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Anna Carter, M.D.
Jasmine Hawkins, M.D.

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PRACTICE POLICIES AND GUIDELINES AGREEMENT

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Our treatment relationship is a partnership, and we look forward to helping you achieve the best health outcomes possible.

First Time Visit: Please arrive at least **30 minutes** prior to your appointment time. An assistant will go over your past medical history at the time of your visit. Please bring all your medications in their original containers.

Follow-Up Visits: Please arrive **15 minutes** before your scheduled appointment time. It is our goal for you to be ready to see your physician on time. Notify us if you have any changes in your insurance or contact information. Please make us aware of any significant updates in your medical history, such as hospital or urgent care visits, and any changes in your medications by another healthcare provider.

Follow-up Care: Your treatment plan may involve follow-up care. As such, we may schedule you for diagnostic tests, follow-up appointments with us or other providers. If you do not keep the appointment, it is important that you contact us to discuss alternatives. Likewise, if you decide to seek care from another provider, please let us know. It is our policy to inform you of test results, however, if you have not received your test results within the expected time, please contact our office.

Late Arrivals: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back into the schedule. Depending on how busy we are, you may be required to reschedule your appointment. Please note, we have a 15-minute grace period (*this does not apply to Ultrasound or Procedure appointments due to the extent of these visit types. Please be sure to arrive before or at your scheduled Ultrasound/Procedure appointment time*).

Cancellations for Office Appointments: We ask that you cancel and/or reschedule appointments *at least 24 hours* in advance so that we may give that time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 1 appointment without following the cancellation protocol, you will be charged **\$50.00** for a missed office visit, **\$75** for a missed ultrasound visit and **\$100** for a missed procedure.



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If you miss 2 appointments without following the cancellation protocol, you must settle your past due no-show fee balance **prior** to scheduling any future appointments.

Surgery Cancellations:

If you are scheduled for surgery, we ask that you reschedule/cancel at least **3 weeks** prior to your surgery. If you reschedule or cancel your scheduled surgery in less than **3 weeks**, you will be charged **\$150** that will be billed directly to you.

Problem Visits: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to see another provider. **Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.**

Visitors Policy:

- Only **ONE** support person over the age of 18 is allowed to attend a visit with patient.
- Newborns are allowed at post-partum visit only. Otherwise, no children are allowed.
- All patients & visitors should be healthy. **Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.**

Mask Policy:

- Masks are optional for patients who are fully vaccinated. **Please do not visit if you are sick, have flu or cold-like symptoms, or any other illness.**

Photography, Video and Audio Policy: For the protection of patients and staff privacy, photography, video, and audio recording are strictly prohibited without expressed permission.

Financial Policy:

- It is required that you bring your current and valid insurance card and driver's license, or government issued ID card to **EACH** visit.
- If you cannot provide valid insurance at the time of scheduling your appointment for our team to verify active coverage **PRIOR** to your visit, you will be considered as a self-pay patient and responsible for all charges at the time of your visit.
- If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. Payment is due at the time of service.
- Please note that we are contractually obligated to collect your co-pays or estimated deductible at the time of service.
- Notify us if you have any changes in your insurance or contact information.



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After Clinic Hours and Weekends: You may reach the on-call physician by calling 770-972-0330 and our after-hour service center will assist you in reaching the on-call physician.

We respectfully request that you turn off or silence your cell phone during your office visit.

I have read and understand the above office policies and agree to abide by them.

Print Name

Sign Name

Today's Date

Gwinnett OB/GYN Associates, P.C.
1700 Tree Lane Road
Suite 290
Snellville, GA 30078

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ Acct# _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people:

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

Yes or No You may leave medical information (test results) on my voice mail at:
(circle one)

Cell # _____

Home # _____

Signed _____ Date _____

Patient Account # _____

Acceptance of Blood Products

At Gwinnett OB/GYN we strive for optimum health and to preserve life. In the case of a life threatening emergency, **it is our policy to transfuse with blood if it is necessary to save your life.**

Please sign one of the below:

I understand and **agree** with the above transfusion policy.

Print Name	Signature	Date
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Witness Signature	Date
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I **disagree** and will be transferring my care elsewhere.

Print Name	Signature	Date
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Witness Signature	Date
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