Primary Care
Internal Medicine
in Evans

Zhenrong Zhang, M. D.

Thank you for choosing Primary Care Internal Medicine in Evans. We are delighted to welcome you and will make every effort to serve you in a manner that will meet your expectations.

Please assist us by completing the attached forms and bringing them with you for your initial visit. If you need to change or cancel this appointment, please call us so we can offer this date and time to another patient.

Please bring the following items with you to assist with your examination.
• Any medical records from your referring or previous physician.
• Picture ID
• Insurance Card(s)
• A list of or in the original bottle all of your medication that you are currently taking.
• Co-payment if applicable.

If your appointment is scheduled for diabetes management, you will also need to bring:
• Your glucometer
• A two week record of your blood sugars

If your appointment is scheduled for hypertension, you will need to bring in your blood pressure machine annually and 2 weeks record of blood pressure reading.

We are located conveniently at the University Complex Professional center 3 - Evans at 465 N Belair Road, Suite 2C.

You may reach us by calling (706)-364-4775.

On behalf of our entire medical team, we would like to thank you for choosing Primary Care Internal Medicine in Evans for your health-care needs.

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Office Information and Policies

Office Hours: 8:00 am - 5:00 pm Monday through Friday with lunch hour 12:00 pm-1:00 pm
Contact Information:
706-364-4775 Phone
706-364-6992 Fax line
678-275-8379 Billing line

We appreciate the opportunity to provide your health care needs. These policies are intended to allow us to provide better health care services to patients in a timely manner. Thank you for understanding and cooperating.

Scheduled Appointments

- Please arrive 15 minutes before your appointment time to register.
- If you are unable to keep your appointment, please call our office the day before to cancel or reschedule. We reserve the right to charge for missed appointments
- We do our best to see you in a timely manner when you come in for your appointment. Therefore, if you are more than 15 minutes late, we reserve the right to reschedule you for another time. If no show for 3 times, patient will be discharged from the practice.

Prescription Refills

Prescription refills should not be an emergency. They should be handled during scheduled office appointments or by calling the prescription refill line during regular office hours. Refills will be filled within 2 business days (not including holidays and weekends). Please do not walk-in to request refills.
Prior Approvals are sometimes needed on medications that are not preferred meds with your insurance company. We ask that you allow 2 business days for this to be obtained, as these are very time consuming phone calls.

Referrals and Authorizations

We refer patient to subspecialists per patient's reference. If patient doesn't know who you want us to be referred, we will choose the physician who we believe can provide the best care for you.
If an authorization or pre-certification is required by your insurance, we will need a minimum of 48 hours to contact your insurance company for authorization. And in some cases, it is necessary for you to be seen by Dr. Zhang first.

Hospitalization for patients and after hour coverage

We offer quick sick visit throughout the day as much as possible if you can call us or book online before you come in. You can go to Prompt Care or ER if you are sick after office hour or weekends and need immediate attention.
We utilize hospitalist group which are located in each of the area hospitals per patient's preference. They accept most insurance plans, they provide the specialized care that is needed in the hospital.

Laboratory Services

We do have a laboratory on site. We use LabCorp® as a reference lab. Our staff will attempt to determine the lab or facility that your insurance covers, but it is ultimately your responsibility as the patient/insured to confirm the correct lab or facility.

Letter or Forms

Physicians will complete forms and letters as time permits. We ask that you give the physician 7 business days for this. If forms or letters are needed prior to 7 business days, an appointment will need to be made.

Signature _____Date _____

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HIPAA PATIENT QUESTIONNAIRE

Privacy Notice (HIPAA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Primary Care Internal Medicine in Evan. I hereby authorize Primary Care Internal Medicine in Evans to disclose information about myself that is protected under federal law for the purposes of treatment, payment, and healthcare operations.

Patient Name: _____ D.O.B.:_____

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____-_____
Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____-_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____-_____
Name: _____ Relationship: _____ DOB: _____ Phone :(_____) _____-_____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home.
_____

4. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, and other health care information if other than your home phone number:
Phone :(_____) _____-_____

I am fully aware that a cell phone is not a secure and private line.

5. Can confidential messages be left on your telephone answering machine?
Yes No

6. I am fully aware my health information will/may be transmitted by electronic transmission, by secure fax transmittal, by internet or by email for continued health care needs.

Patient Signature (Guardian if under 18 years) _____
Date _____

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Financial Policy

Thank you for choosing Primary Care Internal Medicine in Evans. We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing quality healthcare services to our patients. Our financial policy is as follows:

1. Payment - Payment is expected at the time of service.
2. Insurance -
    a. Please provide a copy of your insurance card prior to each visit.
    b. We will file Insurance for you under most circumstances as long as you provide us with current information. You are ultimately responsible for understanding the details of your coverage and what charges you may incur.
    c. If your insurance company does not respond to us within 60 days of a filed insurance claim, the charges will be sent to you to follow up on and you will be responsible for payment.
3. Minor Children Patients
    a. Minor children patients must be accompanied by a parent or legal guardian.
    b. Charges for services rendered to minor children are the responsibility of the parent who seeks treatment for the child and are due at the time of service regardless of court-ordered responsibility.
4. Self-Pay Patient Discounts - We offer discounts to our self-pay patients (patients who have no insurance coverage) who pay in full at the time of service
    a) New patients visit $150. Follow up visit $100.
    b) We offer very competitive self pay labs and imaging study fees.
5. Restricted Service -All account balances must be in good standing prior to receiving additional services. Please contact our office if you are unable to pay your balance.
6. Missed Appointment Charge - Please notify our office at least 24 hours in advance if you are unable to keep a scheduled appointment or you may be charged a $25 fee.
7. Additional Service Charges - A service charge of up to $35 may be added for each of the following:
    a). Returned Checks;
    b). Additional forms (FLMA etc.).
8. Past Due Accounts of 60 days or longer may be turned over to a third party for collection, along with collection costs, attorneys' and court fees. You may also be discharged from the practice.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles, are my responsibility.

Patient Printed Name_____DOB_____

Patient Signature (Guardian if under 18 years) _____Date _____

Relationship to Patient_____

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Consent

SECTION I. CONSENT TO TREATMENT: I hereby request, authorize, and consent to the rendering of such care at Primary Care Internal Medicine in Evans as may include treatments and diagnostic procedures considered necessary or advisable by Dr. Zhenrong Zhang in charge of this case and her assistants, designees, or consultants and all other acts appropriately related to the procedures described above as may be necessary, appropriate, or helpful. I understand the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury; or even death. I acknowledge that no guarantees have been made to me concerning the results of examination or treatment.

SECTION II. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION;
I hereby authorize Primary Care Internal Medicine in Evans to release all medical and other Information, specifically including but not limited to information contained in its medical records, whether or not privileged under applicable law, to Dr. Zhenrong Zhang and her consultants. Primary Care Internal Medicine in Evans are authorized to release this information at this time and in the future after my discharge to the patients commercial insurance firms and their utilization management agencies for the purpose of certifying that this provision of health care is medically necessary; to the Health Care Financing Administration and its intermediaries or carriers if there is Medicare coverage.

I have read or have had read to me the above Sections I, II and understand them. I certify that the information I have given during this processing is true, accurate, and complete as evidenced by my signature:

_____ _____
(Signature of patient or surrogate decision maker) (Date)

_____
(Witness)

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Patient Information

Patients Name (First, Middle, Last): _____

D.O.B.: _____/_____/_____ Age: _____ Marital Status: _____ SSN#: _____-_____-_____

Address: _____ City: _____ State: _____Zip: _____

Primary Number I wish to have used for contact: Home Work Mobile

Home Phone: (_____)-_____-_____Work: (_____)-_____-_____

Mobile: (_____)-_____-_____

Patient Email Address: _____ Male Female

Race: Caucasian African American Hispanic Asian Other _____

Emergency Contact: _____ Phone:(_____)-_____-_____Relationship:_____

Preferred Pharmacy: _____

Preferred Lab: _____

Employment Status: Full time Part time Retired Unemployed

Employer: _____

Guarantor of Account: Self Other: _____ D.O.B.: _____/_____/_____Relationship: _____

Primary Insurance: _____ID No.:_____ Group No.:_____

Subscriber: Self Other: _____ Relationship: _____

D.O.B.: _____/_____/_____ SSN#:_____-_____-_____ Phone Number:(_____)-_____-_____

Secondary Insurance: _____ID No.:_____ Group No.:_____

Subscriber: Self Other: _____ Relationship: _____

D.O.B.: _____/_____/_____ SSN#:_____-_____-_____ Phone Number:(_____)-_____-_____

All information given is accurate. I give permission for this practice to contact me regarding practice information by the above methods .

Print Name: _____ Signature: _____

Date: _____/_____/_____

Reason for visit today: _____

_____

_____

_____

465 N. Belair Road, Suite 2C
(706) 364-4775