



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: _____

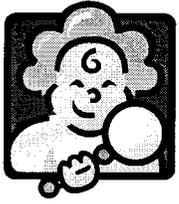
Policy Holder Date of Birth: _____

Policy Holder Social Security: _____

Policy Holder Relationship: _____

Signature of Parent/Guardian of Minor Time: _____ Date: _____

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



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 policies 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)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Nurse Notes | <input type="checkbox"/> Autopsy Report |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Neuro/Pathology | <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Operative Notes |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> ER Record | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> 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: _____