



GARY DAWSON, M.D.
2300 13 St, Suite A • Columbus, Georgia 31906
TELEPHONE: 706/243-7010
FAX: 706/243-7019

Dear Patient:

An appointment has been scheduled for you to see Dr. Gary Dawson.

On _____ at _____

Please complete the enclosed documents and bring them with you to the office on your scheduled appointment date. Please check with your insurance company prior to your visit for your co-pays and deductibles. **You will be expected to pay your co-pays and deductibles for each visit at check-in.** Items that we will need in order for you to be seen by the physician:

1. **Insurance card(s)**
2. **Photo ID (ie., drivers license, anything that has your photo on it)**
3. **Referrals from your primary care provider (if needed)**
4. **Medications and/ or a list of medications you are currently taking**
5. **All x-ray film and reports pertinent to your current condition**

Also, please note, that patients arriving 15 minutes late for a scheduled appointment will be rescheduled to the next available day and time.

We look forward to meeting you in the near future. If you have any additional questions, please do not hesitate to contact our office @ 706/243-7010.

Sincerely,

River City Rehabilitation
& Spine Specialists, P.C.

RIVER CITY REHABILITATION & SPINE SPECIALISTS, P.C.

PATIENT INFORMATION (INFORMATION YOU NEED TO KNOW)

Prescription Refill Call-ins: Our policy on prescription refills is as follows: A request should be made to our office 24-48 hours prior to your prescription running out. When making a refill request the following information will be needed: your full name; date of birth and a current telephone number where you can be reached. All prescriptions will be called to the pharmacy we have on file and should be called in at the end of each business day. We encourage you to contact your pharmacy after 4:00 p.m. when a request has been made to our office. If for some reason your request will not be honored you will be notified by our office.

Appointments: Our policy on appointments is as follows: If you miss an appointment you will be sent a letter. The letter will warn you that after 3 missed appointments, you will be charged \$25.00. The \$25.00 charge cannot be billed to your insurance company; therefore you will be responsible for the bill. This will encourage you to call and cancel so we can fill the needs of other patients who may actually need to see the doctor. Thanks for your cooperation on this matter.

Triage Area: We would like to inform you that the triage area is a multipurpose area. The Medical Assistant, nurse or doctor may ask you personal questions, while another person/patient could be in the area with you. If you prefer to be triaged alone with a Medical Assistant or nurse only, you need to let us know ahead of time. We want to make every effort to make your visit here as pleasant and comfortable as possible.

Returned Checks: Our policy on returned checks will also be modified as follows: Once you have a returned check with our office, we will no longer accept checks from you. You will have to clear up any balance in our office with cash, money order, or credit card. Keep in mind we only take Visa and Mastercard.

PATIENT SIGNATURE

DATE

(THE ABOVE INFORMATION IS FOUND IN THE NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS AND RESPONSIBILITIES GIVEN TO EACH NEW PATIENT BY MAIL OR AT THE TIME OF CHECK IN)

Patients' Rights and Responsibilities

At River City Rehabilitation and Spine Specialists, we are committed to serving you with compassion, care, skill, and respect. Our policy is to respect the individuality and dignity of all patients, and to honor, in accordance with law, an adult patient's right to make decisions regarding treatment. This includes an adult patient's right to consent to, refuse, or alter treatment plans and the right to formulate advance directives, which will govern if you become incapacitated.

You have the right:

- To receive fair and humane treatment and you will not be denied access to treatment or accommodations that are medically indicated on the basis of race, sex, age, creed, national origin, or source of payment for care;
- To privacy regarding information necessary for medical care and regarding the privacy of your body and the right to expect all communications and records pertaining to your care to be treated as confidential;
- To talk with the physician responsible for your care and to receive information necessary to understand your medical problem and planned treatment,
- To participate (yourself or family member if patient incapable) in decisions regarding your care including treatment plans and the right to refuse or withhold care;
- To demand and receive an explanation of your bill and to request estimated charges for routine services or procedures;
- To reasonable attention to complaints and grievances when communicated to any member of the health care team; you have the freedom to voice such concerns without fear or reprisal or compromise of care;
- To file a grievance with the Composite State Board of Medical Examiners concerning the physician, staff, office, and treatment received; you may call the Board with such complaint or send a written complaint to the Board, being able to provide the physician or practice name, the address, and the specific nature of the complaint; you may notify the Georgia Composite Board of Medical Examiners, 2 Peachtree Street NW, 10* Floor, Atlanta, GA 30303 (404) 656-3913.

You have the responsibility:

- To provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health;
- To ask questions when you do not understand what you have been told about your health care and what you are expected to do;
- To follow the treatment plan developed with your practitioner and if you refuse treatment or fail to follow the practitioner's instructions, you are responsible for the outcomes;
- To follow and have your family follow the hospital's rules and regulations concerning patient care and conduct;
- To be considerate and have your family be considerate of other patients and office personnel by not making unnecessary noise, smoking, or causing distractions; patients and families are responsible for respecting the property of other persons and that of the office.

PATIENT REGISTRATION
PLEASE PRINT

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: ____/____/____ SSN: _____

TELEPHONE NUMBERS: (PLEASE LIST ALL TELEPHONE NUMBERS)

HOME: ____/____ WORK: ____/____

CELL: ____/____ PAGER: ____/____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MARITAL STATUS: __ (M) __ (S) __ (W) __ (D)

ARE YOU? EMPLOYED ____ RETIRED ____ STUDENT ____ DISABLED ____ OTHER ____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: ____/____

FULL-TIME: _____ PART-TIME: _____ TEMPORARY: _____

WHO REFERRED YOU: _____

ADDRESS AND TELEPHONE #: _____

EMERGENCY CONTACT: _____
(OTHER THAN SPOUSE)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: ____/____ TELEPHONE2: ____/____

PLEASE COMPLETE BACK PORTION

SPOUSE INFORMATION

NAME: _____ DOB: _____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

EMP.
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S TELEPHONE NUMBERS:

HOME: _____ / _____ WORK: _____ / _____

CELL: _____ / _____ PAGER: _____ / _____

(IF PATIENT IS A MINOR (*ie. UNDER 18 YEARS OF AGE), BILL RESPONSIBILITY INFO]

NAME: _____

RELATIONSHIP TO PATIENT: _____ DOB: _____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

EMP.
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBERS:

HOME: _____ / _____ WORK: _____ / _____

CELL: _____ / _____ PAGER: _____ / _____

WORKER'S COMPENSATION INFORMATION:

EMPLOYER'S NAME: _____ DATE OF INJURY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ PHONE: _____ / _____

W/C INS CARRIER: _____ TELEPHONE #: _____ / _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ADJUSTER'S NAME _____

PHONE: _____ / _____ FAX: _____ / _____ OTHER PHONE: _____ / _____

CLAIM#: _____

ALL INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED: _____ DATE: _____
PATIENT'S SIGNATURE



Gary N. Dawson, M.D.
Office: (706) 243-7010
Fax: (706) 243-7019

2300 13th Street, Suite A • Columbus, Georgia 31906

Patient Consent Form & Acknowledgement of 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. The Notice contains a Patient Rights section describing your right under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient Understands That:

Protected health information may be disclosed or used for treatment, payment or health care operations.

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to view this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Relationship to Patient (if other then patient): _____ Date: _____

WITNESS: (OFFICE STAFF PERSONNEL) _____

Print -Name- Practice representative

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received Our Notice of Privacy Practices. Return this acknowledgement of receipt to the receptionists or to the address listed below:

Susan Hero
River City Rehabilitation & Spine Specialists
2300 13th Street, Suite A
Columbus, GA 31906

Signature of Patient or Legal Representative: _____

Name (print): _____ Date: _____

Reason notice not given: _____

River City Rehabilitation and Spine Specialists
Consent for Purposes of Treatment, Payment and Healthcare Procedures

I consent to the use or disclosure of any protected health information by **River City Rehabilitation and Spine Specialists** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of River City Rehabilitation and Spine Specialists. I understand that diagnosis or treatment of me by **Dr. Gary Dawson** may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **River City Rehabilitation and Spine Specialists** is not required to agree to the restrictions that I may request. However, if **River City Rehabilitation and Spine Specialists** agrees to a restriction that I request, the restriction is binding on **River City Rehabilitation and Spine Specialists** and **Dr. Gary Dawson**. I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Gary Dawson** or **River City Rehabilitation and Spine Specialists** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review **River City Rehabilitation and Spine Specialists'** Notice of Privacy Practices prior to signing this document. **River City Rehabilitation and Spine Specialists'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **River City Rehabilitation and Spine Specialists**. The Notice of Privacy Practices for **River City Rehabilitation and Spine Specialists** is provided in this office. This Notice of Privacy Practices also describes my rights and **River City Rehabilitation and spine specialists'** duties with respect to my protected health information. **River City Rehabilitation and Spine Specialists** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

**RIVER CITY REHABILITATION AND SPINE SPECIALISTS
GARY DAWSON, M.D.**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I, the undersigned have Insurance Coverage with:

NAME OF INSURANCE COMPANY

I directly assign to Dr. Gary N. Dawson of River City Rehabilitation and Spine Specialists all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all co-pays and deductible amounts at the time service is rendered. I also understand that if my Insurance Company requires a Referral Number and/or Referral Form, **IT IS MY RESPONSIBILITY TO OBTAIN THIS REFERRAL PRIOR TO MY VISIT.** If I have not obtained the above referral, I understand that my visit will either be rescheduled or I will be solely responsible for this visit at the time service is rendered.

I hereby authorize the Doctor to release information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

PATIENT SIGNATURE AND/OR RESPONSIBLE PARTY

DATE

MEDICARE AUTHORIZATION

I request that payment of covered Medicare benefits be made on my behalf to Dr. Gary Dawson with River City Rehabilitation and Spine Specialists for any services furnished to me by Dr. Dawson. I authorize any holder of medical information about me to be released to The Health Care Financing Administration and its agents, and/or any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of information necessary to the claim. If "Other Health Insurance" is indicated in Item 9 in the HCFA 1500 Form, or elsewhere on other approved claim information to the Insurer or Agency shown.

Signature of Beneficiary

Date Signed

RIVER CITY REHABILITATION AND SPINE SPECIALISTS, PC

GARY N. DAWSON, M.D. • 2300 13th Street, SUITE A • COLUMBUS, GA 31906 •
706/243-7010 • FAX 706/243-7019

DATE: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION (MEDICAL RECORDS)

PATIENT NAME: _____

(PRINT)

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law, as described below:

Specific Description of the Information to be Used or Disclosed Including the Dates of Service(s): ALL MEDICAL INFORMATION TO INCLUDE MEDICAL RECORDS, X-RAY FILMS, LAB RESULTS AND PSYCHOLOGICAL EXAMS.

Persons or Class of Persons Authorized to Make the Use of Disclosure: RIVER CITY REHABILITATION AND SPINE SPECIALISTS, P.C., AND/OR GARY DAWSON, M.D., 1900 10TH AVENUE, SUITE 300, COLUMBUS, GA 31909, PHONE: 706/243-7010 FAX: 706/243-7019

RELEASED FROM: _____

The protected health information will be used and/or disclosed for the following purposes:

Other: Review by Physician. At the request of the individual

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying River City Rehabilitation and Spine Specialists, P.C., in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by River City Rehabilitation and Spine Specialists, P.C. before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in health plan, or eligibility for benefits.
- I understand that River City Rehabilitation and Spine Specialists, P.C. may require me to sign an authorization prior to receiving research-related treatment or for treatment solely for the purpose of creating health information for another party.

This authorization expires in 12 months or on the following date: _____

Print Name of Patient: _____

Signature of Patient: _____

Patient's DOB: _____ Patient's SSN: _____ Date: _____

FOR PERSONAL REPRESENTATIVE OF THE PATIENT (IF APPLICABLE):

NAME OF PERSONAL REPRESENTATIVE: _____

DESCRIBE PERSONAL REPRESENTATIVE RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

WITNESS/TITLE: _____ /OFFICE STAFF DATE: _____

