Patient Registration *(Pediatric)*

Patient Information

Date _____ Chart # _____

Patient _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Mother/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Father/Guardian _____ DoB___/___/___ SS# _____

Address _____ Home Phone _____

City/State/Zip _____ Occupation _____

Employer _____ Work Phone _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Sibling _____ Sex: ☐M ☐F DoB___/___/___ SS# _____

Children live with: ☐ Mother ☐ Father ☐ Guardian _____

Emergency Contact Person _____ Relation _____ Phone _____

Party Responsible for Payment of Medical Services: ☐ Father ☐ Mother ☐ Guardian ☐ Both _____

Who referred you to our office? _____

How did you hear about our practice? ☐ Referral _____ ☐ Friend/Family ☐ Phone Directory ☐ Internet ☐ Newspaper ☐ Magazine ☐ Other _____

Insurance Information

Primary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____ Co-payment $ _____

Name of Insured _____ DoB___/___/___ Relation _____

Medicaid/Champus/Other _____ Current Card # _____

Physician Listed on Card _____ Phone _____

Authorization of Treatment and Assignment of Benefit

I authorize _____ to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to _____ for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care or immunizations cannot be given unless my child is accompanied by one of the following: _____

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature _____ Relationship _____ Date _____

Witness' signature _____ Date _____

☐ I prefer to do my own insurance filing. Signed _____ Date _____

HIPAA Authorization Statement

Complete and sign the section on the back regarding confidential release of information.

500-41
Rev. 7/08

Please complete the following so that we may contact you properly and securely.

- Please list the family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

  Name_____
  Phone_____
  Name_____
  Phone_____

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

  Name_____
  Phone_____
  Name_____
  Phone_____

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

  _____
  _____
  _____

- Please print the telephone number where you want to receive calls about your appointments, lab and X-ray results, or other health care information if other than your home telephone number.

  _____
  _____
  _____
  _____

  Please be aware that a cell phone is not a secure and private line.

- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL". ☐ Yes ☐ No

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

_____
PATIENT NAME *print* (Parent / Guardian, if under 18 years)

_____ Date _____
PATIENT SIGNATURE (Parent / Guardian, if under 18 years)

Notes

New Patient Record

Today's Date ___/___/___ Chart No. _____

Drug Allergies and Important Diagnoses

Drug Allergies: ❑ yes ❑ no _____

Illness/Injury _____

Patient's Name _____ DOB ___/___/___ Sex: ❑ M ❑ F

Parent (s)' Name _____ Phone No. (H) _____

Home Address (street, city, state) _____

Employer _____ Phone No. (W) _____

Referred by _____ Address _____

Current Medical History

Is your child having any medical problems? ❑ yes ❑ no

_____

_____

_____

_____

Maternal and Newborn History

Pregnancy (Check problem areas.)

- ❑ Excessive wt. gain
- ❑ Excessive swelling
- ❑ Toxemia
- ❑ Urinary Tract Infection
- ❑ Rubella (3 day measles)
- ❑ Venereal Disease

❑ Other _____

_____

Birth Delivery: ❑ Vaginal ❑ Caesarean Section

_____

Baby was ❑ full term ❑ premature Birth Wt. _____

Was labor difficult or prolonged? ❑ yes ❑ no

Was delivery difficult or complicated? ❑ yes ❑ no

_____

_____

Newborn ❑ Breast ❑ Formula _____

- ❑ Feeding problems
- ❑ Colic
- ❑ Recurrent vomiting
- ❑ Recurrent diarrhea
- ❑ Multiple formula changes
- ❑ Blood in stools
- ❑ Slow weight gain
- ❑ Jaundice

❑ Other _____

History Update

_____

_____

_____

Family Medical History

	Age	Good Health	Poor Health	Deceased
Father	____	_____	_____	____
Mother	____	_____	_____	____
Brother (s)	____	_____	_____	____
Sister (s)	____	_____	_____	____
Gr. Parent (s)	____	_____	_____	____

_____

_____

_____

Check if patient (P) or a member of the family [father (F), mother (M), siblings (S) or grandparents (G)] have had the following illnesses or problems. *List the appropriate initial after each.*

- ❑ Allergies _____
- ❑ Allergy shots _____
- ❑ Drug allergies _____
- ❑ Asthma _____
- ❑ Eczema _____
- ❑ Frequent respiratory infections _____
- ❑ Chronic cough, recurrent fever weight loss, night sweats, blood in sputum _____
- ❑ Tuberculosis _____
- ❑ Ear tubes _____
- ❑ Anemia or blood disorders _____
- ❑ Stomach or intestinal problems _____
- ❑ Diabetes _____
- ❑ Growth problems _____
- ❑ Seizures _____
- ❑ Cholesterol problems _____
- ❑ High blood pressure _____
- ❑ Heart attack or stroke before 55 years of age _____
- ❑ Cancer _____
- ❑ Hereditary problems _____
- ❑ School problems _____
- ❑ Emotional or behavior problems _____
- ❑ Alcohol or drug abuse _____
- ❑ Mother used alcohol or recreational drugs during pregnancy. _____

_____

_____

_____

_____

_____

_____

Do you have any other concerns? ❑ yes ❑ no (List on back)

Signed _____ Date ___/___/___

CHILDREN FIRST PEDIATRICS

101 Beckett Lane, Suite 502, Fayetteville, GA 30214

OFFICE VISIT TREATMENT AUTHORIZATION FORM

The following listed person(s) have my authorization to bring my children to the office of **Children 1st Pediatrics** for medical treatment.

I understand that it is my responsibility to inform those authorized below of any and all pertinent issues regarding my child's need for medical treatment in my absence.

Parent/Guardian – Emergency Contact phone: **(____)**_____

_____ _____

Parent/Guardian Signature: **Date:**

_____ _____

Witness: **Date:**

==========

Child/Children	**Birth Date/ Drug Allergies**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

Authorized Person(s)	**Relationship to Patient**
1._____	_____
2._____	_____
3._____	_____
4._____	_____

CHILDREN 1ST PEDIATRICS
101 Beckett Lane, Suite 502
Fayetteville, GA 30214

Office Policy

We at Children 1st Pediatrics would like to take this opportunity to welcome new patients to the practice and to thank our returning patients. To avoid confusion regarding our current policies, please review the following and sign below. A copy will be provided for your records.

1. Co-payments are due at the time of service. If the copay is not paid at this time, an administrative fee of $15.00 will be charged in addition to the copay amount due.
2. If you are without insurance or minimally insured, or subject to a deductible, payment is due at the time of service. If payment arrangements are allowed, these arrangements must be made **prior to** your child being seen. We accept checks, debit cards, Visa, MasterCard, American Express and Discover for your convenience. These are processed electronically.
3. If you have insurance coverage, private or Medicaid, you must present your current card prior to being seen. If we are unable to verify coverage or if your child is not eligible, you will be responsible for. full payment at the time of service.
4. Whoever brings your child to the office is responsible for payment. This includes babysitters and other caretakers.
5. Know your insurance coverage! We do our best to verify your coverage and benefits before you are seen. However, this verification is NOT a guarantee of coverage and if at anytime your insurance company refuses payment for your child's services, you are then responsible for payment. You should know if you have well child coverage, if your insurance requires a referral, and if you are seeing an in or out of network physician. You also should know if your insurance will cover a visit to Urgent/Immediate Care instead of an emergency room.
6. If one of our physicians refers your child to the emergency room or urgent care, please contact our office **the next business day.** We will complete a referral with your insurance company when you call and advise the front office of your child's emergency room visit.
7. If you are sent to a specialist and your insurance requires a referral, please contact the front office **once you have the appointment scheduled.** We often need 3 —*5* business days to obtain authorization from the insurance company, and to complete the referral.
8. In order to ensure that each parent has the opportunity to make an appointment and have his or her child seen, there will be a **$30.00 charge for a missed appointment unless cancelled 24 hours in advance.**
9. Should you need a copy of your child's medical records, there is a charge for this service. This information is posted in the office and a copy is available upon request.

We appreciate your cooperation. If you have any questions or need assistance with your account, please feel free to contact the insurance coordinator or front office personnel.

By signing below, I acknowledge that I have read this information and have been provided a copy of the same for my records.

_____ _____

Parent/Guardian's Signature **Date**

Revised: 01/15/2014

COORDINATION OF BENEFITS FORM

PATIENT NAME: _____

MEMBER ID#: _____

DATE OF SERVICE: _____

Dear Patient:
Your insurance company contract has a Coordination of Benefits Provision. Coordination of Benefits (COB) prevents duplicate payment for the same covered health expense; thus helping to control the cost of coverage. ,

This provision applies when a member is covered under more than one group health plan. Your insurance company needs you to confirm whether you (or a family member) have other medical coverage. -

FAILURE TO DISCLOSE ANY OTHER INSURANCE COVERAGE FOR THIS PATIENT MAY RESULT IN DISMISSAL PROCEEDINGS FROM THIS PRACTICE.. NON-DISCLOSURE OF ADDITIONAL COVERAGE IS CONSIDERED **FRAUD** BY THE INSURANCE COMPANY INDUSTRY, AND YOU MAY BE DISMISSED FROM THE PRACTICE.

Is your spouse or any dependent employed?_____ If yes by whom?_____

Do you or your family members have other medical coverage? YES_____NO_____

If NO, the form is completed, please sign below and date the form. If YES, please continue.

==========

Is this coverage through employment? YES:_____ NO:_____

Insured Name/SSN#: _____

Employer Name/Phone#: _____

Policy Name/Phone#: _____

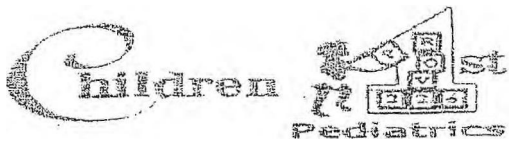
When did coverage begin? _____

Signature: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____



101 Beckett Lane, Suite 502
Fayetteville, Ga. 30214
678-817-1000

PATIENT PRIVACY ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding Children First Pediatrics Privacy Practices

Patient's name:_____Date of birth: ____/____/____SSN:_____

I understand that the patient's health information is private and confidential.
I understand that Dr. Valarie Wright Manley and her staff work very hard to protect the patient's privacy and preserve the confidentiality of the patient's health information.

I understand that Dr. Valarie Wright Manley's office may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payments, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission These situations are very unusual. One example would be if a patient or patient's parent threatened to hurt someone.,

Children First Pediatrics, PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available in the waiting room. I understand that I have the right to read the "Notice" before signing this Acknowledgment. I may also request a copy to take home.

Children First Pediatrics, PC may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Dr. Valarie Wright Manley's staff will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures are required by law; knowing in what ways my records are used by this practice; understanding how this office protects my privacy (for example rules regarding our sign-in sheet); and requesting communication be by specified methods of communications or alternative location.

Children First Pediatrics, PC has established procedures, which help them, meet their obligations to patients. These procedures may include other signature requirements, written 'acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Children First Pediatrics, PC by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Children First Pediatrics PC "Notice of Privacy Practices".

_____ _____ _____
Patient or legally authorized **individual** signature Date Time

_____
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)