GOODLIFE MEDICAL CENTER, PLLC

Olugbenga A. Adebanjo, MD
Lola T. Adebanjo, DNP-BC

EAST OFFICE
1719 Kirby Parkway
Memphis, TN 38120
Phone: (901) 685-1994
Fax: (901) 685-1997

SOUTH OFFICE
1264 Wesley Drive Suite 301
Memphis, TN 38119
Phone (901) 345-1022
Fax (901) 345-1033

Date: _____

PATIENT INFORMATION

Name:_____ _____ _____Race:_____Sex:_____
Last First MI

Mailing Address:_____ _____ _____
Street City State Zip Code

Home Address:_____ _____ _____
Street City State Zip Code

Home Phone: (___)_____Work Phone: (____)_____ Cell Phone: (___)_____

Social Security Number:_____Date of Birth:____/___/_____

Employer:_____Occupation: _____

Primary Insurance Carrier:_____

ID Number:_____Group Plan Number:_____Insured Date of Birth:___/___/____

Last Physician Seen:_____

Marital Status (please circle one): SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED ○

Spouse's Name: _____

Spouse's Employer: _____

Names and Ages of Dependent Children:

_____

_____

_____

EMERGENCY CONTACTS

(1)_____, _____
Name Relationship

(___)_____,_____,_____,_____
Phone Number Street City State Zip Code

(2)_____
Name Relationship

(___)_____,_____,_____,_____
Phone Number Street City State Zip Code

RESPONSIBLE PARTY

Name (if other than the patient): _____

Mailing Address:_____ _____ _____
Street City State Zip Code

Home Address:_____ _____ _____
Street City State Zip Code

Home Phone: (__)_____Work Phone: (___)_____Cell Phone: (___)_____

Social Security Number:_____Date of Birth:____/___/_____

Employer:_____ Occupation: _____

Primary Insurance Carrier:_____

ID Number:_____Group Plan Number:_____

I hereby request that payment of authorized insurance, Medicare or Medigap be made either to me or made on my behalf to my physician for any services furnished me by that physician, I AUTHORIZE GOODLIFE Medical Center, PLLC to act as my agent to help determine and obtain benefits from my insurance company, Medicare or Medigap insurer, I AUTHORIZE any holder of medical information about me to release it to my insurance company, Medicare or Medigap insurer along with any information needed to determine these benefits. I AGREE TO PAY all collection expenses incurred in connection with this account.

_____Date:___/___/____
Signature

_____Date:___/___/____
Witness

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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize _____
Address_____City_____State_____Zip_____to release confidential information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the person(s) or entity listed above.

HIV/AIDS: I consent to the release of my positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any causative agent of AIDS with the rest of medical records.

Initial_____Date:____/____/____

Limitations on the information you may release subject to this release form are as follows:

_____
_____
_____

_____**Date of Birth:___/___/___**
Print Name of Patient

_____
Signature of Patient or Responsible Party

-FOR OFFICE USE ONLY-

The reason for the release of information is as follows:

_____
_____
_____

The following items are pertinent for treatment:

_____
_____
_____

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I. ASSIGNMENT OF BENEFITS

I hereby assign to GoodLife Medical Center, PLLC any insurance or other third party benefits available for healthcare services provided to me. I understand that GoodLife Medical Center, PLLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to GoodLife Medical Center, PLLC, I agree to forward to GoodLife Medical Center, PLLC all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt.

_____ _____
Signature of patient/legal guardian date

II. ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY

I have received a copy of the Privacy Practices as required by HIPAA Privacy Regulations, developed October 2002.

_____ _____
Signature of patient/legal guardian date

III. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize GoodLife Medical Center, PLLC to release all medical information (including, but no limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third party payers. I authorize GoodLife Medical Center, PLLC to release all medical information to my referring physician and my primary (family) physician. I authorize GoodLife Medical Center, PLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy, I direct the insurance company or health plan administrator to release such information to GoodLife Medical Center, PLLC. I agree that these provisions will remain in effect until I provide written revocation to GoodLife Medical Center,
PLLC.

_____ _____
Signature of patient/legal guardian date

IV. CONSENT TO TREAT

I (or my legal guardian or parent), authorize GoodLife Medical Center, PLLC to provide medical care reasonable by today's standards.

_____ _____
Signature of patient/legal guardian date

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FINANCIAL POLICY STATEMENT

Thank you for choosing GoodLife Medical Center, PLLC as your healthcare provider. We are committed to providing you and your family with the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The cost of healthcare is rising and in order to keep the costs reasonable, our policy is to receive payment at the time of your visit.

INSURANCE

When we are a participating provider with your insurance plan, we will immediately file your office visit with your insurance plan. All co-payments and deductibles are due at the time services are rendered. You will be responsible for any amount your insurance plan states is due from the patient.

Regarding Insurance Plans in which we are NOT a participating provider, you are considered as a "self-pay" patient. Payment is due in full at the time of service and you will need to file your office visit with your insurance. If you have financial constraints, payment arrangements can be made prior to your actual visit.

PAYMENT METHODS/ LATE FEES/ FORMS:

The following payment methods will be accepted:
Cash, check, money order, VISA, or MasterCard. In the event my payment balance becomes more than 30 days past dues I agree that I will be assessed a $10.00 late/rebilling fee each month. *I agree that any outside forms that need to be completed by any physician will be assessed a fee of $30.00.

RETURN CHECK AND DECLINED CREDIT CARD FEES:

GoodLife Medical Center, PLLC. will charge a fee for all NSF associated with credit cards declines or returned checks. By my signature below, I understand and agree to pay an assessed fee of $30.00.

UNINSURED or "SELF PAY"

Do NOT let the lack of health care insurance deter you from seeking medical advice and treatment at our practice. An office visit Payment of $150.00 for new patients and $75.00 for subsequent visits, is due in full at the time services are rendered and any remaining costs will be billed to you accordingly. If you have financial constraints, payment arrangements can be made prior to your actual visit.

LAB TEST FEES:
Some lab tests may not be covered by the patients insurer(s) and upon verbal agreement with the patient (prior to completing the lab test), they may be billed for that lab if the insurer denies it. In such cases the fee charged shall be no more than $25.

REFERRAL FOR OUTSIDE COLLECTIONS:
Accounts which cannot be collected by GoodLife Medical Center, PLLC after normal in-house collection procedures, will be referred to a collections agency, magistrate, or attorney for further collections. By my signature below, I understand and agree that I will be responsible for all collection, court costs, or attorney fees.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients, and we charge what is customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

DISCOUNTS/CHARITY ALLOWANCES:
Accounts will not be reduced or discounted. If a patient is determined to be financially indigent, the Billing Department will assist the patient in applying for other financial assistance. If no source of financial assistance is available, the physician may review the account for a charity allowance. All charity allowance must be approved by the physician or practice administrator.

REFUNDS
Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $5.00 will not be issued unless specifically requested.

By signing this statement I understand and agree to adhere to all regulations indicated.

_____ _____
(Patient Signature) (Date)

PREFERRED PHARMACY: _____