

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

APPOINTMENT INFORMATION

DAY: _____ DATE: _____

TIME: ____ am ____ pm _____

Please fill out all the enclosed paper work and bring with you to your appointment .

THANK-YOU

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

AUTHORIZATION TO DISCUSS HEALTH AND TREATMENT

I, _____ authorize the following persons to have access to my medical condition and treatment.

NAME, TELEPHONE NUMBER AND RELATIONSHIP REQUIRED

1. _____
2. _____
3. _____

By law, no other person/persons will be allowed any information per patient confidentiality.

SIGNATURE: _____ **DATE:** _____

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

AGREEMENT LETTER

I, _____ understand my insurance company may or may not cover my charges in full. I agree to be responsible for all charges and services my insurance company may not cover.

SIGNATURE: _____ **DATE:** _____

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041

PHARMACY INFORMATION
MEDICATION INFORMATION

PHARMACY NAME: _____

PHARMACY PHONE: _____ PHARMACY FAX: _____

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

LIST OF MEDICATIONS WITH DOSAGE:

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE: _____

** If you have a mail order prescription service, we will need the following information.

Mail order company name:

Phone number :

Fax number:

Member ID number:

Bob G. Lanier, M.D.,P.C.
4730 Hammond Industrial Drive
Cumming, Georgia 30041

PATIENT REGISTRATION

NAME: _____

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

HOME PHONE: _____ CELL PHONE: _____

SOC SEC# _____ SEX: _____ MARITAL STATUS _____ DATE OF BIRTH: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PRIMARY INSURANCE COMPANY: _____ PHONE: _____

INSURANCE MAILING ADDRESS: _____

INSURED PARTY: _____ DATE OF BIRTH: _____ RELATIONSHIP: _____

POLICY# _____ GROUP# _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE COMPANY _____ PHONE: _____

MAILING ADDRESS: _____

INSURED PARTY: _____ DATE OF BIRTH: _____ RELATIONSHIP: _____

POLICY # _____ GROUP# _____ EFFECTIVE DATE: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information necessary to process my insurance claim.
I hereby authorize payment directly to the Physician for any professional services rendered to my dependent or me.
I further understand that I am financially responsible for any charges not paid by my insurance carrier, unless my insurance plan is one that contracts directly with the Physician and they determine that I am not responsible.
Regulations pertaining to medical assignment of benefits apply, in the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court cost will be paid by the guarantor. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services.

SIGNATURE: _____ **DATE:** _____

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

Our office would like to send you your normal laboratory reports either by fax or by e-mail. HIPPA requires us to obtain your approval for this.

We are asking you to designate either a home fax number or home e-mail address below.

Home fax:

Home e-mail address:

Please note however, all abnormal results will be reviewed, if there are any changes to your treatment, our office will contact you. All other abnormal results will be discussed with you at your next office visit.

Name:
please print

Signature:

Date:

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Suite 400
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

This notice is to advise you that an administrative fee of \$50.00 will be charged if you do not make your scheduled appointment.

Cancellations must be made 24 hours in advance, or this fee applies.

Please sign and date this notice, then mail back to our office prior to your first appointment.

Thank-you

Patient's name: _____

Date: _____

BOB G. LANIER, M.D.
4730 Hammond Industrial Drive
Cumming, Georgia 30041
Phone: 770-205-2220
Fax: 770-205-7112

DRIVING DIRECTIONS

Directions from the South:

GA 400 North to exit 17. Turn right off of the exit onto Hwy 306. Follow Hwy 306 to Hwy 369-Browns Bridge Road (second traffic light). Turn right onto Hwy 369-Browns Bridge Road, go east .6 of a mile, turn left onto Hammond Industrial Drive. Take an immediate right into the first complex on the right. We are at the end of the building in Suite 400.

Directions from the North:

GA 400 South to Hwy 369-Browns Bridge Road. Turn left onto Hwy 369-Browns Bridge Road. Travel east towards Gainesville. Pass through one traffic light (Hammonds Crossing). Continue on Hwy 369 approximately .4 of a mile, turn left onto Hammond Industrial Drive. Take an immediate right into the first complex on the right. We are at the end of the building in Suite 400.

Directions from the East (Gainesville)

Hwy 369-Browns Bridge Road approximately 12 miles towards Cumming. Turn right on Hammond Industrial Drive. Take an immediate right into the first complex on the right. We are at the end of the building in Suite 400.

Directions from the West (Woodstock-Canton)

From Woodstock. Hwy 92 east to GA 400 North. Follow the directions above for the north.

From Canton. 575 North to Hwy 20 east towards Cumming. Travel approximately 8 miles to the intersection of Hwy 369. Turn left, travel approximately 16 miles, cross over GA 400. Follow the directions above from the south.