PRIMECARE PEDIATRICS

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

[Established Patient]

DEMOGRAPHICS UPDATE FORM

Please PRINT clearly and complete ALL sections

PATIENT'S INFORMATION

PATIENT'S NAME: _____ (LAST) _____ (First) _____ (Middle)

What do you want us to call you? *(Alias)* _____

Patient's Date of Birth	Age	Sex	NATIONALITY	Patient's Social Security Number (SSN)
_____/_____/_____		☐M ☐F		- -

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)* ☐**SAME** | Email Address: Consent for Email Communications: : ☐**Yes** ☐**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
			☐**HOME** ☐**WORK** ☐**CELL**

Assignment of Benefits · Financial Agreement

The above information is true to the best of my knowledge. I authorize PRIMECARE PEDIATRICS (PCP) to provide the child named above 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 all 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 ALL CHARGES AT TIME OF VISIT, now and in the future. These charges may include co-pays, deductibles and other fees not covered by my insurance. I am also responsible for any and all collection costs on my account. 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

OFFICE 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 according to the American Academy of Pediatrics immunization schedule. This authorization will remain in effect and active unless revoked or modified by me in writing. ***(Please see our Immunization Policy).***

☐ **I CONSENT**

Parent or Guardian's Initial: X_____

IF YOU DECLINE IMMUNIZATIONS, YOU MUST SIGN THE REFUSAL OF IMMUNIZATION FORM, AND WE MAY NOT BE ABLE TO ACCEPT YOUR CHILD AS A PATIENT IN OUR PRACTICE.

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.