

T. DOUGLAS GURLEY MD, LLC



Personal/Contact Information

Patient Name: _____ Male Female Date of Birth: ____ / ____ / ____
SS#: _____ Marital Status: Single Partnered Married Widowed Divorced
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell #: _____ OK to leave messages? Yes No
Email Address: _____ OK to send email? Yes No
Emergency Contact: _____
Relationship: _____ Phone #: _____

Employment Information

Employment Status: Employed Retired Disabled Student
Employer: _____ Work #: _____ Ext: _____

Payment Information

Relationship to Insured: _____ Form of payment: _____
Primary Insurance: _____ Policy/ Group #: _____
Policyholder's Name: _____ Policyholder's DOB: ____ / ____ / ____
Member ID #: _____ Customer Service Phone #: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Secondary Insurance: _____ Policy/ Group #: _____
Policyholder's Name: _____ Policyholder's DOB: ____ / ____ / ____
Customer Service Phone #: _____ Member ID #: _____
Member ID #: _____ Customer Service Phone #: _____
Billing Address: _____
City: _____ State: _____ Zip: _____

Referral Information

How did you hear about us? Established Patient Phone Book Website/Search Engine Print Ad
 Insurance Network List: _____ Referred by Patient: _____ Other _____
 Referred by Physician: _____ Referring Physician Name & Phone: _____

Important Information About Using This Form

We have digitized our new patient form and placed it on the website for the convenience of our clients. You can use your computer to type in the requested information using the free software package Adobe Acrobat Reader®. Please remember the following tips:

1. Adobe Acrobat will not allow you to save information you type into this form. Please print the form when complete.
2. After completing the form, you must print the form from your computer and bring it with you to your appointment
3. When the form requests a signature, you must sign the printout, you cannot type in your name.
4. You can always, of course, print out the form and fill in the blanks with pen. Just remember to bring it with you to your appointment.

T. DOUGLAS GURLEY MD, LLC



Receipt of Notice of Privacy Practices

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by mail or in person at our office.

By signing below, you acknowledge that you have read and/or received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name: _____

Patient DOB: ____ / ____ / ____

Patient/ Responsible
Party Signature: _____

Date: ____ / ____ / ____

Insurance Assignment

I authorize payment of insurance benefits to be made directly to T. Douglas Gurley MD, LLC for medical services or supplies rendered to me by their practice. I authorize T. Douglas Gurley MD, LLC to release any information needed to process my medical claims

I understand my insurance company may not pay the entire amount of my bill and I am responsible for the balance that the insurance company does not pay.

Patient/ Responsible
Party Signature: _____

Date: ____ / ____ / ____

Missed Appointment Policy

If you are unable to keep an appointment, please let us know no less than 24 hours in advance. Please be advised that your account will be charged a \$50 missed appointment fee for office, massage therapy, or aesthetician visits and a \$150 missed appointment fee for physical examinations if 24 hour cancellation is not given.

Patient/ Responsible
Party Signature: _____

Date: ____ / ____ / ____

Out of Network Benefit Acknowledgement

(Only applicable if your insurance plan is out of network.)

T. Douglas Gurley MD, LLC may not be a participating physician with your insurance plan, and if not, benefits may be reduced as such. We can help you determine if T. Douglas Gurley MD, LLC is a network provider with your insurance plan and the ins and outs of network benefits of your plan. Should you choose T. Douglas Gurley MD, LLC as your provider and your insurance plan is out of network, you may have a higher deductible and co-insurance dependant upon your specific out of network benefits.

I acknowledge that T. Douglas Gurley MD, LLC is not in network with my insurance plan and I am responsible for any costs in accordance with my individual insurance policy.

Patient/Responsible
Party Signature: _____ Date: ____ / ____ / ____

Disclosure of Private Medical Information

I authorize T. Douglas Gurley MD, LLC to disclose medical information pertaining to my personal health to the following persons:

Name	Relationship	Comments
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above will stay in effect until voided by you.

Print Patient Name: _____ Date of Birth: ____ / ____ / ____

Patient/Responsible
Party Signature: _____ Date: ____ / ____ / ____

Directions From Midtown (14th and Piedmont)

- Head west on 14th St NE toward Juniper Street 0.2 mi
- Turn left at Juniper St, travel 1.1 mi
- Turn left at North Ave, travel 0.7 mi
- Turn right at Boulevard, NE, travel 0.7 mi
- Turn left at Highland Ave, travel 0.2 mi
- Turn right at Randolph St., NE 0.3 mi
- Turn left at Gaspero Street

Directions From Northwest Atlanta

- Merge onto I-75 S, travel 1 mi
- Take exit 248C for Freedom Parkway, travel 0.8 mi
- Turn right at Boulevard, NE, travel 0.2 mi
- Turn left at Irwin St, NE travel 0.2 mi
- Turn right at Randolph St, NE travel 358 ft
- Turn left at Gaspero St., NE travel 335 ft

T. DOUGLAS GURLEY MD, LLC



Authorization for Release of Medical Information

I, _____, authorize the release of all my medical information (including but not limited to information on psychiatric conditions, alcohol and drug abuse, and HIV or communicable diseases).

From: _____

To:
T. Douglas Gurley MD, LLC
659 Auburn Avenue, NE, Suite 156
Atlanta, GA 30312
Phone (404) 888-0228 Fax (404) 888-0552

Phone _____

I agree that these provisions will remain in effect until I provide written revocation to T. Douglas Gurley MD, LLC.

Print Patient Name: _____ Date of Birth: ____ / ____ / ____

Patient/Responsible

Party Signature _____ Date: ____ / ____ / ____