Care Specialist* may call my home or other alternate location as provided by the patient and leave a message on the voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information and any calls pertaining to my clinical care. I also understand that it is my responsibility to notify the practice of changes related to my address, phone number, email address, insurance information or any other personal information required to contact or bill me.

With this consent, *Southeastern Primary Care Specialist* may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. The envelope will be marked Personal and Confidential. The practice name will also be included on the envelope. *Southeastern Primary Care Specialist* may also email to my home or alternative location as provided by the patient. I have the right to request that Harsch and Osborne, M.D.,P.C. restrict how it uses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, I understand that if I call to obtain lab results, or test results, I will be asked for my date of birth. Likewise, if I am called by Southeastern Primary Care Specialist to notify me of lab results or test results, I will be asked my date of birth before scheduling an appointment. These confirmations will serve to protect the identity of the patient.

With this consent, I also authorize the following person (s) (if any) to inquire or be notified of my PHI should I be unable to inquire for myself. They will also be required to know my date of birth

1._____ Name/ Relation

2._____ Name/ Relation

Email
I authorize Southeastern Primary Care Specialist to communicate my protected health information (PHI) my personal email address as listed below. By providing the email address, I authorize test results and lab results to be conveyed by email and confirm that email communication is a reliable means of contact.

_____
Personal email address

By signing this form, I am consenting to Southeastern Primary Care Specialist 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. I have also read the Office Policy and Mission Statement of the practice.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

Acknowledgement of Notice of Privacy Practices

I acknowledge that Southeastern Primary Care Specialist has made the Notice of Privacy Practices available to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian