Amazing Pediatrics

Patient Information

Name of Child _____

Sex: ____M ____F Birthdate: _____ SSN# _____

Address: _____

Phone #: _____ Whom may we thank for referring you? _____

Pharmacy Name & Address: _____

_____

PARENT/GUARDIAN INFORMATION

Mother/Guardian Name: _____

Birthdate: _____ Phone# _____

Email: _____

Employer: _____

Father/Guardian Name: _____

Birthdate: _____ Phone# _____

Email: _____

Employer: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

INSURANCE INFORMATION

Does the child have insurance coverage? ___ YES ____NO

Plane Name:_____ Ins Telephone# _____

Subscriber ID# _____ Group# _____

Claims/Billing address: _____

AMAZING PEDIATRICS

The following form is designed for situations in which minors not accompanied by their parents or legal guardians can have someone else bring their child(ren) in.

This gives authority to a designated adult to arrange medical care that cannot be provided to a minor without the authorization of the parent or legal guardian unless there is written consent authorizing an agent to give approval.

Child's full name: _____

Date of Birth: _____

I authorize _____ (child's name) to be evaluated by the provider at Amazing Pediatrics.

Authorization is granted for all treatments and procedures. Unless it is revoked in writing. my signature below will act as the authorization for today and all future medical treatment.

The following person(s) are authorized to participate in the medical treatment of my child in particular bringing him/her to the office visits and to make necessary medical decisions.

Name _____ relationship _____

Name _____ relationship _____

Name _____ relationship _____

Parent/Guardian signature _____

Address _____

_____

Phone # _____

Date of authorization _____

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY NOTICE

Acknowledgment:

I acknowledge that I received the Notice of Privacy Practices.

_____ _____

Patient or personal representative signature Date

If personal representative's signature appears above, please describe relation to patient.

_____

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with

_____

and assign directly to Dr Angela Butler-Rice all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether medical or electronic.

Parent/Guardian Signature_____

Date_____

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I _____, understand that as part of my health care, Amazing Pediatrics, originates and maintains paper and/ or electronic records describing my health history, symptoms, examination
And test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care,*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third party payer can verify that services billed were actually provided, and*
- *A tool for routine healthcare operations such as assessing quality and reviewing the competence of*
- *healthcare professionals*

I understand and **have been provided with a *Notice of Privacy Policies*** that provides a more complete description of information uses ad disclosures. I understand that I have the following
rights and privileges:

- *The right to review the notice prior to signing this consent,*
- *The right to object to the use of my health information for directory purposes, and*
- *The right to request restrictions as to how my health information may be used or disclosed to*
- *carry out treatment, payment, or health care operations (details below)*
- *The right to revoke this Consent in writing at any time and all future disclosures will then cease (details below)*
- *The practice may condition receipt of treatment upon the execution of this Consent (details below)*

I understand that **Amazing Pediatrics, LLC** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization
has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted
by Section 164.506 of the Code of Federal Regulations.

I further understand that **Amazing Pediatrics, LLC** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code

of Federal Regulations. Should **Amazing Pediatrics, LLC** change their notice they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, I agree, email)
I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and (circle one) accept/decline the terms of this consent.

_____/_____/____ _____/_____/_____

Patient's Signature **Date** **Practice Representative/Witness- Date**

NO SHOW/MISSED APPOINTMENT POLICY

We, at Amazing Pediatrics, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 770-696-2968

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Amazing Pediatrics and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Amazing Pediatrics will assist you to reschedule this appointment if needed.

5. If you have 3 "No-Show/Missed" appointments within a one calendar year, you will be dismissed from the practice.

I have read and understand Amazing Pediatrics' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Amazing Pediatrics appropriately if I have difficulty keeping my scheduled appointments.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient Signature or Parent/Guardian if minor Relationship to Patient

_____ _____

Staff Signature Date