Hugo D. Ribot Jr., M.D., F.A.C.O.G.
D. Malcolm Barfield, D.O., F.A.C.O.G.

Dear Valued Patient,

Welcome to the Georgia Advanced Surgery Center for Women – and thank you for making an appointment with us! Whether you were referred to us by your primary care physician, other doctor, family member or friend – or learned about us through the Internet – we appreciate that you've chosen us to discuss treatment options for your unique condition or need.

Our state-of-the-art facility provides women with the very highest level of gynecological treatment and care. Specializing in the most modern, minimally invasive surgical solutions available, we are the only fully accredited surgery center in Georgia for performing all major and minor gynecological procedures in a true outpatient setting. And, we are among only a few such facilities in the entire country qualifying as a prestigious "Center of Excellence" by the American Association of Gynecological Laparoscopists for our highly advanced techniques, rigorous safety standards and commitment to excellent patient outcomes.

Should surgery be recommended for your condition or need, you can trust that you will be in the hands of experts. Our board certified surgeons have more than 25 years of combined experience in performing thousands of minimally invasive gynecological procedures, and are recognized leaders in their specialty. Additionally, you will be in a warm, comfortable environment with a caring, attentive staff that is dedicated to providing you with the best surgical experience possible.

***Please note that all patient appointments, including surgical consultations, take place in the offices of our professional practice, Cartersville Ob/Gyn Associates, located in Suite 102 of our medical building (just down the hall from us). If you should need further information or have questions, please visit www.GA-AdvancedSurgeryCenter.com or call us at 678-605-9399.***

We look forward to meeting you.

Sincerely,
Hugo D. Ribot, Jr., M.D.
Medical Director

P.S. To help us most efficiently serve you, please bring the following to your appointment:

- New Patient Forms (enclosed and also available on our website).
- Insurance card(s) and picture ID.
- List of any questions or concerns that you may have.
- If possible, please fax (678-605-9398) all medical records, reports and test results related to your current condition at least three business days prior to your appointment. Bring to your appointment any medical records that you could not fax.

958-A Joe Frank Harris Parkway • Building 2 • Suite 107 • Cartersville, GA 30120 • 678-605-9399 • Fax 678-605-9398
www.GA-AdvancedSurgeryCenter.com

# PATIENT REGISTRATION FORM

TODAY'S DATE:_____________

**PLEASE PRINT**

NAME:_________________________________________ AGE:_____ BIRTH DATE:____________________

ADDRESS:_________________________APT#:_____CITY:_______________ STATE:____ ZIP:_____________

HOME PHONE:___________________ CELL PHONE:________________ SS#:_________________________

EMPLOYER:___________________________________ WORK PHONE:______________________________

ADDRESS:_____________________________ SUITE:_____ CITY:____________STATE:____ ZIP:__________

EMAIL ADDRESS:_____________________________________________________________________

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED SEPARATED

**IF APPLICABLE:**

HUSBAND'S NAME:_____________________________ AGE:_______ BIRTH DATE:_____________________

EMPLOYER:_________________________________ WORK PHONE:___________ SS#:___________________

EMPLOYER'S ADDRESS:_______________________________CITY:_________ STATE:____ ZIP:__________

NEAREST RELATIVE: (OTHER THAN HUSBAND)

NAME:_______________________________________ RELATION:____________________________________

ADDRESS:______________________________ APT#:_____ CITY:_____________STATE:____ ZIP:__________

PHONE:_________________________________

DO YOU HAVE MEDICAL INSURANCE?________ IF SO, PLEASE LIST BELOW:

1. NAME OF INSURANCE COMPANY:___________________GROUP NAME:____________________________

INSURED NAME:_______________________________________ INSURED DATE OF BIRTH:_______________

INSURED SS#:_____________________________ GROUP#: ________________ MEMBER#:_______________

2. NAME OF SECOND INSURANCE COMPANY:___________________GROUP NAME:______________________

INSURED NAME:__________________________________ INSURED DATE OF BIRTH:____________________

INSURED SS#:_____________________________ GROUP#: ________________ MEMBER#:_______________

NAME OF PRIMARY CARE PHYSICIAN:______________________________ PHONE:_____________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?____________________________________________

NAME:_______________________________________________ADDRESS:____________________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. MY SIGNATURE ALSO AUTHORIZES PAYMENT OF MEDICAL BENEFITS TO THE GEORGIA ADVANCED SURGERY CENTER FOR WOMEN FOR ALL SERVICES PROVIDED.

_____________________________________

(PATIENT'S SIGNATURE)

**ALL PATIENTS ARE REQUESTED TO PAY BY CHECK OR CASH AT THE TIME OF THEIR VISITS. WE ALSO TAKE VISA OR MASTERCARD. PLEASE FEEL FREE TO DISCUSS OUR CHARGES.**

# MEDICAL RECORDS AUTHORIZATION FORM

PATIENT NAME:_______________________________ DATE OF BIRTH:________________________

ADDRESS:___________________________________________________________________________

PHONE #:____________________________ SOCIAL SECURITY:______________________________

I AUTHORIZE THE GEORGIA ADVANCED SURGERY CENTER FOR WOMEN TO **OBTAIN** MY MEDICAL RECORDS

***FROM:**____________________________________________________________________________

ADDRESS:___________________________________________________________________________

PHONE #:_________________________________ FAX #:_____________________________________

**OR**

I AUTHORIZE THE GEORGIA ADVANCED SURGERY CENTER FOR WOMEN TO **RELEASE** MY MEDICAL RECORDS

***TO:**_______________________________________________________________________________

ADDRESS:___________________________________________________________________________

PHONE #:_________________________________ FAX #:_____________________________________

**CIRCLE THE REQUESTED INFORMATION**: PAP SMEARS, OPERATIVE REPORTS, H&Ps, BIOPSY REPORTS, DISCHARGE REPORTS, X-RAYS, PATH & LAB REPORTS, OR **ALL RECORDS**.

**PATIENT SIGNATURE:**_______________________________________________________________

**DATE:**____________________________ **WITNESS:**______________________________________

MEDICAL RECORDS MAY CONTAIN THE FOLLOWING INFORMATION:
OFFICE NOTES, TREATMENT, HOSPITALIZATION, AND/OR CARE FOR PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSE, ALCOHOLISM, CONTAGIOUS, COMMUNICABLE OR VENERAL DISEASE, ACQUIRED IMMUNODEFICIENCY SYNDROME (**AIDS**), OR TEST FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS **(HIV).** PATIENTS REQUESTING MEDICAL RECORDS WILL BE CHARGED A FEE OF $10.00, AND DOCTORS REQUESTING MEDICAL RECORDS REQUIRE NO FEE.

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# HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form

Women's Surgery Center (d/b/a Georgia Advanced Surgery Center for Women, LLC)

Acknowledgment of receipt of Information Practices Notice (§164.520(a))

I understand that as part of my health care, Georgia Advanced Surgery Center for Women, LLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Georgia Advanced Surgery Center for Women, LLC **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.
I understand that:

I have the right to review Georgia Advanced Surgery Center for Women, LLC Notice of Privacy Practices prior to signing this acknowledgment; that Georgia Advanced Surgery Center for Women, LLC reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Others (please specify)

______________________________________________________________

______________________________________________________________

______________________________ ______________________________

Kristi Plank, R.N. Date