Village Pediatrics Patient Registration Form

PATIENT INFORMATION

Child's Full Legal Name (Last, First, Mid)	Date of Birth	Sex	Preferred Name

Child's Home Address (Street, City, State, Zip)	Telephone #	Parent's Email Address

Other Children in Family (Name/DOB):	Race:	Ethnic Group: o Hispanic o Non-Hispanic
1. 2. 3. 4. 5.	o African American/Black o American Indian or Alaska Native o Asian o Caucasian/White o Native Hawaiian/Other Pacific Islander o Other_____	Patient's Primary Language: o English o Spanish o Other_____ Parent's/ Legal Guardian's Primary Lang: o English o Spanish o Other_____

EMERGENCY CONTACTS

Mother's Name	Phone #:	Alternate Phone #:
Mother's Home Address (if different from patient)		
Father's Name	Phone #:	Alternate Phone #:
Father's Home Address (if different from above)		
Additional Contact's Name	Relationship to Patient	Phone #
Additional Contact's Address		
Who may we thank for referring you to our practice?		

GUARANTOR INFORMATION (Person financially responsible)

Name	Date of Birth	Relationship to Patient
Street Address (if different from patient)		Phone Number
Employer Name/Address		Work Phone Number

INSURANCE INFORMATION

Insurance Name/Type	Claims Address	Telephone #
Subscriber/Member ID	Group #	Patient Relationship to Subscriber
Subscriber's Name	Subscriber's Date of Birth	
Subscriber's Address (if different than guarantor)	Subscriber's Employer	

Village Pediatrics, P.C.

Patient Contact Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

Patient Names: _____ DOB _____
_____ _____
_____ _____
_____ _____

Parent/Guardian: _____ Relationship to Patient _____

I wish to be contacted in the following manner (check all that apply):

Home Telephone:_____
___ O.K to leave message with normal results
or
___ Leave message with call back number only

Work Telephone:_____
___ O.K to leave message with normal results
or
___ Leave message with call back number only

Cell Phone:_____
___ O.K to leave message with normal results
or
___ Leave message with call back number only

Written Communication:
___ O.K to mail to my home address
___ O.K to leave test results with:
Name:_____
Name:_____

Signature:_____ Print Name:_____

Date:_____

AUTHORIZATION FOR TREATMENT OF CHILD IN ABSENCE OF PARENT/LEGAL GUARDIAN

Child's Name: _____ Date of Birth: _____

Authorization Given To:

Name:_____ Relationship to Child_____

Name:_____Relationship to Child_____

Name:_____Relationship to Child_____

Name:_____Relationship to Child_____

I, the undersigned parent or legal guardian of the above named child, give permission to the adult(s) named above to act on my behalf to obtain medical care and treatment for my child as deemed advisable by the providers at Village Pediatrics.

Parent/Legal Guardian:_____ Date:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This form applies only to the release or disclosure of your health information. It is not consent for treatment and is not intended for any other purpose.

By signing this form, I authorize the release or disclosure of the protected health information (PHI) described below:

TO: **Village Pediatrics, P.C.**
Name: **1862 Auburn Road, Ste 107**
Address: **Dacula, GA 30019**
PH 678.288.4142 FAX 678.288.4143

FROM: Pediatric Office/Doctor
Name: _____
Address: _____
_____

Reason for transfer: _____

Note: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization.

Patient(s) full name _____ **Date of Birth** _____
_____ _____
_____ _____
_____ _____

*****Our office requires 3 to 5 business days to copy medical records and there is a $15.00 fee.**

I authorize the following information to be sent to the address above:

____ Copies of all records for the period
____ Copies of the information described below
____ Problem list & vaccine record From _____
____ History & physical examination To _____
____ X-ray reports
____ Lab reports
____ Other (please specify)

I understand that this information is of personal medical nature and may include any history of or references to Acquired Immunodeficiency Syndrome (AIDS); Sexually Transmitted Diseases (STDs); Human Immunodeficiency Virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.
The following information should not be released, even if occurring during dates above: _____
Special requirements: certified mail, extended expiration date, and the like: _____

I have been provided a copy of Village Pediatric P.C.'s notice of privacy practices and am aware that there are charges for copies of records made pursuant to this authorization. I understand that Village Pediatrics P.C. assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Village Pediatrics P.C. from all legal liability that may arise from release of my information under this authorization.

Signature _____ **Date** _____
(parent or legal guardian)

The patient or their representative may revoke this authorization by notifying in writing to Village Pediatrics P.C. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Village Pediatrics P.C.

Prepared by: _____ Date sent out: _____

***** **PLEASE DO NOT FAX RECORDS OVER 15 PAGES** *****

OFFICE/FINANCIAL POLICY

Our goal at Village Pediatrics is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have questions, please do not hesitate to ask a member of our staff.

1. Out of consideration for our staff, we expect our families to respect our staff and treat them kindly. We will not tolerate aggressive or hostile behavior. Failure to abide by this policy will result in immediate dismissal from our practice.
2. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf.
3. On arrival at your first visit, you will need to provide your driver's license or other form of government identification.
4. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physician as of this date, you may be financially responsible for the visit.
5. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances. All outstanding balances must be paid prior to scheduling any further visits.
6. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
7. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
8. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
9. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
10. Co-payments are due at time of service.
11. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due ***within*** 10 business days of your receipt of your bill. Any balance over 60 days will be forwarded to a collection agency.
12. We require 24 hour notice for canceling any appointments. There is a **$50** charge for appointments if they are not canceled **OR** if 24 hour notice is not given.
13. A **$50** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
14. We charge **$20** per child to copy medical records for a parental copy. There is no fee when we send to the next physician once we receive a release of records from their office.
15. One school, camp, or sports form will be completed free of charge if brought to your well child check/sports physical. If your child needs any additional forms to be completed there is a **$5** charge per form. Payment is due when the forms are dropped off. We have a 3 to 5 day turnaround time for forms.
16. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
17. Before making an annual physical appointment, check with your insurance company to confirm

the visit will be covered as a well child check or preventative care visit. Not all plans cover annual physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of the visit.

18. Not all services provided by our office are covered by every plan. Any service determined not to be covered by your plan will be your responsibility.
19. We require a parent or legal guardian to accompany the child to all visits unless specifically designated on the Authorization to Treat form.
20. For monthly medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly. We will NOT call in medications after-hours.

I have read and understand this office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name(s):_____

_____ _____

Responsible party's name Relationship to child (parent/legal guardian)

_____ _____

Responsible party's signature Date

PRIVACY NOTICE

I have read and understand Village Pediatrics, PC Privacy Notice. My signature below is my acknowledgement that I have been provided access to this policy.

Patient Name:_____

Responsible party's name:_____

Relationship to patient:_____

Responsible party's signature:_____

Date:_____