Caedel Medical Group

&

Caedel Wellness Center

Welcome Package

Telephone number

(770) 907-4949

Revised 09/08/2021

Important office information

Our Office will be available to handle calls at 8:00 am daily

Our last appointment of the day is scheduled 30 minutes prior to close.

Hours of operations

Caedel Medical Group
1324 Hwy 138 S.W.
Riverdale, Ga 30296
T: (770) 907-4949
F: (678) 961-2235

Monday	8:00am - 6:00 pm
Tuesday	8:00am – 6:00 pm
Wednesday	8:00am – 6:00 pm
Thursday	8:00am – 6:00 pm
Friday	8:00am – 5:00 pm
Saturday	8:00am - 2:00pm

Caedel Medical Group
559 Flat Shoals Ave SE
Atlanta, GA 30316

Monday	10:00am – 7:00pm
Tuesday	10:00am – 7:00pm
Wednesday	10:00am – 7:00pm
Thursday	10:00am – 7:00pm
Friday	10:00am – 7:00pm
Saturday	9:00am – 5:00pm

Co-payments

Due on the day of your appointment (no exception will be made)

Deductible & Co- Insurance

Due on the day of your appointments (no exceptions will be made)

Account Balances

Payments must be made for all accounts with outstanding balance on a monthly basis to avoid collections or denial of service.

Medicare Deductible

The 2019 Deductible for Medicare is $183.00 Our office will collect $85.00 per visit until your deductible is met.

Appointments

Appointment time

To maintain timely schedules our office will not see you if you arrive more than 10 minutes late for an appointment. We will only be able to move you to the next available appointment.

Missed appointment

A $25.00 charge will be billed for all appointments that are not rescheduled or cancelled 24 hours prior to the appointment time. A $50.00 charge for all procedures and wellness appointments.

Routine Services

Physicals and Pap smears are not performed on same session or in conjunction with a new patient visit.

Provider schedule change

If the provider you are scheduled with is out, our office will not call to reschedule your appointment if another provider is available to evaluate you.

Insurance cards and Identification

Must be available for every visit.

Update forms

Patients are required to complete the update form twice a year and the medical history once a year.

Forms and paperwork completion

All forms except FMLA will require a fee of $30.00 to be paid prior to completion. FMLA forms will require a $50.00 payment prior to completion. All forms will not be processed until payment is received. Please allow 7-10 business days for completion.

Medical Records Request

Cost to patient is $25.00 . All patients requesting medical records must complete a release of records form. Please allow 7-10 business days for our office to complete your request. Payment for records are required when the request is submitted.

Prescription refills

Please allow 48 to 72 hours for all prescription refills. No refills will be called in during non-business hours.

If the patient has not been seen in the last six months, a prescription refill will not be available until the patient is evaluated by a provider.

Nurse line

Please allow 24 to 48 hours for all nurse calls to be returned. If you need immediate assistance please speak with front office.

Laboratory Bills

Please contact the lab company prior to contacting our office. We are unable to see the explanation of benefits from your insurance.

New Patient Registration form:

Section I: **Patient Information** **Date_____**

Name:_____ I Prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Spouse or Parent's Name:_____ Employer_____ Work Phone_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____
Email Address_____
Spoken Language: _____ Race: _____

Section II **Responsible Party**
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

Section III **Insurance Information**

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF TREATMENT

I hereby authorize medical treatment by the medical providers of Caedel Medical Group, PC and I authorize the provider of medical services to release information for these services to my insurance carrier for payment. I understand that I am financially responsible for all charges not covered by my insurance company.

_____ _____

Patient Signature Date

Caedel Medical Group

Patient Medical History - Please complete this two-sided form prior to your appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦			
Condition / Disease	***Year Began***	***Condition / Disease***	***Year Began***
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦			
Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

♦ Other Physicians and Specialists ♦
List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦			
List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦		
Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Grandmother				
Grandfather				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Patient Financial Policy

Thank you for selecting our practice as your healthcare provider. We are committed to providing you with compassionate and quality medical care. Please understand that payment is expected for services rendered. The following is a statement of our financial policy. Please read, sign and date this policy prior to treatment. Please provider receptionist any current medical insurance cards that should be used to cover services rendered. For your convenience, our practice accepts Visa, MasterCard, Discover, American Express, Cash, and Personal Checks.

Insurance

We accept assignment of benefits for most insurance plans. However, we do require that all co-payments, co-insurance and deductibles be paid at the time of service.

Your insurance policy is a contract between you and your insurance carrier. You are responsible for providing our practice with the correct insurance information at the time of service or you may be responsible for the charges in full. Should your insurance company fail to pay the insurance claim for services rendered by Caedel Medical Group, you may be responsible for the entire charge submitted to the insurance carrier. Therefore, we recommend that you follow-up with the insurance carrier if your claim has not been paid within 30 days from the date the claim was submitted.

You are also responsible for determining what services your insurance company covers. Therefore, if your insurance coverage is verified and certain procedures are not covered, you will be required to sign a waiver indicating that you understand that you policy does not cover this service and you will be responsible for the charges associated with this service.

Co-insurance and any balances that remain the responsibility of the patient, according to the insurance terms, should be remitted to the practice upon notice of balance due. **Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any account turned over to an outside collections agency will incur a 30% collection agency fee and these fees will become the responsibility of the patient.**

Non-Insured Patients

Patients that are not covered by an insurance plan are responsible for services rendered at the time of service. For patients unable to pay for services in full, a minimum of 50% of the charges are due at the time of services. Payment for any remaining balance is payable within 30 days of the date of services. **Failure to remit payment may result in your patient account being turned over to an outside collection agency. Any account turned over to an outside collections agency will incur a 30% collection agency fee and these fees will become the responsibility of the patient.**

Missed Appointments

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment, please kindly give us a 24 hour notice. Failing to provider notice of cancellation for two or more consecutive visits, will result in a $25.00 missed appointment charge. This charge is the responsibility of the patient and it is not covered by most insurance carriers.

Forms

Disability, Life Insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the physicians and completion of detailed medical history questionnaires. Please allow 7-15 days for completion of any requested forms. The charge for this service is $25.00 cash. This charge is payable upon submission of the forms, therefore forms will not be competed unless pre-payment is made.

Outstanding balances

All outstanding balances that are not paid

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and agree to abide by the financial policy of Caedel Medical Group.

X _____ _____

Patient Signature Date

Authorization to Release Private Healthcare Information

Patient Name: _____ Date of Birth _____ Date: _____
I hereby allow Caedel Medical Group to release any and all of my medical history to

_____ . My relationship with this individual is_____.

_____
Patient Signature

I hereby allow Caedel Medical Group to release any and all of my medical history to

_____ . My relationship with this individual is _____.

_____
Patient Signature

I hereby allow Caedel Medical Group to release any and all of my medical history to

_____ . My relationship with this individual is _____.

_____
Patient Signature
Patient Signature

Agreement will remain in effect until written request is submitted to make a change in current signed authorization.

CAEDEL MEDICAL GROUP, PC

● Claire K. Willie MD ● James Oliviere MD ● Itauma Udosen DO ● Lula Mitchell PA-C ● Retta Bright FNP-C

Riverdale Office: 1324 Hwy 138 S.W. Riverdale, GA 30296 T: (770) 907-4949 F: (678) 961-2235
Fayetteville Office: 101 Devant St. Suite 803 Fayetteville, GA 30296 T: (678) 216-0342 F: (678) 216-0348

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This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule - Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints - You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at: **770-907-4949**
We will not retaliate against you for filing a complaint.
Effective Date **10/31/2013** Publication Date: **11/01/2013**

RECEIPT OF OUR 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 our front receptionist.

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

Patient Name _____

Patient/Responsible Party Signature _____

Date _____

CAEDEL MEDICAL GROUP, PC

Consent to Obtain External Prescription History

I, _____, whose signature appears below,
authorize The Caedel Medical Group, P.C. and Its Affiliated Providers to view
my external prescription history via the surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____
Patient Date

_____ _____
Witness Date

ASSIGNMENT OF BENEFITS/AUTHORIZATION OF TREATMENT

I hereby authorize medical treatment by the medical providers of Caedel Medical Group, PC and I authorize the provider of medical services to release information for these services to my insurance carrier for payment. I understand that I am financially responsible for all charges not covered by my insurance company.

_____ _____
Patient Name Date

_____