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

Financial Policy

Thank you for choosing Atlanta Pediatric Partners (APP) for your child's healthcare. APP is committed to keeping your insurance and other financial arrangements made with us as simple as possible. To assist in meeting this goal, please read and follow the guidelines below.

For Patients With Insurance

· APP is a provider of medical services. We are not party to the contract made between you and your employer and/or your insurance company. Therefore, we encourage you to contact your insurance carrier personally in order to remain informed of your benefits. Please bring your current insurance information to each visit.

· If APP is not a participating provider listed on your insurance plan, payment in full is due today. (See APP's Self-Pay Discount Policy.)

· Since insurance plans cannot guarantee all eligibility or benefits, we cannot do so either. In those situations where the services APP provides are not covered by your insurance carrier, you will be responsible for any and all services over and above your insurance limits, as well as all non-covered medical services.

· **Co-payment or co-insurance** specified by your insurance carrier **is expected at the time services are rendered**. Cash, checks, money orders, credit/debit cards are all acceptable forms of payment.

· If you are unable to make your co-payment at the time of your child's medical visit, your account will be charged a **service fee of $30.00**. Both the co-payment and service fee are due prior to your next office visit.

· The responsible party (whether single, divorced or legally separated) accompanying the child at the time of his/her medical visit is the person responsible for making the co-payment as well as payment of any additional bills related to the medical service provided that date, regardless of who provides the insurance coverage.

· Bills and bill-related correspondence are sent to the responsible party whose name is on the insurance card. Please notify APP's billing office, 404-699-1339, if someone other than this person should receive copies of bills/correspondence.

· APP will process and file your insurance claims for medical services performed at our clinic at no cost to you.

· Any outstanding claims not paid by your insurance company within 60 days of billing will be due by the patient's responsible party.

For Patients Without Insurance

· Patients who do not have insurance or who cannot provide proof of insurance at the time of treatment, are considered self-pay patients. Please see APP's Self-Pay Discount Policy for details, including special discounts for payment in full at time of service.

For ALL Patients (With and Without Insurance)

· Any balance over 90 days old is considered delinquent and will be turned over to an outside collection agency. In the event your account is turned over to collection, you will be billed and are responsible for paying the balance, **plus a $30.00 service charge**. Once an account has been turned over to collection, your account must be paid in full before any future services are rendered.

· Returned checks are subject to a handling fee of $30.00.

If you have any questions about APP's Financial Policy, please discuss them with our business office, 404-699-1339. Thank you.
I have read, understand and agree to my financial responsibilities under this policy.

_____ _____

Parent/Guardian/ Responsible Party **Date**

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

Initial History Questionnaire

FORM COMPLETED BY _____ DATE COMPLETED _____

Name _____

ID NUMBER _____

BIRTH DATE _____ AGE _____

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain _____
Does your child have any serious illness or medical condition?	☐ Yes	☐ No	Explain _____
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain _____
Has your child had any surgery?	☐ Yes	☐ No	Explain _____
Has your child ever been hospitalized?	☐ Yes	☐ No	Explain _____
Is your child allergic to any medicines or drugs?	☐ Yes	☐ No	Explain _____

Development

Are you concerned about your child's physical development?	☐ Yes	☐ No	Explain _____
Are you concerned about your child's mental or emotional development?	☐ Yes	☐ No	Explain _____
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain	_____
Any other significant problem	☐ Yes	☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain	_____