Print Form

Atlanta Pediatric Partners
Patient Registration Form

Patient Information:

Patient Name Last First Middle	Date of Birth	Gender (Circle One) M F
Street Apt.	Patient's Social Security Number	
City State Zip	Home Phone Number	

Parent Information: Child lives with ? _____

Mother's Name Last First Middle		Father's Name Last First Middle	
Mother's Date or Birth	Mother's SS#	Father's Date of Birth	Father's SS#
Employer		Employer	
Business Number		Business Number	
Mobile Number		Mobile Number	
Mother's Email Address		Father's Email Address	

Referred By:

Name	Other

Emergency Contact:

Name	Phone Number

Primary Insurance:

Insurance Company Name:
Claims Address:
Name of Policy Holder:
Member Identification Number
Group Number

Revision Date: 8/13/2010

Who should correspondence regarding bills go to ? **Mother** ☐ or **Father** ☐
I authorize the release to my Insurance Company of any information required for processing claims. Research, chart reviews and quality control.

Signature _____ Date _____
(Guarantor, if minor)

I hereby assign payment directly to Atlanta Pediatric Partners, P.C. for medical benefits payable for these services. Although covered by insurance, I understand I am responsible for all charges unless covered by a managed care plan, Medicaid/Peach Care, or Worker's Compensation.

Signature_____ Date _____

As a responsible party for the above named patient, I authorize Atlanta Pediatric Partners. P.C to render necessary treatment in my absence. I authorize the release of any personal, demographic or medical information required to provide continuing and/or consultative medical care.

Signature _____ Date _____

I have agreed to let certain individuals participate in the discussion and decisions to my medical care. Therefore, I hereby give my permission for Atlanta Pediatric Partners, PC to disclose my personal medical information to the following individual (s):

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Conditions for Disclosure (Check the item(s) that apply):

- ☐ The practice may disclose my personal health information to the individual(s) above only in my presence.
- ☐ The practice may disclose my medical information to the individual(s) above in discussions during my presence and when I am not physically present, including disclosures by telephone, facsimile, email or regular mail.
- ☐ Other conditions of disclosure:

_____

_____

I understand that this consent may be revoked at any time by written notice to the practice.

Patient (parent's signature, if under the age of 18 yrs old) Signature:_____

Date:_____

Witnessed by:_____ Title/Position:_____

Print Name of Witness:_____ Date:_____

The Doctors and Staff of Atlanta Pediatric Partners Want You to Know How We will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, since April 14,2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

Give patients more control over their health information;

Set boundaries for the use and release of health records;

Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;

Hold violators accountable, with civil & criminal penalties; and

Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14,2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below confirming that a full version of the policy is readily available in the waiting room for review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our (Office Manager/Privacy Officer).

Thank you for your cooperation.

I acknowledge that a copy of the Atlanta Pediatric Partners Notice of Privacy Practices policy is available, if requested, and have been given an opportunity to ask questions.

Patient Name: _____
(Please Print)

Signature of Patient or Personal Representative:

_____Date: _____

If Personal Representative, give relationship to patient:

_____

Revision Date: 8/13/2010

ATLANTA
PEDIATRIC PARTNERS, P.C.

FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, Atlanta Pediatric Partners requires the co-payment or co-insurance specified by your insurance carrier. Cash, checks, money orders, credit/debit cards are all acceptable forms of payment.
- All co-payments are expected at the time services are rendered. The responsible party accompanying the child at the time of the visit is responsible for making the payment, regardless of which parent provides insurance coverage. If you are unable to make your co-payment at the time of the visit, your account will be charged a service fee equal to the amount of your co-payment. This payment will be due by or before the next office visit.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Patients who do not have insurance, or who cannot prove insurance coverage at the time of the visit are considered self-pay patients. APP will require you to complete and sign the *Self Pay Poli*cy form, which will be given to you prior to rendering services. Details of the policy appear in the form.
- Returned checks are subject to a handling fee of $25.00.
- Any delinquent balance over 120 days old will be turned over to an outside collection agency. In the event your account is turned over for collection, you will be billed and responsible for paying the balance, in addition to a $30.00 service charge. Once an account has been turned over to collections, your account must be paid in full before any future services are rendered.
- Bills and correspondence regarding bills are sent to the responsible party whose name is on the insurance card. Please notify our billing personnel if someone other than this person should receive copies of bills/correspondence.
- In cases where parents are divorced or legally separated, the adult seeking treatment is the one responsible for the co-payment and any bills related to that date of service. Both parents will be required to complete and sign a patient registration sheet and practice financial policy.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or those they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING

Signature:_____ Date:_____

(Patient and/or Responsible Party)

Revision Date: April 2010

Dear Parents,

We would like to inform you that the following services/procedures will be filed with your insurance company as a courtesy to you. We feel that the service we provide is not only medically necessary, but also essential to ensure we are continuously providing exceptional customer service. Some insurance carriers do not pay for these services. Please note that if your carrier does not cover these services, or if they are applied to your deductible, you will be responsible for the charges.

PROCEDURES INVOLVED, BUT NOT LIMITED TO, ARE AS FOLLOWS:

VISION AND HEARING WHEN DONE AS PART OF A PHYSICAL

URINALYSIS WHEN DONE AS PART OF A PHYSICAL

HEMOGLOBIN WHEN DONE AS PART OF A PHYSICAL

HEMOCULT

BLOOD STICK, GLUCOSE

DEVELOPMENTAL TESTING

ROCEPHIN INJECTIONS

DECADRON INJECTIONS

CHOLESTEROL SCREENING

HUMAN PAPILLOMAVIRUS VACCINATION (HPV)

TELEPHONE SERVICES

_____ _____

Signature of Parent/Guardian **Date**

Revised: 3/22/10

ATLANTA
PEDIATRIC PARTNERS, P.C.

Late Policy

- You are considered late if you arrive minutes after your appointment.
- You will receive a warning notice after each late appointment. If, after you have received three late notifications, you are late for the fourth time, you will be assessed a fee of $25.00 payable at the time of your visit. This fee must be paid before your child will be seen.
- If you receive a total of five notifications within a six month period, you will be dismissed from the practice. We will notify your insurance carrier.
- If your insurance company does not allow Atlanta Pediatric Partners, PC to assess a late fee, you will be dismissed from the practice after three late notifications. We will notify your insurance company.

No Show Policy

- You are considered a "no show" if you do not arrive for your scheduled appointment or you do not call to reschedule at least 24 hours before the appointment.
- If you are a no show for an appointment you will be assessed a fee of $25.00 at your next appointment.
- After three no "shows" within a six month period, you will be dismissed from the practice. We will notify your insurance company.
- If your insurance company does not allow Atlanta Pediatric Partners, PC to assess a "no show" fee, you will be dismissed from the practice after two "no shows". We will notify your insurance carrier.

By signing below, you agree to the late and no show policies of Atlanta Pediatric Partners, PC.

Signature_____ Date_____
Parent/Guardian

Revised: 9/2/10