# PATIENT REGISTRATION FORM

**(Please Print)**

Name _____ DOB _____ M/F___

Name _____ DOB _____ M/F___

Name _____ DOB _____ M/F___

Name _____ DOB _____ M/F___

## FATHER'S INFORMATION

| | | | |
|---|---|---|---|
| Father's last name: | First Name: | Birthdate: | Social Security #: |
| Are you the Policy Holder for Primary Insurance? ☐ Yes ☐ No | Address, City, State & Zip: **(if different)** | | |
| Primary Phone # (cell, home, office) ( ) | Alternate Phone # (cell, home, office) ( ) | Marital Status: S M D W | |
| Employer: | Occupation: | Email: | |

## MOTHER'S INFORMATION

| | | | |
|---|---|---|---|
| Mother's last name: | First Name: | Birthdate: | Social Security #: |
| Are you the Policy Holder for Primary Insurance? ☐ Yes ☐ No | Address, City State & Zip: **(if different)** | | |
| Primary Phone# (cell, home, office) ( ) | Alternate Phone# (cell, home, office) ( ) | Marital Status: S M D W | |
| Employer: | Occupation: | Email: | |

**Please give Insurance Card(s) to Front Desk Personnel**

## INSURANCE INFORMATION

**Please give Insurance Card(s) to Front Desk Personnel**

| | | | |
|---|---|---|---|
| Name of Primary Insurance: | Policy # | Group # | Effective Date: |
| Policy holder of **Primary Insurance**: | Claims Address: | | |
| Name of Secondary Insurance: | Policy # | Group # | Effective Date: |
| Policy holder of **Secondary Insurance**: | Claims Address: | | |
| **Pharmacy Name** | **Pharmacy Phone #** | **Pharmacy Address** | |

## Emergency Contact Information

| | | | |
|---|---|---|---|
| Name of friend/relative (not living at the same address) | Relationship to Patient | Work Phone No: | Cell phone No: |

## CONSENT & HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

**Please sign below that an opportunity to review a copy of our HIPAA notice for all children listed has been made available for you upon request and found on our website at www.georgetownpediatrics.com.** You are entitled to a copy of the notice at any time to keep for your records. This is also a consent that I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child/children's status.

**Signature:** _____ **Date:** _____

## CANCELLATION & NO SHOW POLICY

Our requested cancellation policy is a 24 hour notice for well child checkup visits and consultations. A $50.00 fee will be assessed per child for any missed or cancelled appointment without 24 hour notice. Your cancellation must be made during regular office hours. As always, emergencies and unforeseen circumstances are taken into consideration. By signing below I am aware and understand the policy.

***Signature:*** _____ ***Date:*** _____

# Georgetown Pediatrics' Policies & Fees

Georgetown Pediatrics, PC is committed to providing your child with the best possible medical care. It is our belief that an informed patient is a more satisfied patient; consequently, we are providing the following information to avoid any misunderstanding or disagreement about payment and policies for our professional services.

**Co-Pays:** Payments are to be paid at the time of service. This includes co-pay and/or any deductible amount at each visit. We will not bill for co-pays. If co-pay payment is not made same day and is billed an **additional $25.00** fee will be added to the account.

**Insurance:** We participate contractually with a number of insurance companies. If we participate with your child's insurance company; as a courtesy, we will file any claims made for your visit. It is your responsibility to bring your insurance card and photo identification to every visit.

If your child is a visitor to our practice, has no insurance, a participant in a plan we do not accept or participate with, or we are unable to verify your insurance is effective, you will be responsible for **payment in full at the time of service** and will be considered a "Private Pay" patient. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service and no insurance is to be filed. In the event we cannot verify your insurance, you will be responsible for payment in full at the time of services or you may choose to reschedule.

If your child is covered by a HMO or POS plan and we are not listed as your primary care provider, we will see your child, but you will be considered "Private Pay" and required to pay for services as they are rendered until Primary Care Provider is correct.

**Should any discrepancy occur regarding your understanding of benefits and coverage, it is your responsibility to resolve such matters with your insurance company. Georgetown Pediatrics, P.C. will expect payment from you as indicated by your insurance carrier.**

**Payment Arrangements:** If you are unable to pay your balance in full from the statement date, please contact our office immediately for a written and signed payment plan. Failure to do so may result in additional finance charges being applied to your account. If you fail to make payment in full for services rendered in a timely manner, your outstanding balance will be sent to a collections agency. You will be responsible for any fees associated with the collection of your balance. Failure to meet your financial responsibility with our practice may lead to dismissal from the practice.

**Methods of Payment:** We accept cash, checks, Visa, MasterCard, American Express, Discover and Debit Cards.

**Divorce, Separation or Blended Family:** At Georgetown Pediatrics, PC, we understand that issues related to divorce are very difficult for the entire family. However, we will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. All copays, co-insurance, and deductibles will be collected at the time of service from the individual accompanying the child at the visit. Both parents have access to the minor child's medical record unless we are provided with a copy of a court order that mandates otherwise. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

**Annual Administrative Fee (effective 6/1/2013)** Our office finds it necessary to collect an annual Administrative Services Fee (ASF). The ASF will be $20.00 for one child or $30.00 per family. These administrative fees are intended to cover the cost of certain administrative services we provide that are not covered by your insurance. Such as, after hours calls to CHOA (these calls are charged to our practice), completion of all forms including, FMLA, disability forms, physical forms, school forms, patient requested generated reports, such as claims, statements, payment histories as well as pharmacy preauthorization's and insurance pre-certification's. **If the ASF is not paid annually, you understand that you may be billed on a per item basis.**

I have read, fully understand, and agree to abide by the above consent for medical treatment, financial responsibilities, release of medical information, fees and insurance authorization for child/children listed below.

Name: _____ DOB _____ Name: _____ DOB _____

Name: _____ DOB _____ Name: _____ DOB _____

**Parent/Guardian Signature: _____ Date: _____**

# GEORGETOWN PEDIATRICS. P.C,

| New Patient Medical History | | |
|---|---|---|
| Patient's Name: | Today's Date: | Called by: |
| Birth Information: Date: | Wt.: | Length: Sex: (M) (F) |
| Neonatal Problems: | | |
| Jaundice (Y) (N) Required Treatment (Y) (N) if yes, explain: | | |
| Breathing Problem (Y) (N) Required Oxygen (Y) (N) Infection (Y) (N) Required Antibiotics (Y) (N) If yes, explain: | | |
| Other problems related to birth? | | |
| Patient lives with: (Give name and relationship) | | |
| Parents are: Married: ☐ Divorced: ☐ Separated: ☐ Other: ☐ | | |
| Patient attends school or daycare facility? | | |
| Approximate age of housing where patient resides? (Considered for possible lead exposure) | | |
| Any medications currently or frequently used: (Y) (N) if yes, please list below | | |
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |
| Any hospitalizations or surgeries: (Y) (N) if yes, please list | | |
| Any known allergies: (Y) (N) if yes, please list | | |
| Any adverse reaction to medications: (Y) (N) if yes, please list | | |
| Any adverse reaction to immunizations: (Y) (N) if yes, please list | | |
| Family History: Is patient adopted? (Y)(N) (If yes, please complete as much information below as know) | | |
| Mother's birth year: | Mother's height: | |
| Father's birth year: | Father's height: | |
| Brother's birth year: | Brother's height: | |
| Sister's birth year: | Sister's height: | |

# GEORGETOWN PEDIATRICS. P.C,

**Please fill in the appropriate column if either the patient or the family member has had a history of any of the following medical problems:**

| **Medical Diagnosis** | **Y** ✓ | **N** ✓ | **Patient** (Age of Diagnosis) | **Family** (Member and *Age of Diagnosis)* |
|---|---|---|---|---|
| Addictions (drug, alcohol, tobacco) | | | | |
| Anemia or Bleeding Disorders | | | | |
| Asthma, breathing problems | | | | |
| Behavioral, psychological | | | | |
| Cancer | | | | |
| Chronic Skin Disorders | | | | |
| Cystic Fibrosis | | | | |
| Deafness or Hearing Disorder | | | | |
| Diabetes | | | | |
| Digestive Disorders | | | | |
| Fracture or Bone/Joint Disorder | | | | |
| Frequent or severe infections | | | | |
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| High Cholesterol | | | | |
| Kidney Disease | | | | |
| Learning Disorders | | | | |
| Liver Disease | | | | |
| Mental Retardation | | | | |
| Migraine | | | | |
| Seizures | | | | |
| Significant Heart Murmur | | | | |
| Thyroid Disease | | | | |
| Tuberculosis | | | | |
| Unexplained Death | | | | |
| Urinary Tract Infections | | | | |
| Visual Disturbances | | | | |

**Please list any other problems or concerns the doctor should be aware of:**

_____

_____

**Parent or Guardian Signature** _____ **Date** _____

**Reviewed by:** _____ **Date** _____

# INSURANCE VERIFICATION FORM

The following information is needed to file your claim:

Policy Holder: _____

Date of Birth: _____

Employer: _____

Patient's Name: _____

Insurance Company: _____

ID Number: _____ Group Number: _____

Product Type: _____ HMO_____PPO_____POS_____EPO_____POS/PPO _____HMO/PPO

Claims Address: _____

Phone Number: _____

Co-Payment Amount: _____

Effective Date: _____

Parent's/Patient's Signature: _____ Date: _____

# Record Release

**Name of Patient** **Date of Birth**

**Please mark the box of the type of records you are requesting:**

☐ ALL Medical Records ☐ Billing Records ☐ Other: (Please specify) _____

**Reason for requesting records:**

☐ **Transferring to** Georgetown Pediatrics ☐ Transferring to Adult Doctor

☐ Moving ☐ Not Satisfied: **Transferring out** (***Please Specify Reason***) _____

## Becoming a Georgetown Patient?

**If transferring to Georgetown Pediatrics,** please provide previous PCP information to request medical records from:

**Name of Practice** _____**Phone #**_____**Fax#**_____

**Address** _____ **City** _____ **State**_____ **Zip**_____

## Transferring out or a Georgetown record request:

I authorize Georgetown Pediatrics to release my medical records as requested above. I understand there will be a $25.00 record fee for each child listed, for a **complete** copy of medical records (not including records originating from other medical facilities). I understand that I may be given a copy of my child(s) immunizations (3231) and/or hearing and vision (3300) at no charge. Please be advised a signature is required for ALL records requested. Once you transfer out of Georgetown Pediatrics, P.C., the records will be transferred to an off-site storage facility. If records are requested once transition has been made, it may take up to 30 days for us to retrieve the records from the facility and an additional charge will be assessed). We recommend that we mail your records to your home address so you may make a copy before providing them to your new physician. **By law your new physician is unable to release our records to you. If you are 18 years or older you must sign for your own records.**

## How would you like them delivered?

☐ Fax: _____ (charts over 50 pages cannot be faxed)

☐ I would like to pick up the records at: ☐ Dunwoody ☐ Cumming ☐ Johns Creek

☐ I would prefer to have my records mailed to the following address: _____

_____

## Signature: *(Valid Driver's License will be requested from parent or guardian BEFORE release of any medical records)*

_____ _____

Signature of Parent/Guardian or Patient (18 or older) Date completed by: (Georgetown Employee Signature) Date


11 Dunwoody Park
Suite 190
Dunwoody, GA 30338
(770) 392-6555 office
(770)392-6550 fax

416 Pirkle Ferry Road
Suite J300
Cumming, GA 30040
(770) 889-9142 office
(770) 889-7151 fax

6300 Hospital Parkway
Suite 125
Johns Creek, GA 30097
(770) 814-8883 office
(770) 814-8162 fax

# Consent To Treat Form

I hereby give authorization to the following named individuals to accompany my child/children for treatment at Georgetown Pediatrics, PC:

_____

_____

_____

_____

_____

This includes, but is not limited to, medical evaluation, treatment and administering of immunizations.

_____ _____

**(Parent Signature)** **(Date)**

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

# HIPAA Notice of Privacy Practices

_____(Name)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

**Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Workers' Compensations: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate to determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**
Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**
You may complain to us or to the Secretary of Health and Human Services. If you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____Date_____