PIEDMONT
INTERNAL
MEDICINE

November 1, 2019

Dear Medicare Patient:

At Piedmont Internal Medicine we strive to provide the best care that we can for our patients. Our Medicare patients are an important part of our practice. We have plans to indefinitely provide care to all our patients however Medicare Advantage plans provide some uncertainty with respect to benefits and eligibility. We do not and have not participated as providers in any of the plans. This recently became an issue for our Medicare Advantage HMO patients as out of network services were not covered and we were unable to provide services to those patients. Fortunately, many of our patients in those plans were able to switch to plans with out of network benefits.

Moving forward toward open enrollment we continue all our present policies, so no changes are occurring from our perspective. However, since Medicare Advantage Plans may alter their benefits, we wish for you to consider any changes to an Advantage Plan carefully as it may potentially have consequences. We will continue to be out of network for HMO Advantage plans.

While PPO Medicare Advantage plans don't require in-network providers at present to provide service there may be increased restrictions on PPO plans that limit the benefits to patients such as prior authorization for procedures and radiologic studies. Traditional Medicare plans don't have restrictions of this sort and there are no network restrictions. Because of this we will continue to be participating in traditional Medicare plans for the indefinite future.

Please keep these considerations in mind for upcoming open enrollment periods.

As always it is a pleasure to continue to be a part of your healthcare at Piedmont Internal Medicine!

Sincerely,

The Physicians of Piedmont Internal Medicine, PC

3280 Howell Mill Road NW ● Suite 150 ● Atlanta, GA ● 30327
Telephone 404.351.7467
www.PiedmontInternalMed.Com

PIEDMONT INTERNAL MEDICINE

Medicare and Medicare Advantage Physical Exams

Dear Patient,

Wellness and proactive health management is our collective goal and patient care philosophy. Your health and wellbeing are very important to us. You may not be aware that Medicare does not cover all the costs associated with a complete physical exam. Medicare only covers what they call an "Initial Preventative Physical Exam (IPPE)" and an "Annual Wellness Visit (AWV)."

An Initial Preventative Physical Exam (IPPE) is only covered **once** during the first year of your enrollment of Medicare B benefits. An IPPE includes an EKG, a depression check, height and weight check, and obtaining a medical history.

An "Annual Wellness Visit" (AWV) only includes a weight and height check, a blood pressure check, and a depression screening. Please note neither the IPPE nor an AWV is a complete physical, nor do they include clinical laboratory tests or services.

To efficiently examine our patients and screen for potential problems, our physicians at Piedmont Internal Medicine encourage all of our patients to schedule an annual physical to ensure all appropriate screening tests are performed.

A full physical includes **ALL** services for both an AWV and IPPE, in-depth physical examination, review of medical history, review of medications, and maintenance medication refills. In addition to your exam, your physician will order relevant laboratory tests.

Traditional Medicare - Please note Medicare **DOES NOT** pay for a complete physical, nor laboratory testes associated with a "Well Visit."

- **The fee for a complete physical is $375.00 and is NOT covered or reimbursed by Medicare.** The fee will be collected on the day of your physical upon check-in. In addition, you may also receive a bill from the company that performs our laboratory services.

Medicare Advantage Plans – Effective January 1, 2019, Piedmont Internal Medicine is no longer a participating provider with any of these plans (thus not in-network).

- **Effective immediately, we will continue to see those patients for an upfront fee of $325.00 on the day of your physical upon check-in** due to recent changes within our practice.

Thank you for understanding, and if there are any additional questions, please do not hesitate to ask. We are here to ensure our patients have a complete understanding of the services provided and the fees charged.

Thank you,
Piedmont Internal Medicine Physicians

Patient Acknowledgement

I have read and understood the statement above.

Patient Name:_____ Date: _____

PIEDMONT INTERNAL MEDICINE

PATIENT INFORMATION

Patient Name:_____ **Today's Date:** _____

Social Security Number: (Last 4 Digits)_____ **Birth Date:**_____ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address _____

Phone Numbers: Primary_____ **Work** _____ **Email** _____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race/Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic/Latino ☐ Other _____

Emergency Contact Name:_____ **Phone Number:** _____
Relationship to Patient: _____

Whom may we thank for referring you? _____

EMPLOYMENT INFORMATION

Employer: _____ **Position:** _____

Employer's Address: _____

PREFERRED PHARMACY

Pharmacy Name:_____ **Phone:** _____

Pharmacy Address: _____

INSURANCE INFORMATION

Responsible Party: If patient check here: ☐

Name:_____ **Date of Birth:**_____ **Relationship:**_____

Phone Number:_____ **Address** _____

Primary Insurance Co:_____ **Group Number** _____

Subscriber's Name: _____ **ID Number:**_____

Relationship to Patient: _____ **Date of Birth**_____ **Ins. Phone Number** _____

Secondary Insurance Co:_____ **Group Number:**_____

Subscriber's Name: _____ **ID Number:**_____

Relationship to Patient: _____ **Date of Birth:**_____ **Ins. Phone Number:** _____

(PLEASE BRING YOUR INSURANCE CARD AND PHOTO ID TO ALL APPOINTMENTS)

PIEDMONT INTERNAL MEDICINE

Medical History Questionnaire

Name:_____ **Date of Birth**: _____

List main reason for today's visit: _____

_____

List any other active problems (include treating physician if applicable): _____

_____

_____

Allergies and reaction: _____

Medications and dosages (please include supplements): _____

_____

_____

Do you feel you have problems with sleep, snoring or day time sleepiness? ☐ Yes ☐ No
Would you like to speak with us about this? ☐ Yes ☐ No

Past medical illnesses (Please place a check by all which applies):

☐ Alcohol/Drug Abuse	☐ Cancer	☐ Heart murmur	☐ STD(type)
☐ Anemia	☐ Crohn's disease	☐ Hepatitis B/C	☐ Sickle cell disease
☐ Aneurysm	☐ COPD/Emphysema	☐ High cholesterol	☐ Sleep apnea
☐ Anxiety disorder	☐ Depression	☐ HIV	☐ Stomach ulcer
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Kidney disease	☐ Thyroid disease
☐ Blood disorder	☐ Gout	☐ Kidney stones	☐ Tuberculosis
☐ Blood clot	☐ Hay fever	☐ Liver disease	☐ Positive TB skin test
☐ Blood transfusion	☐ Heart disease	☐ Seizure	☐ Ulcerative colitis

☐ Other: (please specify) _____

Past Operations/Procedures and/or Hospitalizations (please include date): _____

_____

_____

Family history (please indicate major medical problems; If deceased, please indicate cause of death):

Maternal Grandmother_____

Maternal Grandfather_____
Paternal Grandmother_____
Paternal Grandfather_____
Mother_____

Father_____
Siblings_____
Children_____

Social History

Occupation:_____ Marital Status:_____ Children: _____
Alcohol Use: Yes☐ No☐ How often:_____ Quantity:_____
Tobacco Use: Yes☐ No☐ Pack per day:_____ How many Years: _____
Former Smoker: Yes☐ No☐ Pack per day:_____ Year quit: _____
Other Tobacco/Nicotine: Yes☐ No☐ Type:_____ Quantity:_____
Other Drugs: Yes☐ No☐ If yes, please specify: _____
Exposure to asbestos or other hazardous material: Yes☐ No☐ If yes, please specify: _____
Do you have a living will? Yes☐ No☐
Healthcare proxy: Yes☐ No☐ If yes, please indicate Name:_____ Relationship: _____

Health Maintenance

Last known Menstrual cycle:_____ Last known Pap Smear: _____
Last known Mammogram:_____ Last known Colonoscopy: _____
Last known Prostate Cancer Screening:_____ Last Bone Density scan: _____

Immunizations:

Pneumonia:_____ Flu:_____ Tetanus/TD/Tdap:_____
Hepatitis A:_____ Hepatitis B: _____

Review of Systems: (Please place a check by all which applies):

☐	Weight Gain	☐	Weakness	☐	Insomnia	☐	Blood in vomit
☐	Persistent Cough	☐	Fainting	☐	Mood Swings	☐	Bowel Changes
☐	Blood in Stool	☐	Frequent urination	☐	Difficulty swallowing	☐	Runny nose
☐	Headache	☐	Tremor	☐	Nausea	☐	Feeling cold
☐	Weight loss	☐	Fatigue	☐	Change in vision	☐	Back pain
☐	Fever	☐	Change in exercise Tolerance	☐	Vaginal discharge/bleeding	☐	
☐	Chest Comfort	☐	Penis Discharge	☐	Anxiety	☐	Blood in sputum
☐	Difficult urinating	☐	Breast pain	☐	Change in hearing	☐	Nipple discharge
☐	Memory Loss	☐	Leg swelling	☐	Depression	☐	Short of breath
	Night Sweats	☐	Pain with intercourse		Heartburn	☐	Diarrhea
☐	Breast Lump	☐	Trouble breathing	☐	Skin rash	☐	Nose bleed
☐	Leg pain	☐	Palpitations	☐	Feeling hot	☐	Constipation
☐	Dizziness	☐	Numbness/Tingling				

Patient Signature:_____ Date: _____

Reason Patient is Unable to Sign:_____ Date:_____

PIEDMONT INTERNAL MEDICINE

MEDICARE HEALTH RISK & SCREENING TOOL

In order for Medicare to pay for a wellness visit, the patient MUST complete a Health Risk Assessment Form. Please complete the form. If you need our assistance, please ask and our staff will be happy to help you.

Patient Name:_____ **Birth Date:** _____

EXERCISE: Type: _____

How Often?_____ How long each time? _____

DIET: On average per day, how many servings of the following do you eat?

Fruits:_____ Dairy:_____ Vegetables:_____ Fiber: _____

In an average week, how many servings of the following do you eat?

Red Meat (beef/pork) _____servings per week
Chicken _____servings per week
Fish _____servings per week
Fried Foods _____servings per week
Fast Food _____servings per week
Restaurant _____servings per week

Do you take supplements?

Calcium ☐ Yes ☐ No _____ How many units/milligrams
Vitamin D ☐ Yes ☐ No _____ How many units/milligrams
Multi-Vitamin ☐ Yes ☐ No
Other (Please list) _____

ALCOHOL: How many drinks per day?_____ OR per week? _____

Have you drunk more heavily in the past? ☐ Yes ☐ No

TOBACCO: Do you currently smoke? ☐ Yes ☐ No If yes, how much? _____

Have you smoked in the past? ☐ Yes ☐ No If yes, when did you quit? _____

Have you ever chewed tobacco or used snuff? ☐ Yes ☐ No If yes, when? _____ how much? _____

AUTOMOBILE: Do you drive? ☐ Yes ☐ No

Do you wear a seat belt? ☐ Yes ☐ No

Do you drive after drinking or ride with a driver who has been drinking? ☐ Yes ☐ No

SUN: Do you wear sunscreen? ☐ Always ☐ Sometimes ☐ Never

SELF CARE:

Do you have problems with your vision? ☐ Yes ☐ No

Last eye doctor appointment _____ How often? _____

Last dental appointment _____

Do you have problems doing things with your hands such as buttoning, cooking, cleaning? ☐ Yes ☐ No

Are you having problems with your memory? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Have you named a Medical Power of Attorney? ☐ Yes ☐ No

Have you discussed your wished for what happens to you if you can't communicate? (I.e. had a stroke or been in an accident?) ☐ Yes ☐ No

SOCIAL: Do you feel safe where you live? ☐ Yes ☐ No

Do you feel you can count on family or friends to help you? ☐ Yes ☐ No

Sleep:

Do you feel you have problems with sleep, snoring or day time sleepiness? ☐ yes ☐ no

Would you like to speak with us about this? ☐ yes ☐ no

LIST OTHER PROVIDERS RENDERING YOU CARE:

_____

_____

COGNITIVE SCREEN: Draw a clock face, including all the numbers. Place the hands on the clock to read 4:10.

PATIENT TO LEAVE THE BELOW BLANK. TO BE COMPLETED BY THE PROVIDER. RECALL 3 UNRELATED ITEMS

1. _____
2. _____
3. _____

PROVIDER SIGNATURE: _____ DATE: _____

PIEDMONT INTERNAL MEDICINE

PATIENT FINANCIAL AGREEMENT

Welcome to Piedmont Internal Medicine. We are dedicated to making sure that our patients are provided with exceptional medical care. **We strongly encourage each patient to contact their insurance company to confirm their doctor is a participating provider in their plan.**

As a service to our patients, we are currently enrolled in numerous Managed Care plans. However, it is impossible for the practice to know all the requirements of each individual plan. **It is the patient's responsibility to be aware of the parameters of your individual plan and to notify the office of any changes or restrictions.** Any charges which are accrued because of failure of notification will be the responsibility of the patient. If insurance cannot be verified prior to each appointment, payment will be due at the time of service.

Patients who have a HMO policy must ensure their physician is listed on their insurance card. If not, the insurance provider will not cover the services provided. Any unpaid charges will be the patient's responsibility.

At Piedmont Internal Medicine, PC we provide diagnostic procedures, examinations and medical treatment including laboratory work. As a courtesy, we file charges directly to your insurance. At times, it is required that we send medical records to assist with payment of these charges.

Please be aware some of the services billed to your insurance may result in charges to you depending on your individual insurance plan coverage. Please take the time to acquaint yourself with your insurance policy.

Please note Piedmont Internal Medicine, PC follows all Federal laws. We are not able to rebill due to services not being covered by your insurance policy. If you receive a bill from an outside facility such as LabCorp, Quest, or Piedmont Hospital, you will need to contact them directly.

Self-pay patients are required to pay at the time services are rendered. An initial deposit of 150.00 will be required at Check In. Upon check out charges will be reconciled. As a courtesy, Piedmont Internal Medicine, PC offers a self-pay rate on same date services provided, including most laboratory services, only if charges are paid the day of services.

We contact every patient to remind them of their appointment. We ask all patients to give at least 24 business hour advanced notice in canceling or rescheduling an appointment. Failure to do so will result in a fee of $75.00 for an Office Visit, $150.00 for a Physical Exam/Annual Wellness Visit and $150.00 for an Echocardiogram. This will be your responsibility to pay.

Any **returned check** will incur a $35.00 charge to cover bank charges associated with the returned check in addition to the amount of the check. NSF checks must be redeemed with certified funds and check will no longer be accepted as payment.

An upfront fee of $35.00 will be collected for administrative tasks such as completing disability forms, FMLA, biometric screening form, medication prior authorizations and some medical records request. These tasks may require up to ten days to complete.

If any bills are acquired, it must be paid within 30 days of receipt. If you are unable to pay your balance, please contact the billing office to make payment arrangements. Any balance left unpaid nor under arrangements may be sent to a collection agency. If your account is sent to collections, there will be a $30.00 collection fee added to the total outstanding balances.

I acknowledge I have read and understand the policies above. I accept the rights and responsibilities outlined within them.

Patient/Guardian Signature:_____ Date: _____

PIEDMONT INTERNAL MEDICINE

CONSENT AND RELEASES

Consent for Treatment

I,_____, hereby voluntarily consent to outpatient care at Piedmont Internal Medicine, PC encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine, and other studies), and administration of medications prescribe by the physician. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physicians and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the physician's judgment.

Notice of Patient Privacy Consent (HIPAA)

☐ I have been provided with a copy (electronic and/or printed copy) of the practice's Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. (The Notice of Patient Privacy Consent is posted on our website at www.PiedmontInternalMed.com for your convenience.)

Authorized Release of Medical Information

There are times where the physicians and employees of Piedmont Internal Medicine need to contact you. Our primary method is through our "My Chart" patient portal, however, circumstances may require us to contact you via mail, email, telephone, voice mail, and/or text messaging. Please check the additional approved methods of how we may contact you regarding your personal and private health information. Please note, you may change or revoke your authorization approvals at any time. ***Check all that apply:***

☐ Home Answering Machine ☐ Text Message ☐ Work Voice Mail ☐ Mailing Address
☐ Cell Phone Voice Mail ☐ Personal Email ☐ Work Email

I authorize the release of medical information to the following:_____

_____

Name and Relationship *Name and Relationship*

Lifetime Medicare Authorization & Consent for Medicare Patients Only

☐ I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance, we will bill your secondary insurance after Medicare pays the requested amount. I understand that I am responsible for my health insurance deductible and coinsurance.

Medigap Authorization Statement

☐ I authorize any holder or other information about me to release Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Consent for Use, Disclosure of Patient Information for the purposes of Treatment, Payment, and Healthcare Operations

☐ I hereby consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to Piedmont Internal Medicine, PC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information for another provider or health care entity to conduct health care operations

Health Information Exchange

☐ Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Practice for treatment, the physicians and/or their staff may get a copy of my medication history and other health care information electronically through various health information exchange connections with other health care providers. **I understand I may request that my health care information not be shared through electronic health information exchange by following the directions in the Practice's Notice of Patient Privacy Practices.**

Terminating Services

☐ All the providers at Piedmont Internal Medicine value a meaningful and productive relationship with our patients. Unfortunately, there are occasions when this is no longer feasible. Please be advised that the Practice reserves the right to terminate the provider/patient relationship for the following reasons:

1. Multiple cancellations or missed appointments.
2. Medical Non-Compliance, including violation of Therapeutic Drug Agreement.
3. Failure to comply with practice policies, including yearly physical exams.
4. Rude, abusive behavior, use of obscene language, mistreatment of staff in person or on the phone.
5. Failure to pay a debt/account sent to collections

If the relationship is terminated, you will be notified in writing. Your provider will provide emergency medical care for 30 days following the date of the written notice and will send medical records to a new provider with a written release.

COVID-19

☐ I understand that the 2019 novel coronavirus, which causes the disease COVID-19, has been declared a pandemic by the World Health Organization, is extremely contagious and is believed to be spread by person-to-person contact. I recognize the staff of Piedmont Internal Medicine has put in place reasonable preventative measures aimed at reducing the spread of COVID-19. However, I acknowledge and accept the risk of becoming infected by virtue of seeking services in-person at Piedmont Internal Medicine.

Patient Signature: _____Date: _____

PIEDMONT INTERNAL MEDICINE

MEDICARE AUTHORIZATION STATEMENT

I,_____, authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

_____ _____

Patient Signature **Date**

Only complete the Medigap Authorization Statement if you have secondary insurance to Medicare that pays for deductibles and co-insurance after Medicare has paid their portion.

MEDIGAP AUTHORIZATION STATEMENT

I,_____, authorize any holder of medical or other information about me to release to Piedmont Internal Medicine, P.C. any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ _____

Patient Signature **Date**

Policy Number: _____

PIEDMONT INTERNAL MEDICINE

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Date: _____

Patient Name: _____ **Birth Date:** _____

Medicare requires that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items provided. Therefore, Piedmont Internal Medicine is requesting that the information below be completed so that a determination can be made if Medicare is the primary insurance, please answer all the questions.

	Please check all that apply:	Yes	No
1.	Is the illness/injury due to an automobile accident, liability accident, or Workman's Compensation?	☐	☐
2.	Is illness covered by the Black Lung Program or Veterans Administration program?	☐	☐
3.	Are the services to be paid by a government research/ grant program?	☐	☐
4.	Is the patient covered by an employer group health plan (EGHP), including Federal Employees?	☐	☐
5.	Is this patient or his/her spouse actively employed by an employer of 20 or more employees?	☐	☐
6a.	If under age 65, is your Medicare coverage due to disability? *If "yes" go to #6b, if "no", go to #7.*	☐	☐
6b.	Is the patient or his/her spouse or parent actively employed by, or is the patient considered an employee of an employer having 100 or more employees? *If "yes", please complete information below.*	☐	☐
7a.	Is the patient entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD)? *If "yes", go to #7b*	☐	☐
7b.	Has the patient completed the ESRD coordination period? *If "no", enter information below.*	☐	☐

If you answered "Yes" to any of the above questions, please complete the following:

Name of Insurance Company: _____

Street Address of Insurance Company: _____

City, State, Zip Code: _____ Telephone: _____

Name of Policy Holder: _____

Street Address of Insurance Company: _____

City, State, Zip Code: _____ Telephone: _____

Relationship to Patient: _____ Date of Birth of Policy Holder: _____

Insurance I.D. Number: _____ Group Number: _____

If Accident/Injury, Date of Accident/Injury: _____ Do you have an attorney? ☐ Yes ☐ No

Attorney Name and Contact: _____

Name of Research/Grant Study: _____

Patient Signature: _____

PIEDMONT INTERNAL MEDICINE

Piedmont Internal Medicine

Medication Prior Authorization Request

Patient Name: ______________________________ **MRN/SSN:** __________________________

Date of Birth: ____________________ **Phone # (best reached):** _________________________

I, _________________________________ request Piedmont Internal Medicine, PC to obtain a prior authorization from my insurance for a prescription medication

Authorization Needed for:

Name of Prescription Medication (s): (please specify: name, quantity and dosage)

____

Insurance to Be Contacted:

Name of Insurance Company: ____

Member Identification Number**: ____**

PLEASE NOTE: Medication prior authorization initiation and completion time will be approximately 5-7 days depending on your insurance company.

Authorization:

By signing this form, I am acknowledging I will be charged an administration fee for completing the requested medication prior authorization. This fee will not be covered by my insurance and I will need to complete payment prior to the prior authorization being initiated. Additionally, I am aware the insurance may approve or deny this medication based on my insurance plan's guidelines. This associated fee does not include second level appeals or future reauthorizations.

Number of Authorizations	Fee Associated
1-2	$35.00
3	$40.00
4+	$50.00

Signature: ____Date:__________________________________

(Patient/Legally Authorized Representative)

- -

Information below this in line is to be shredded after processing

Name on Card: ___________________________________ Credit Card Number: _____________________________

Expiration Date: _________________________________ CVS Number: ____________________________________

Charge Amount: ____