CONCIERGE PATIENT REGISTRATION (please print)

BARRY K. HULL, M.D.
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115 Habersham Drive, Fayetteville, GA 30214
678-788-7500 phone / 678-788-7501 fax

PATIENT INFORMATION

DATE: _____ Preferred Contact number:_____ OK to leave message? ☐YES / ☐NO

Patient Name: _____ Date of Birth: _____ Age: _____

Parent / Guardian Names: _____ Relationship: _____

Address:_____ Insurance: _____

City: _____ State: _____ Zip: _____ Email: _____

Phones: Cell _____ Home _____ Work _____

Occupation / Grade in school: _____ Place of Employment / School: _____

Whom may we thank for referring you? _____

PAYMENT & CONFIDENTIALITY

_____ Concierge patient fees are $1750 per patient per year.
Initial

_____ I am aware that I may not file a reimbursement claim with Medicare or Medicaid.
Initial

_____ All aspects of a patient's care are confidential. The patient's records may only be
Initial released when the requesting provider obtains the patient's written permission. However, as required by law, confidentiality must be broken under the following circumstances:

1. Evidence of child or elder abuse. The law requires that the healthcare provider report this to the appropriate authorities immediately.
2. Evidence of endangerment to self or others requires that appropriate action must be taken.
3. Receipt of a court subpoena requires release of records.

_____ Patient has received access to this office's Privacy Policy, and a paper copy is
Initial available upon request.

Your signature below signifies you have read, understand and agree to all of the above stated policies and procedures.

_____ _____ _____
PATIENT PRINTED NAME SIGNATURE OF RESPONSIBLE PARTY DATE