Peachtree Pediatrics

Appointment Date: _____

Appointment Time: _____
Arrival Time: _____

Please bring insurance cards and photo ID.

Patient Information:

Pharmacy Name/Location:

_____

Last Name: _____ **First Name:** _____ **Middle:**

_____

Preferred Name: _____ **Date of Birth:** _____ **Primary Language:** _____

Social Security #: _____ **Sex:** M F

Race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Race

Ethnicity: Not Hispanic or Latino _____ Hispanic or Latino _____ Decline _____

Mailing Address: _____ **Zip:** _____ **City:** _____ **State:** _____ **Co:** _____

Phone #: Home: _____ **Work:** _____ **Cell:** _____ **Preferred:** _____

Primary Care Physician: _____

Parent / Responsible Party

Last Name: _____ **First Name:** _____ **Relationship:** _____

Preferred Name: _____ **Maiden Name:** _____ **Prefix/Suffix:** _____

Marital Status: S M W D **Driver's License State/#:** _____ **Sex:** M F

Mailing Address (If different from patient): _____

Social Security #: _____ **Date of Birth:** _____

Phone #: Home: _____ **Work:** _____ **Cell:** _____

Email: _____

Child lives with: ___ Both Parents ___ Mother ___ Father ___ Foster Parent ___ Relative: _____

Parent/Responsible Party Employer Information:

Employer Name: _____ Status: Full-Time Part-Time Retired Unemployed Student

Occupation: _____ Hire Date: _____ Phone/ext: _____

Siblings:

_____

_____

_____

Emergency Contact: (If different than Parent/Responsible Party)

Last Name: _____ First Name: _____

Relationship: _____

Preferred Phone #: _____ Date of Birth: _____

Insurance Information:

Primary Plan Name: _____ *Policy Holder Name:* _____

Policy # (ID) _____ *Group #* _____ *Effective Date:* _____

**If Policy Holder is not Patient:* _____ *Policy Holder Date of Birth:* _____

Policy Holder Social Security: _____ *Policy Holder Relationship:* _____

_____ Time: _____ Date: _____

Signature of Parent/Guardian of Minor

Print Parent/Legal Guardian Name: _____ Date of Birth: _____ SS#: _____

Peachtree Pediatrics

Peachtree Pediatrics PLLC

Authorization and Acknowledgements

CONSENT TO TREATMENT OF MINOR CHILD;
Having a condition requiring medical care, I hereby consent to the rendering of such care for my child, which may include routine diagnostic procedures and such treatment as the attending provider(s) who see himself and/or render diagnosis, care or treatment considered to be necessary. I understand that the provider(s) who see me and/or render diagnosis, care or treatment to me may not be employees of the hospital and that therefore this hospital is not legally responsible for the assistance or lack of assistance they render to me. I understand that some providers provide their services as independent contractors to this medical facility, and that the medical facility does not exercise any control over the means employed by the provider in the performance of his or her services.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION;
I authorize Peachtree Pediatrics PLLC to disclose my child's protected health and prescription information for treatment, payment and healthcare operations. This authorization would also include disclosures pertaining to the treatment of psychiatric, drug, alcohol, or abuse conditions, AIDS, AIDS-related conditions, HIV status or any other information protected by Federal or State statutes. This information may be released to, but is not limited to insurance companies known and unknown at the times services are provided, worker's compensation carriers and/or employers responsible for payment of worker's compensation claims. Quality Improvement Organizations responsible for reviewing the medical care and other provider's rendering services to my child. All used and disclosures of protected health information are more fully explained in the Privacy Notice. I understand that this authorization will remain in effect until revoked in writing. I understand that I may revoke this authorization by providing written notice to Peachtree Pediatrics. I understand that the revocation of the authorization will only apply to future disclosures of protected health information and will not include disclosures already honored prior to receipt of revocation.

ACKNOWLEDGMENT OF NOTICE OF ADVANCE DIRECTIVES, NOTICE OF PATIENTS RIGHTS AND PRIVACY PRACTICES;
I have received a copy of the Peachtree Pediatric PLLC Notice of Privacy Practices eff. 10/15/06 _____ Refused copy _____

Please list names of persons we may speak to about your child's condition(s) or write none:

_____ _____

_____ _____

PATIENT'S INSURANCE CERTIFICATION; (Please Initial after this paragraph)
I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request payment of authorized benefits be made on my child's behalf. _____

PROMISE TO PAY;
I understand that I am responsible, whether as patient agent, to Peachtree Pediatrics PLLC for all charges incurred and not paid by third party benefits, and hereby guarantee payment of same together with previously incurred and yet unpaid medical charges. Should the account be referred to an attorney or small claims court for collection, the undersigned shall pay reasonable attorney's fee(s) and collection expense. I authorize Peachtree Pediatrics PLLC to obtain other credit information deemed necessary, including accessing my nation credit file, to collect my unpaid charges.

OVERPAYMENTS;
I authorize the refund of overpaid insurance benefits in accordance with my insurance policy provisions whereby coverage's are subject to a coordination of benefits clause. I further authorize over payments due me to be applied to any open accounts of my dependents.

PHOTOGRAPHING PATIENT PROCEDURE;
I understand and accept photography at the time of registration for the purpose of identification throughout my child's medical treatment.

_____ _____ _____ _____
Signature of Responsible Party Date of Birth Time Date

Relationship to patient: _____

Witness: _____

Revised 03/07/2012

Peachtree Pediatrics

Acknowledgment of Patient Payment Policies

Thank you for choosing Peachtree Pediatrics PLLC to provide your child's medical care. We are committed to the success of your child's medical treatment and care. Please understand that payment of your bill is part of this. We would appreciate your review and acknowledgment of the following financial policies.

I understand and acknowledge that it is my responsibility to know and understand the nature and extent of any insurance coverage that may apply to medical bills for this claim. This may include any available health insurance, Medicaid, liability or other insurance benefits. Specifically, I understand that it is my responsibility to know and be responsible for any DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, ETC., and further acknowledge that it is not the responsibility or duty of Peachtree Pediatrics PLLC to determine this information.

Peachtree Pediatrics PLLC will file insurance that is provided to us under most circumstances. We do not accept assignment with all insurance plans, as we are not contracted with all insurance companies. Patients are responsible for fees or deposits for all known deductibles, co-pays, co-insurance, etc. at the time of service and /or prior to any non-emergency procedure.

I understand and acknowledge that all co-payments, and/or co-insurances **are to be paid at the time that medical services are provided** and that amounts not covered by my insurance company will be billed to me for payment within 30 days. If my child is a self-pay patient, I understand that payment for services **is to be paid at the time of that medical services are provided.** I further understand that my account may be turned over to a collection agency, the courts and /or an attorney for collection. In that event, I will be responsible for reasonable attorney fees and cost that may apply and which are incurred in collection of the account.

In the event that my check is returned for insufficient funds, I am aware that a fee of $35.00 (in addition to the amount of the check) will apply.

If the medical service being sought is the result of an **auto accident or liability injury,** we will do our best to work with the insurance and /or attorney that the patient provides. Doing so is a courtesy to our patients. We are under no obligations to do so. These types of polices do not pre-certify services nor do they guarantee payment for the services provided. The patient is ultimately responsible for payment of services in full. If insurance benefits are not forthcoming in a reasonable amount of time, the balance will then become the patient's responsibility and all future services will be expected at the time of service. If a patient accepts a settlement that does not cover the balance for services provide, the balance is still the patient's responsibility and payment will be expected.

-I authorize Peachtree Pediatrics PLLC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

-I authorize my insurance benefits be paid directly to Peachtree Pediatrics PLLC.

By signing below, I acknowledge that I understand and agree to the above terms. I represent that I have full legal authority and representative capacity to execute this document on behalf of the patient.

Parent/Legal Guardian Signature	Date of Birth	Time	Date

125 Medical Park Lane Suite F
Murphy, NC 28906
Phone (828) 837-2128
Fax (828) 835-9311

AUTHORIZATION TO RELEASE/RECEIVE PROTECTED HEALTH INFORMATION

Please Print Clearly:

PATIENT NAME: _____ DATE OF BIRTH: _____

PARENT/GUARDIAN NAME: _____ RELATIONSHIP:_____

ADDRESS: _____ PHONE:_____

_____

I authorize Peachtree Pediatrics PLLC to (circle one) SEND or RECEIVE by fax medical information from/to the following physicians/hospitals.

Name of Physician/ Hospital: _____

City:_____ State:_____

Phone: _____ Fax:_____

The following documents are to be Released/Sent: (Check all that apply)

☐ Entire Record	☐Face Sheet	☐Nurse Notes	☐ Autopsy Report
☐ History & Physical	☐Neuro/Pathology	☐Clinic Notes	☐ Operative Notes
☐ Immunization Record	☐Discharge Summary	☐Lab Reports	☐Progress Notes
☐ER Record	☐Medication Records	☐Radiology Reports	☐Other: _____

I give special permission to release any information regarding the following: (Please Initial)
Substance Abuse _____ Psychiatric/ Mental Information _____ HIV Information_____

This authorization will expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed: _____ Date:_____

Witness: _____ Date:_____