

REGISTRATION FORM

Please PRINT and complete ALL sections

PATIENT'S INFORMATION

PATIENT'S NAME:					What do you want us to call you? (Alias)
_____		_____		_____	
<i>LAST</i>		<i>First</i>		<i>Middle</i>	
Patient's Date of Birth ____/____/____	Age _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	NATIONALITY _____	Patient's Social Security Number (SSN) - - - - -	
Street Address (Not P.O. Box)		Apt #	City	State	Zip Code
HOME TELEPHONE NO. () - - - - -					

FINANCIALLY RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN)

RELATIONSHIP: SON DAUGHTER OTHER _____

NAME: (Parent/Guardian)		Parent or Guardian's Address (if different from above) <input type="checkbox"/> SAME		Email Address:	
				Consent for Email Communications: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOME TELEPHONE NO. () - - - - -	WORK TELEPHONE NO. () - - - - -	MOBILE/CELL PHONE NO. () - - - - -	Fin. Responsible Party SSN - - - - -	Fin. Responsible Party DOB / /	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST)

PRIMARY Insurance Policy Holder's Name		Policy Holder's SSN - - - - -		Policy Holder's Birth Date ____/____/____	
Name of Insurance Company		Insurance Company Address			Co-Payment Amount \$ _____
Insurance Policy #	Group #	Effective Date	Relationship to Patient		
SECONDARY Insurance Policy Holder's Name		Policy Holder's SSN - - - - -		Policy Holder's Birth Date ____/____/____	
Name of Insurance Company		Insurance Company Address			Co-Payment Amount \$ _____
Insurance Policy #	Group #	Effective Date	Relationship to Patient		

PARENT INFORMATION

Father's Name:		Mother's Name:	
Address		Address	
City	State/Zip Code:	City	State/Zip Code:
Tel:(Home)	Tel:(Cell)	Tel:(Home)	Tel:(Cell)
Employer:		Employer:	
Occupation:		Occupation:	
SSN:	DOB:	SSN:	DOB:

REFERRAL SOURCE _____ How did you hear about us?

EMERGENCY CONTACT (Not living at the same address)

Name:		Address:			
City:	State:	Zip Code:	Relationship to Patient		
Tel:(Home)	Tel:(Work)	Tel:(Cell)	INDICATE PREFERRED NUMBER TO CALL <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL		

Assignment of Benefits - Financial Agreement

The above information is true to the best of my knowledge. I authorize PRIMECARE PEDIATRICS (PCP) to provide my child with medical care. I hereby give lifetime authorization to the insurance company or any third party payer to pay any benefits due directly to this office on any claim. I also authorize PCP or the insurance company to release any information required to process my claims. I agree to forward to PCP all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES. I have read and agree to the terms of the PCP Notice of Privacy Practices, Financial Responsibility and Billing Policy and No Show Policy. These authorizations remain in effect indefinitely unless revoked by me in writing. A photocopy or fax of this signed form is considered as valid as the original.

X _____
PARENT/GUARDIAN SIGNATURE

X _____
DATE

PAST MEDICAL AND SOCIAL HISTORY

(Attach a separate sheet for details if necessary)

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: _____

MEDICAL DIAGNOSIS: (List all diagnosis or conditions pertaining to your child if any): _____

PRESENT HEALTH CONCERNS: (If any) _____

MEDICINES:(Please list all medications your child is taking): _____

ALLERGIES: (Please list all) _____

PREGNANCY & BIRTH: Where was your child born? _____

Child is yours by: Birth Adoption Stepchild Other: _____

Was he child born premature? NO YES If premature, how early? _____

Please indicate any medical problems during pregnancy _____ NONE

Please indicate any medical problems during the Baby's newborn period _____ NONE

NUTRITION & FEEDING: Any unusual feeding/dietary issues? NO YES (Please specify) _____

SLEEP: Any sleep problems? NO YES (Please specify) _____

DEVELOPMENT: Any concerns? NO YES (Please specify) _____

At what age did your child: Sit alone _____ Walk alone _____ Say words _____ Toilet train (daytime) _____

Girls only: Age at first menstrual period _____ years old

DENTAL HISTORY: Does your child see a Dentist? NO YES. If yes, how often? _____ Date of last visit _____

IMMUNIZATIONS: (Please present your child's immunization records).

Is your child up to date on his/her immunizations? YES NO

Any previous immunization reactions? NO YES (Please give details) _____

PAST MEDICAL HISTORY: (Please describe any major past medical problems and their dates)

Previous Hospitalizations and Dates: _____

Previous Surgeries/Procedures and Dates: _____

SOCIAL HISTORY: Child's Parents are Married Unmarried Separated Divorced.

If divorced or separated, who has custody? _____

Who does your child live with? _____

CHILD CARE SITUATION: PARENT(S) Day-Care Baby-Sitter Others: (Please specify) _____

SCHOOL HISTORY: Does your child currently attend School or Pre-school? NO YES

Name of School _____ Current grade _____

Any concerns about school performance? NO YES (Please specify) _____

PETS: (List all pets) _____

FAMILY HISTORY

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Problem												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth Defect												
Heart Attack/Heart Disease												
Depression												
Diabetes, on insulin shots												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Retardation or Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56 for reason not listed above												
Other: <i>(please specify)</i>												

HOME SITUATION: Please list all those who live at home with the child.

	Name (Last, First)	Age	Sex	Relationship	Highest Education Level
1			M F		
2			M F		
3			M F		
4			M F		
5			M F		
6			M F		
7			M F		

PLEASE LIST ALL PERSONS, APART FROM PARENTS, ALLOWED TO BRING CHILD FOR TREATMENT (if any)

1			M F		
2			M F		
3			M F		

PRIMECARE PEDIATRICS

15A Baynard Park, Newnan, GA 30265

Phone: (770) 251-5253; Fax: (770) 251-5254

**HIPPA COMPLIANT AUTHORIZATION
FOR THE RELEASE OF PATIENT INFORMATION**

PATIENT'S NAME: *(Last, First, Middle Initial)*

DATE OF BIRTH:

I hereby request and authorize the release and disclosure of all health information by:

 [Name of Person or Facility required to release information]

Address: _____
 Street City State/Zip Code

Tel: (____) _____ - _____

Fax: (____) _____ - _____

The purpose of this release is *(check all applicable)*

- Continuity of Care
- Change of locality
- Moved out of state
- At the request of parent/guardian
- Other *(state reason)* _____

TO PRIMECARE PEDIATRICS

[Check one box only]

FROM PRIMECARE PEDIATRICS

Information Requested *(Please mark box to indicate all items to be released)*

From Date _____ To Date _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Full Medical Records | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Health Physical Forms |
| <input type="checkbox"/> Problem List | <input type="checkbox"/> List of Medications | <input type="checkbox"/> List of Allergies |
| <input type="checkbox"/> AIDS/HIV Information | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> X-ray and Imaging Reports |
| <input type="checkbox"/> Mental Health information | <input type="checkbox"/> Genetic testing information | <input type="checkbox"/> Drug/Alcohol abuse, diagnosis, treatment |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Doctor's Notes | <input type="checkbox"/> Other <i>(specify)</i> _____ |
| <input type="checkbox"/> Chart <i>(Chart summary, immunization record, growth charts, problem list, list of medication and allergies)</i> | | |

EXPIRATION OF AUTHORIZATION:

Unless otherwise revoked in writing, this Authorization expires on _____ *(insert applicable date or event).*

If no date is specified or indicated, the Authorization will expire in 12 months from the date of signing.

PrimeCare Pediatrics, PC will not charge for copies of Immunizations Records or a Medical Summary. We charge a minimum fee of \$5.00 for Forms 3231, 3300, 3189, or College Immunization Forms and a minimum fee of \$15.00 for forms that require a doctor's review such as, but not limited to, Sports, Camp, College, or Physical Forms. We charge a minimum fee of \$25.00 for full medical records for the first request and a minimum fee of \$15.00 for each additional requests (for the first ten pages), and \$1.00 per page after that, per child. All requests must be made by signing the proper form by an authorized party. In each instance, the applicable fee is due and payable on the day the request is made.

I understand that I do not have to sign this authorization in order to receive treatment from PrimeCare Pediatrics, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: PrimeCare Pediatrics, P.C., 15A Baynard Park, Newnan, GA 30265.

A photo or fax copy of this consent shall be considered as valid as the original.

X _____
 Name of Parent/Legal Guardian
 (Photo ID Required)

X _____
 Signature

X _____
 Date

*****If unable to sign, please document reason*****

POLICIES AND AUTHORIZATION

RECEIPT OF NOTICE OF OFFICE PRIVACY POLICY

I, the undersigned, acknowledge that PRIMECARE PEDIATRICS will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices (HIPPA).

I assign the benefits payable for services to PRIMECARE PEDIATRICS and its Physicians. I acknowledge that I have been given the PRIMECARE PEDIATRICS Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official or Practice Administrator.

Parent or Guardian's Initial: X _____

FINANCIAL POLICY

Patients and/or guarantors are responsible for charges incurred. It is a courtesy for our office to file charges to your insurance for services rendered, however you are responsible for your co-pay, deductible and/or any percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 45 days you are responsible for the balance due. It is also the parent or guardian's responsibility to make sure that requested services are covered by their insurance policy at time of service. If coverage is not obtained from insurance company before the visit, the parent or guardian is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable, including collection costs and/or attorney fees.

Coordination Of Benefits (COB): The responsible party must respond to the request for information from the health insurance company within 10 business days. This is in the interest of the responsible party to facilitate the processing of any health insurance benefits on their account, and serves to prevent their account from becoming over-due or delinquent. A failure to respond to a request for COB information from the health insurance company will result in all charges becoming the responsibility of the patient, and or responsible party.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf to be paid directly to PRIMECARE PEDIATRICS and it's physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits.

Parent or Guardian's Initial: X _____

"NO-SHOW" POLICY

PrimeCare Pediatrics requires a 24-hour advance notice of cancellation or change of an appointment for a well-check, sports or any physical, and at least 3 hours' notice of cancellation for a sick visit. PrimeCare Pediatrics will assess a fee of \$25 for "no-show" any time a patient/responsible party fails to notify it in advance of a "no-show", cancellation or change of appointment as required.

Parent or Guardian's Initial: X _____

RETURNED CHECKS

PrimeCare Pediatrics does not accept personal checks. Occasionally this privilege may be extended to anyone solely at the discretion of the Practice Administrator. Any checks returned to PrimeCare Pediatrics for insufficient funds (NSF) will incur a \$25 charge. It is the responsibility of the check issuer to pay, by cash or credit card, both the check amount and the \$25 charge immediately. A failure to respond to PrimeCare Pediatrics within 10 business days will result in the NSF check and charge being turned over to the collection agency. Check signer/issuer will also be responsible for all collection agency costs and or attorney fees.

Parent or Guardian's Initial: X _____

CONSENT TO TREAT

I authorize the providers at PRIMECARE PEDIATRICS to provide such care and administer such treatment, as they may deem advisable for the diagnosis and treatment of my child. I certify that I have been made aware of the role and services offered by the physicians, physician assistants and nurse practitioners and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Parent or Guardian's Initial: X _____

VACCINE ADMINISTRATION

I hereby authorize PRIMECARE PEDIATRICS to administer all immunizations to my child from time to time as determined by the American Academy of Pediatrics. This authorization will remain in effect unless revoked or modified by me in writing.

I CONSENT

I DO NOT CONSENT

Parent or Guardian's Initial: X _____

IF YOU DECLINE IMMUNIZATIONS, YOU MUST ASK FOR AND SIGN THE REFUSAL OF IMMUNIZATION FORM.

I certify that I am acting on behalf of my minor child and that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

A fax or photocopy of this consent shall be considered as valid as the original.

X _____ X _____ X _____ X _____
Name of Parent/Guardian Signature Relationship to Child Date

You can also request additional copies of our Privacy Policy or all of our other office policies from the Practice Administrator, or download a copy from our website.

Please visit our website www.primecarepeds.com for more details. Policies are subject to change without notice.

[PATIENT COPY]

PRIMECARE PEDIATRICS

15A Baynard Park, Newnan, GA 30265
Phone: (770) 251-5253; Fax: (770) 251-5254

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED PURSUANT TO FEDERAL REGULATIONS. PLEASE REVIEW IT CAREFULLY.

At PrimeCare Pediatrics (PCP), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by PCP.

This Notice will tell you about the ways in which PCP may use and disclose medical information about you, referred to below as protected health information ("PHI"). This Notice also describes your rights and certain obligations PCP has regarding the use and disclosure of PHI.

As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy.

What is HIPPA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPAA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?

Any health information you provide, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our front office informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. Copies are available and you can ask for a copy of the current notice at any time.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different ways in which we may use and disclose your IIHI, without obtaining written authorization from you.

- Treatment
- Appointment Reminders

- Release of information to family/friends
- Payment
- Treatment Options
- Disclosures Required by Law
- Healthcare Operations
- Health related benefits & services

The following categories describe unique situations in which we may use or disclose your identifiable health information:

- Public risks
- Health oversight activities
- Lawsuits
- Law enforcement
- Deceased patient's organ and tissue donation
- Serious health threats/safety
- Research

What are your rights concerning your individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communication
2. Requesting restrictions
3. Inspection and copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide and authorization for other uses

Right to Copy of Notice. This is a brief copy of the HIPAA Notice of Privacy Practices. You have the right to receive a paper copy of this notice upon request. You can review a full copy of this notice at our Web site, www.primecareped.com. To obtain a paper copy of this notice, please contact the Privacy Officer at (770) 251-5253.

Right To File A Complaint. You may complain to PCP if you believe your privacy rights with respect to your PHI have been violated by contacting the Privacy Officer, or Practice Administrator, 15A Baynard Park, Newnan, GA 30265 and submitting a written complaint.

If you have any questions regarding this notice, or our health information privacy policies, or need a full version of this notice, please contact:

The Practice Administrator,
PrimeCare Pediatrics
15A Baynard Park
Newnan, GA 30265.
(770) 251-5253

[PATIENT COPY]

PRIMECARE PEDIATRICS

15A Baynard Park, Newnan, GA 30265
☎ Phone: (770) 251-5253; 📠 Fax: (770) 251-5254

OFFICE POLICIES

FINANCIAL AND INSURANCE POLICY

PrimeCare Pediatrics requires that you provide all current health insurance information each time for your appointment. We may decline to make an appointment without reasonable proof of coverage or ability to pay for services. PrimeCare Pediatrics will verify coverage and confirm that PrimeCare Pediatrics or Dr. Tega is the primary care physician of record. The responsible party must inform PrimeCare Pediatrics of any changes in coverage for existing patients prior to scheduling an appointment. All current patient balances are to be paid prior to scheduling an appointment. We collect ALL co-pays at check in, prior to services being rendered. It is the policy of PrimeCare Pediatrics to also collect ALL amounts that is the patient's responsibility, such as coinsurances, deductibles, non-covered procedures and tests, on the day of service based on the insurance company allowable. Any non-Medicaid patient qualifying for "Vaccines for Children" must pay for immunizations given on the day of service at check out. Uninsured patients, or persons who are self-pay, are required to pay a stipulated amount at check-in. The balance is due for all services on the day of service. It is the policy of PrimeCare Pediatrics to mail as few patient statements as possible, in an effort to reduce healthcare costs. Responsible parties are encouraged to mail ALL payments directly to PrimeCare Pediatrics upon receiving the Explanation Of Benefits (EOB) from their health insurance company. PrimeCare Pediatrics will mail one statement in an effort to collect the patient due. If 30 days after the generation of the first statement it is necessary for PrimeCare Pediatrics to mail a second statement because no payment was received, the account is considered over-due and an interest charge of a flat 12% of the balance, but not less than \$5, will be added to the account. If no payment is received 10 business days after the mailing date of the second statement, the account will be declared delinquent and turned over to the collection agency. All accounts turned over to the collection agency will also be responsible for the collection agency fees. No appointments will be made for any children of the responsible party while the account is delinquent or with the collection agency.

Coordination Of Benefits (COB): The responsible party must respond to the request for information from the health insurance company within 10 business days. This is in the interest of the responsible party to facilitate the processing of any health insurance benefits on their account, and serves to prevent their account from becoming over-due or delinquent. A failure to respond to a request for COB information from the health insurance company will result in all charges becoming the responsibility of the patient, and or responsible party.

RETURNED CHECK POLICY

PrimeCare Pediatrics does not accept personal checks. Occasionally this privilege may be extended to anyone solely at the discretion of the Practice Administrator. Any checks returned to PrimeCare Pediatrics for insufficient funds (NSF) will incur a \$25 charge. It is the responsibility of the check issuer to pay, by cash or credit card, both the check amount and the \$25 charge immediately. A failure to respond to PrimeCare Pediatrics within 10 business days will result in the NSF check and charge being turned over to the collection agency. Check signer/issuer will also be responsible for all collection agency costs and or attorney fees.

NO-SHOW POLICY

- A. **ROUTINE WELL VISITS:** PrimeCare Pediatrics requires a 24-hour advance notice of cancellation or change for a well-check, sports or any physical. PrimeCare Pediatrics will assess a fee of \$25 for "no-show" any time a patient/responsible party fails to notify it in advance of a "no-show", cancellation or change to a well-check, sports, or any physical appointment, as required.

- B. **SICK VISITS:** PrimeCare Pediatrics requires a reasonable advance notice of cancellation or change for a sick-visit. PrimeCare Pediatrics will also assess a \$25 "no-show" fee any time a patient/responsible party fails to notify it at least 1 hour prior to a sick or recheck appointment. This allows the scheduling department to try to give the appointment to another family that has a child that needs to be seen. When a "no-show" fee is incurred, the responsible party is encouraged to mail the payment directly to PrimeCare Pediatrics, or make the appropriate payment directly at our office. It is the policy of PrimeCare Pediatrics to mail one statement in an effort to collect the "no-show" fee. If 30 days after the generation of the first statement it is necessary for PrimeCare Pediatrics to mail a second statement because no payment has been received, the account is considered over-due and an interest charge of a flat 12% of the balance, but not less than \$5, will be added to the account. If no payment is received 10 business days after the mail date of the second statement, the account will be declared delinquent and turned over to the collection agency. All accounts turned over to the collection agency will also be responsible for the collection agency costs and or attorney fees, if applicable.
We will not be able to make any appointments for any child or children belonging to the family of the responsible party while the account is delinquent or with the collection agency.

We will not be able to make any appointments for any child or children belonging to the family of the responsible party while the account is delinquent or with the collection agency.

Please visit our website www.primecareped.com for more details. Policies are subject to change without notice.