Child 1: Last Name: ______________________________ First Name: _________________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ______________________ Policy ID#: _____________________Group #:________________________

Secondary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's SSN: ________-______-________

Insurance Carrier: ______________________ Policy ID#: ______________________Group #:_______________________

Child 2: Last Name: ______________________________ First Name: _________________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

Insurance Information

Primary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ______________________ Policy ID#: _____________________Group #:________________________

Secondary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's SSN: ________-______-________

Insurance Carrier: ______________________ Policy ID#: ______________________Group #:_______________________

Child 3: Last Name: ______________________________ First Name: _________________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: ___________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White/ Unknown

Insurance Information

Primary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ______________________ Policy ID#: _____________________Group #:________________________

Secondary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ____________________ Policy Holder's SSN: ________-______-________

Insurance Carrier: ______________________ Policy ID#: ______________________Group #:_______________________

Mailing Address: ____
(Street or PO Box) (City) (State & Zip)

Home Phone: (________) ___________ - ______________

Who lives at this household? ____

(Please note, this information is being requested to improve intake of your child's Social History.)

Contact Information

Contact 1: Name: ____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:________________________

Is this a cell phone? Yes / No Address: ____

Relation to Patient: ___________________________ Biological Relation to Patient: ______________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) ______ - ___________ Cell Phone: (____) ______ - ___________

Preferred Email: ____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Contact 2: Name: ____ Date of Birth: ____ / ____ / ____

Lives with patient? Yes / No If no, please list Contact's primary phone number:________________________

Is this a cell phone? Yes / No Address: ____

Relation to Patient: ___________________________ Biological Relation to Patient: ______________________

(Please note, this information is being requested to improve intake of your child's Family Medical History.)

Work Phone: (____) ______ - ___________ Cell Phone: (____) ______ - ___________

Preferred Email: ____ Home email / Work email (please circle)

How would this contact ideally prefer to be contacted regarding (circle one):

Medical Issues: Home Phone / Work Phone / Cell Phone / Email

Appointment Reminders: Home Phone / Cell Phone / Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Email

General Practice Notices: Home Address / Home Phone / Cell Phone / Email

Patient Portal Notifications: Cell Phone / Email

Emergency Contacts, other than parents: Name & Relationship

1: ___________________________ Relationship __________________ Phone: (___) _____ - _________

2: ___________________________ Relationship __________________ Phone: (___) _____ - _________

Additional Contact Questions:

Who should receive billing statements? ____

May all contacts have access to the patient's records electronically? Yes / No

If no, list who may have access

____

If parents are divorced or separated please fill out this section:
Who has custody? ____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

Interval History Information

Completed by: ____ Date Completed: ____________________

Allergy / Reaction Information

Medication Allergies: No: ______ Yes: ____ (explain below)

1: ____

(Medication) (Reaction)

2: ____

(Medication) (Reaction)

Non-Medication Allergies: None: ___ Yes (please list):____

Vaccine Reactions: None: ___ Yes (please list): ____

Current/Chronic Medications

1.

____

(Medication) (Dose) (Date Started)

2.

____

(Medication) (Dose) (Date Started)

3.

____

(Medication) (Dose) (Date Started)

4.

____

(Medication) (Dose) (Date Started)

Problem List

1.

____

(Diagnosis) (Date)

Details:

2.

____

(Diagnosis) (Date)

Details:

3.

____

(Diagnosis) (Date)

Details:

Pertinent Past Medical History

(check if Yes and provide details including date)

___ Serious Injuries Please list: ____

___Surgeries Please list: ____

___Hospitalizations Please list: ____

Pertinent Family Medical History:

____

____

____

____

____

Pertinent Social History:

____

____

____

____

____

Consent to Release Medical Records

1800 Northside Forsyth Dr. Suite 460 Cumming, GA 30041

770-888-8888 770-888-4502 fax

Please transfer the medical records of: **D.O.B**

____

____

____

<u>Requesting records from:</u>

Practice/Physician Name: ____

Address/Phone: ____

____

Fax Number: ____

Reason for transferring records

____

The signature below serves as authorization to transfer records. I understand that these records may include psychiatric, chemical, substance abuse, HIV, and AIDS information. I understand that I may withdraw this authorization in writing at any time, except to the extent that action has been taken on this authorization.

Since this patient is under the age of 18 years old, my signature serves as authorization.

Parent/Legal Guardian (Print name)____

Parent/Legal Guardian (Signature)_______________________________________Date____________

1800 Northside Forsyth Drive, Suite 460
Cumming, Ga 30041
Tel: (770)888-8888 Fax: (770)888-4502

Parent or Legal Guardian Consent Form

Patient Name: ____

Date of birth: _____/_____/_____

The following persons have my permission to accompany my child to appointments at Cumming Pediatric Group. I am aware that the office visits may include vaccinations, medications, referrals, or labs.

This form authorizes the following persons to receive information regarding my child's insurance or other medical care.

_____________________________________ Relation_________________________

_____________________________________ Relation_________________________

_____________________________________ Relation_________________________

Parent/Legal Guardian (Print Name)_________________________________

Parent/Legal Guardian (Signature)__________________________________ Date: ____________

1800 Northside Forsyth Drive, Suite 460
Cumming, Ga 30041
Tel: (770)888-8888 Fax: (770)888-4502

CONSENT TO TREAT

Permission is hereby given for patient __________________________, date of birth________________ to receive any medical/surgical procedures, x-rays, drug or laboratory tests, medication or exam as may be deemed necessary by the physicians. In case of a minor, the consent below is given on his or her behalf.

Please initial:

______ I hereby authorize Cumming Pediatric Group to obtain medical records from any other physician or medical facility necessary in the course of my child's treatment.

______ By signing this document, I acknowledge I have received and read the Cumming Pediatric Group Notice of Privacy Practices and Individual Rights.

______ I hereby authorize messages to be left on a voice mail system or answering machine concerning my child.

Parent/Legal Guardian (Print Name) ____________________________________

Parent/Legal Guardian (Signature)______________________________________ Date:_____________

Cumming Pediatric Group

Please initial each section indicating that you have read and understood our financial policy agreement.

Insurance Coverage

You must provide your insurance card or proof of insurance at the time of each visit. If you do not have your insurance, are unable to provide proof of insurance, or on a plan which we do not participate with, full payment is required at the time of your visit. .

It is very important that you become familiar with your insurance plan and understand its benefits. Some plans have restrictions on certain services and procedures that may not be covered in office. It is your responsibility to be aware of these restrictions. If you have any questions regarding your coverage then you need to contact your insurance company directly.

All co-payments, deductibles, and co-insurance fees are your responsibility. If certain procedures and services are not covered by your insurance, you are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay with in 90 days.

If you are self pay, you must pay in **FULL** at the time of service. We do offer a discount.

___________(initial)

Payment Methods

All co-payments are due at time of service. These fees can not be waived. For your convenience, we accept cash, checks, HAS/FSA cards, and all major credit cards.

**Please note, if you have a returned check, you may be charges a return check fee. Any unpaid balances may be sent to our collection agency.

___________(initial)

Referrals

If you are being referred to a specialist and your plan requires a referral, you are responsible for requesting the referral. The physicians may verbally refer you, but no hard copy will be sent without your request. Once services are rendered and a referral has been done, you are responsible for any fees not paid by your insurance company.

___________(initial)

Missed Appointments/Canceling Appointments

Missed appointments seriously disrupt the practice and inconvenience our patients. Therefore please call to cancel you appointment before the visit is missed. If you fail to show for an appointment, our policy requires that we charge a $25.00 fee by our billing department. If you accumulate multiple missed appointments without cancelation, you may be dismissed from the practice.

___________(initial)

Delinquent Accounts

A payment plan can be arranged with our billing department for past due amounts. Failure to pay or arrange payment of a past due amount will result in a referral to our collection agency. **A 25% fee is added to your total balance owed if your account is sent to collections**. In order to re-establish good standing with our practice, your past due balance will need to be paid in full.

___________(initial)

Medical Records Request

If you are requesting medical records to be sent to a specialist, there is no charge and we will forward them as a courtesy. If you are transferring to another practice to continue care, we will send records to you via our web portal, or to the new physician free of charge. If you want to pick up a full set of medical records there will be an $18.00 fee for one child, or a $28.00 fee for a family.

___________(initial)

*****The original copy of this financial policy will be kept on file for future references. If you would like a copy for your records, please ask the front desk to provide you with a copy.

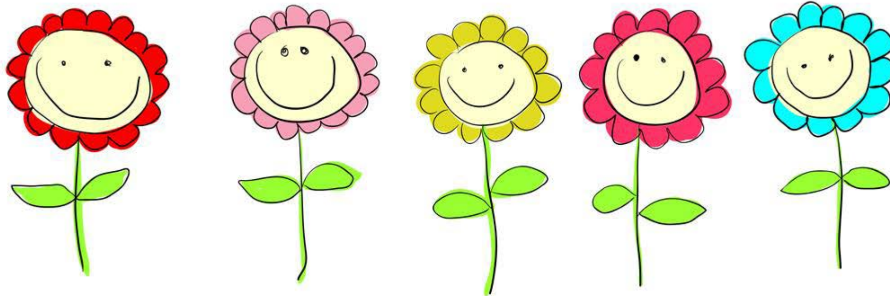
Cumming Pediatric Group

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _________________________, have received a copy of Cumming Pediatric Group's Notice of Privacy Practices.

Parent/Legal Guardian Signature______________________________ Date:____________________



Cumming Pediatric Group

HIPAA

Patient Confidentiality Notice

- Our practice is dedicated to maintaining the privacy of your child's health information. We are required by law to provide you with the notice of our policies that effect the information.

- We will use the data and information we collect to treat your child and will supply this information to those that are helping us diagnose and treat the patient.

- We will disclose this information to your health insurer and others who are responsible for payment of services that are rendered.

- We will disclose the patient's Protected Health Information (PHI) in the conduct of the business of this practice and as required by law to public health organizations, police, and law agencies.

- We will disclose you PHI to family members involved in your child's care, unless instructed not to do so.

- You have the right to request that we handle your PHI in a particular manner, such as instructing us to call your home rather than work, or requesting that we only speak to certain persons about your child's health. To request confidential communication, ask for more information at the front desk. You do not have to give us reason for this request.

- Patients have the right to inspect and obtain a copy of the PHI including medical records and billing records. A written request must be submitted and a small cost may be involved.

- You may ask us to amend the PHI if you believe they are incorrect. This request must be done in writing. If we deny the request, you may appeal and another health care professional will conduct the review. This applies only to records we have created and not records of other physicians.

- You have the right to have a printed copy of out Patient Confidentiality Notice. This can be obtained at any time from the front desk.

- If you believe your privacy rights have been violated, you may file a complaint with our Office Manager, Panayvee Khan MD, or with the Department of Health and Human Services.

This is your copy to keep.