Donnie P. Dunagan, M.D., P.C.
2042 Central Avenue
Augusta, Ga 30904
Phone: 706-733-1104
Fax: 706-736-8465

New Patient Appointment Instructions

In order for us to be able to perform allergy tests, it is important that patients who come for these tests **DO NOT TAKE ANY ANTIHISTAMINES** for a period of 5 days (Zyrtec, Atarax , Clarinex, or Benadryl) prior to your appointment. Also, if you are taking a **BETA BLOCKER** for blood pressure, heart problems, or glaucoma you must be off this medication for at least 24 hours before skin testing can be done. Antibiotics, asthma medications, cortisone, aspirin, hormone pills, vitamins, etc. do not interfere with testing. Any questions concerning the nature of the medications you are now taking should be directed to the physician who prescribed them. Please bring all medications or name and dosage of same that you have taken within the past 12 months to this appointment.

FEE-FOR-SERVICE CONTRACTS: You will be expected to pay in full all co-payments and deductibles at
each visit during the initial allergy work-up.

MANAGED CARE CONTRACTS: This office has contracts with most Managed Care Plans. Please call
the office to see if we participate with your plan. In some instances we may not be aware that we are participating providers, so as always, please check with your insurance plan if there are any questions regarding coverage. We will file all claims for patients holding this type of insurance. You will be expected to pay in full all co-payments and deductibles at each visit. “Balances due” are payable in full at each billing cycle.

For your convenience, we accept most major credit cards as well as, your personal check or cash.

In the event you cannot keep this appointment, please call us within 24 hours prior to the time of your appointment, and we will try to arrange a more convenient time. If our office is not notified 24 hours in advance of cancellation, you will be charged a $50 no show fee and we will be unable to reschedule your appointment.

Account# _____ Dr. Donnie Dunagan

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Primary Phone: Secondary Phone:

Date of Birth: Social Security #

Email Address:

Sex: Male / Female Race: _____ Ethnicity: ____Hispanic ___Non-Hispanic

Employer/School: _____ Full Time / Part Time

Marital Status: Spouse's Name:

Spouse's Phone: Secondary Phone:

Do you have any family members being seen by our doctors? ____No ____Yes If so, who?

Full Name Date of Birth Relationship to Patient

Primary Pharmacy: Pharmacy Phone:

Primary Care Physician: Phone Number:

Address City State

Referring Physician: Phone Number:

Address City State

Responsible Party:

Full Name Date of Birth Relationship to Patient

Primary Insurance: Phone Number:

Subscriber:

Full Name Date of Birth Relationship to Patient

ID Number: Group:

Secondary Insurance: Phone Number:

Subscriber:

Full Name Date of Birth Relationship to Patient

ID Number: Group:

Complete for MINORS

Father's Name: Mother's Name:

Date of Birth: Date of Birth:

Phone Number: Phone Number:

Employer: Employer:

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Patient Payment/Assignment of Benefits Agreement

Thank you for allowing us to serve you. We are committed to providing to our patients the best possible medical care in addition to prompt and courteous service. Our services are based on medical necessity. As a courtesy to our patients, we will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. However, some insurance carriers do not reimburse for certain procedures and/or diagnosis. Donnie P. Dunagan, M.D. will have you sign a *Notice of Likelihood of Medicare Denial* if we believe Medicare will deny any services we provide you. In the event a claim is filed and denied for charges not covered, you are ultimately responsible for all denied charges.

We ask that you sign this agreement for all services rendered

I (print name)_____ , have received instructions that certain procedures and diagnosis may not be covered by my insurance carrier. I further agree to reimburse Donnie P. Dunagan, M.D. for all charges related to services rendered.

Insurance claims are filed as a courtesy to our patients. Patient co-payments and/or patient responsibilities are due at the time service is rendered.

We ask that you sign this agreement so we may file your insurance

I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s), including Medicare (assigned charges), to pay directly to Donnie P. Dunagan, M.D. any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments. I have read and signed Donnie P. Dunagan, M.D.'s Notice of Privacy Practices for Protected Health Information and understand this authorizes my physician to release to my insurance company any medical information necessary to process my claims.

Authorized Signature: _____ Date:_____

Donnie P. Dunagan, M.D.

Patient Acknowledgment Form

Patient Acknowledgment of Understanding of Donnie P. Dunagan, M.D.'s Privacy Practices:

Patient's Name:_____ Date of Birth:_____

SSN:_____ Acct #: _____

I understand that the patient's health information is private and confidential. I understand that Donnie P. Dunagan, M.D. work very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Donnie P. Dunagan, M.D. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

Donnie P. Dunagan, M.D. has a detailed document called the "Notice of Privacy Practices.". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that the right to read the "notice" before signing this Acknowledgment.

Donnie P. Dunagan, M.D. may update this Acknowledgment and "Notice of Privacy Practices". If I ask Donnie P. Dunagan, M.D. will provided me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Donnie P. Dunagan, M.D., P.C. have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorization; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Donnie P. Dunagan, M.D. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to the patient if signed by anyone other than the patient (parent/legal guardian etc.)

Names of individual we may release relevant information to regarding your care:

_____

No Show/Cancellation without 24 Hour Notice Policy

Effective June 2, 2011

We make every effort to notify you via telephone of your scheduled appointment 48 hours in advance. However, due to the increase in No Show and Cancellations on the day of appointments we must start charging a fee for patients not giving a 24 hour notice. This will apply to all established and new patients.

New Patient Fee $50
Established Fee $25

We apologize for any inconvenience this may cause, but the needs of our patients that need to be seen must be taken into consideration.

Thank you,
Dr. Donnie P. Dunagan

_____ _____

Patient Signature Date