ROSWELL PEDIATRIC CENTER, P.C.

Family Information Form

Children's Information **Date:**__________

Name:______________________________ **DOB** ___/___/___ ☐**Male** ☐**Female**

Race
☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity
☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:______________________________ **DOB** ___/___/___ ☐**Male** ☐**Female**

Race
☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity
☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:______________________________ **DOB** ___/___/___ ☐**Male** ☐**Female**

Race
☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity
☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Name:______________________________ **DOB** ___/___/___ ☐**Male** ☐**Female**

Race
☐African-American ☐American Indian/Alaska Native ☐Asian ☐Caucasian
☐Native Hawaiian/Pacific Islander ☐Other ☐Declined ☐Unknown

Ethnicity
☐Hispanic ☐Not Hispanic
☐Unknown ☐Declined

Mother's Information ☐ **Responsible for payment**

Mother's Name: ____________________ DOB________ SS#______________

Street Address:____________________ City__________ State_____ Zip_____

Phone Numbers: Home____________ Cell ____________ Work____________

Employer:____________________ E-mail Address: ____________________

Father's Information ☐ **Responsible for payment**

Father's Name :____________________ DOB________ SS#______________

Street Address:____________________ City__________ State_____ Zip_____

Phone Numbers: Home____________ Cell ____________ Work____________

Employer:____________________ E-mail Address :____________________

Child lives with: ☐ Parents ☐ Mother ☐ Father ☐ Other____________________

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Patient Portal

How were you referred to us? ☐ Friend ☐ Physician ☐ Internet ☐ Other____________________

Insurance Company Name: ____________ ☐No Insurance Primary Practitioner in our office: __________

Pharmacy: ____________ Phone:____________ Pharmacy Address: ____________

Please sign below that you have been offered an opportunity to review a copy of our HIPPA Notice of Privacy Practices. You are entitled to a personal copy of the notice at any time to keep for your records. If you have any questions about our Privacy Policy, please feel free to contact our Privacy Official at 770-751-0800. Thank you for your cooperation.

____

Signature of Patient or Parent/Guardian if Patient is under 18 **Date**

ROSWELL PEDIATRIC CENTER, P.C.
FINANCIAL POLICY

We are committed to providing your child with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.

1. Our office participates with a variety of insurance plans.
   It is your responsibility to:
   - Bring your insurance card and photo I.D. at every visit.
   - Pay your Co-Payment and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept VISA, MasterCard, and Discover. We do not bill for Co-Payments.
   - Pay in full for any medical care or services that are not covered by your insurance plan.
2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients, if the charges are paid at the time of service. Please see one of our front desk employees if you have any questions.
3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be "Private Pay" and required to pay at the time of service until the PCP has been changed to one of our physicians.
4. Secondary Insurance: We do not file secondary insurance. You may request a copy of the claim to file your child's secondary insurance yourself.
5. You are financially responsible for any amount not covered by your child's health insurance plan.
6. You are financially responsible for all charges incurred in your child's care and treatment.
7. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.
8. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
9. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Family Information Form. We will scan your insurance card, ID, and Family Information Form, into your child's electronic medical chart. We will check these documents prior to releasing your child's records. We will take a picture of your child for your child's electronic chart. This photo helps us identify your child during our routine operations. Your child's photo will not be released without your permission.
10. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

Late Arrival/No Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child from the practice.

Missed or cancelled Appointment Policy: Check-up and consultation appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time will be charged a missed appointment fee of $75.00.

Roswell Pediatric Center will not provide medical care to children whose Parents/Guarantors refuse to sign and comply with our financial policy.

Signature of Understanding: I have read and understand the above stated financial policy.

Childs Name	Date of Birth	Childs Name	Date of Birth
Childs Name	Date of Birth	Childs Name	Date of Birth

Patient or Parent/Guardian if Patient is under 18 years of age　　　Date

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to Roswell Pediatric Center, P.C., for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

Patient (if 18 or older) or Parent/Guardian (if Patient is under 18 years of age)　　　Date

Roswell Pediatric Center, PC

Patient Authorization to Communicate with Others

I authorize Roswell Pediatric Center, PC to communicate with the following person(s) on my behalf. I authorize the individual(s) listed below to seek and obtain treatment for my child/children. This authorization will continue until revoked in writing by me.

I authorize:______ Full disclosure ______ Limited information to be released (please specify restrictions)

Restrictions:____

____

Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date
Patient Name (printed)	DOB	Parent or Patient Signature (*if 18 or older*)	Date

Please list name of Individual(s) you are authorizing release of information to:

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

October 2012

ROSWELL PEDIATRIC CENTER, PC

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

With my consent, ROSWELL PEDIATRIC CENTER, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ROSWELL PEDIATRIC CENTER, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Roswell Pediatric Center, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Laurie Viebrock, Privacy Officer at 3400 C Old Milton Parkway, Suite 545, Alpharetta, GA 30005.

With my consent, ROSWELL PEDIATRIC CENTER, PC may call my home or other designated location and leave a message on voice mail; with my consent ROSWELL PEDIATRIC CENTER, PC may communicate via fax, secure e-mail, or text message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's or my clinical care, including laboratory results among others. With my consent, ROSWELL PEDIATRIC CENTER, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that ROSWELL PEDIATRIC CENTER, PC restrict how it uses or discloses my PHI to carry out TPO. I do not have to sign this authorization in order to receive treatment from Roswell Pediatric Center, 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 laws. Roswell Pediatric Center, PC has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Roswell Pediatric Center, PC.

____ Patient's Name DOB	____ Date
____ Signature of Patient (IF 18 OR OLDER) or Legal Guardian	____ Print Name of Patient or Legal Guardian