Patient Registration

Patient Information

First Name:	Last Name:	Middle Initial:
DOB:	Gender:	Primary Number:

Address:

Street:	City:	State:	Zip:

The child lives with?

Mother's Information

First Name:	Last Name:	Middle Initial:
Employer:	Business Number:	Mobile Number:

Email:

Father's Information

First Name:	Last Name:	Middle Initial:
Employer:	Business Number:	Mobile Number:

Email:

Referred by

Name: Phone Number:

Emergency Contact

Name: Phone Number:

Primary Insurance

Insurance company name:

Claims Address:

Street: City: State: Zip:

Name of Policy Holder:

Member Identification Number:

Group Number:

Who should correspondence regarding bills go to? Mother Father

Secondary Insurance

Insurance company name:

Claims Address:

Street: City: State: Zip:

Name of Policy Holder:

Member Identification Number:

Group Number:

Who should correspondence regarding bills go to? Mother Father

I authorize the release to my Insurance Company of any information required for processing claims. Research, chart reviews, and quality control.

Date:

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

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.

Date:

Patient History Form

Household

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

Name:	Relationship To Child:	Birthdate :	Health Problems :
___________________	______________________	_______________	___________________ ___________________
___________________	______________________	_______________	___________________ ___________________
___________________	______________________	_______________	___________________ ___________________
___________________	______________________	_______________	___________________ ___________________
___________________	______________________	_______________	___________________ ___________________
___________________	______________________	_______________	___________________ ___________________

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

if the mother and father are not living together or if the child does not live with the 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 delivery: Vaginal? Cesarian? If cesarean why?

Was the baby born at term? Early? Late?

Did your baby have any problems right after birth? Yes No If, yes why?

Was initial feeding: Breast Bottle

Did the mother have any illness or problems with her pregnancy? Yes No

Did your baby go home with the mother from the hospital? Yes No If, not why?

During the pregnancy, did the mother:

Smoke Yes No

Drink alcohol Yes No

Use drugs or medications Yes No

If yes, what drugs or medications were used and when:

General

Do you consider your child to be in good health? Yes No If no explain:

Does your child have any serious illness or medical condition? Yes No If no explain:

Has your child had serious injuries or accidents? Yes No If no explain:

Has your child had surgery? Yes No If no explain:

Has your child ever been hospitalized? Yes No If no explain:

Is your child allergic to any drugs? Yes No If no explain:

Development

Are you concerned about your childs physical development? Yes No If no explain:

Are you concerned about your childs mental or emotional development? Yes No If no explain:

Are you concerned about your childs attention span? Yes No If no explain:

If your child is in school

How is their behavior in school?

Have they failed or repeated a grade in school?

How are they doing in academic subjects?

Are they in a special or resource class?

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:
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:
Epliepsy or convulsions	Yes	No	Who	Comments:
Alcohol Abuse	Yes	No	Who	Comments:
Drug Abuse	Yes	No	Who	Comments:
Mental Ilness	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 have they ever had::

Chickenpox Yes No

If yes, explain: Comments:

Frequent Ear Infections Yes No

If yes, explain: Comments:

Problems with ears or hearing Yes No

If yes, explain: Comments:

Nasal allergies Yes No

If yes, explain: Comments:

Problems with eyes or vision Yes No

If yes, explain: Comments:

Asthma, bronchitis, bronchiolitis, or pneumonia Yes No

If yes, explain: Comments:

Any heart problem or heart murmur Yes No

If yes, explain: Comments:

Anemia or a bleeding problem Yes No

If yes, explain: Comments:

Blood transfusion Yes No

If yes, explain: Comments:

Frequent abdominal pain Yes No

If yes, explain: Comments:

Constipation requiring doctor visits Yes No

If yes, explain: Comments:

Bladder or kidney infection Yes No

If yes, explain: Comments:

Bed-wetting (after 5 years old) Yes No

If yes, explain: Comments:

(For Girls) Has she started menstrual periods? Yes No

If yes, explain: Comments:

(For Girls) Are there problems with her periods? Yes No

If yes, explain: Comments:

Any chronic or recurrent skin problem (acne, eczema, etc) Yes No

If yes, explain: Comments:

Frequent headaches Yes No

If yes, explain: Comments:

Convulsions or other neurologic problem Yes No

If yes, explain: Comments:

Diabetes Yes No

If yes, explain: Comments:

Thyroid or other neurologic problem Yes No

If yes, explain: Comments:

Any other significant problem Yes No

If yes, explain: Comments:

Use of alcohol or drugs Yes No

If yes, explain: Comments:

Permission Form

I have agreed to allow certain individuals to participate in the discussion and decisions to my child/children's 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 Parent ____

Name ____

Relationship to Parent ____

Name ____

Relationship to Parent ____

Name ____

Relationship to Parent ____

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

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

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

Parent's Signature: ____

Date: _______________________

Billing Guidelines

Atlanta Pediatric Partners, PC billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the practice manager if you have any questions regarding this information.

- **Co-Pays**

  It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.

- **Co-Insurance/Deductibles**

  Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

- **Billing**

  As a courtesy, Atlanta Pediatric Partners bills your health insurance provider on your behalf, with the following guidelines/exceptions:

  - Insurance Card: It is critical that the most current insurance card is brought to every appointment. We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
  - Secondary Insurance: Atlanta Pediatric Partners bills Tricare and Medicaid from the secondary governmental plans
- **Combined Visits (well child exam and a sick visit)**

  If you are scheduled for a well child exam and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly

- **After Business Hours and Holiday Surcharge**

  Some health insurance providers bill a surcharge if you see your pediatrician after normal business hours or on a holiday.

- **Administrative Fees**

  Atlanta Pediatric partners charges various fees for the following items, which require personnel and resources to address:

  - Copies of medical records

    - Completion of additional school physical forms
    - Special request completion of camp or sports physical forms (free during the visit)
    - Completion of FMLA paperwork
    - Returned check (for insufficient funds): $25.00
    - **“No-show” Fee**: Assessed if you do not show up for a scheduled appointment and we do not receive a call at least 24 hours prior to the scheduled time: $25.00
    -
- Medical Record Copies
    - Copying cost per page (1-20) $0.97
    - Copying cost per page (21-100+) $0.83
    - Copying cost per page (100+) $0.66

-Maximum charge of $30.00 per individual plus postage costs.

-Maximum charge of $75.00 per family plus postage cost.

No Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That’s why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Atlanta Pediatric Partners, P.C. sends text messages, email reminders, as well as voice call to our patients in advance of their scheduled appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours’ notice.

If you do not cancel or reschedule your appointment with at least a 24-hour notification, you will incur a $25.00 “No Show” service charge to your account. This “No Show charge” is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no show to your appointment, our practice may decide to terminate its relationship with you.

I understand the “No Show” policy of Atlanta Pediatric Partners, P.C., and understand should I not give at least 24 hours’ notice then my account will be charged $25.00 per appointment. I understand I must cancel or reschedule at 24 hours in advance in order to avoid a potential “No Show” charge to my account.

Parent’s Signature: ____

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 healthcare providers, health insurance companies, and their claim processing staff. In general, HIPAA 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;
- Try to balance the need for individual privacy with the 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 Private 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.

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 arrangement made with us as simple as possible. To assist in meeting this goal, please read and follow the guidelines below.

For Patient with Insurance: APP is a provider of medical services. We are not a 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 insurance card to each visit.

If APP is not a participating provider listed on your insurance plan, then payment in full is due today. (See APP's Self – Pay Discount Policy). Since insurance plans cannot guarantee all eligibility or benefits, APP does not guarantee eligibility benefits. 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-payments or co-insurances: specified by your insurance carrier is expected at the time of services are rendered. Past due balances must be cleared prior to being seen by the physician. Cash, Checks, money orders, credit/debit cards are all acceptable forms of payment. Instamed is a secure and convenient option for patients to manage their healthcare payments.

The responsible party, the individuals named on the permission form (whether single, divorced or legally separated, friend or relative) accompanying the child at the time of his/her medical visit is the person responsible for making the co-payment and payment of past due balances, regardless of who provides the insurance coverage.

Bills and bill related correspondence are sent to the responsible party named on the insurance card. Please notify APP's billing office at (404) 699-1339, in advance, if someone other than this person should receive copies of bills/correspondences. 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 Patient 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 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 with our business office, (404) 699-1339. Thank you. I have read, understand and agree to my financial responsibilities under this policy.

Parent's Signature: ____

Date: _________________________

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below

Person or entity requesting the information and authorized to make the requested use or disclosure: **Atlanta Pediatric Partners, P.C. 4579 S. Cobb Dr SE, Suite 300, Smyrna GA 30080**

Continuation of Medical Care

This authorization shall remain in effect from the date signed below and for up to 90 days thereafter. I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for the research-related treatment)
- If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Parent's Signature: ____

Date: _________________________