Chattahoochee Pediatrics
~Caring for the Whole Child~

Vaishali Kute, MD, FAAP
Priya Thomas, MD, FAAP

PATIENT INFORMATION

Patient Name (First, MI, Last)_____
Birth Date_____ Gender_____ Nickname_____ Primary Language_____
Race: White,Hawaiian/Pacific Islander, Black, AmericanIndian/AlaskanNative,Asian Ethnicity: Hispanic, Non-Hispanic*

Parent/Guardian Name_____
Lives with patient: ☐ Yes ☐ No Birth date_____ Relation to patient_____ M S W D
Address_____
City_____ Zip_____ State_____ County_____
Please check the box next to your preferred contact number
☐ Home_____ ☐ Cell_____ ☐ Work_____
How do you prefer appointment reminders? ☐ Text ☐ Call
Email_____ *May we sign you up for our patient portal?* ☐ Yes ☐ No
Employer Name_____ Occupation_____

Parent/Guardian Name_____
Lives with patient: ☐ Yes ☐ No Birth date_____ Relation to patient_____ M S W D
Address_____
City_____ Zip_____ State_____ County_____
Please check the box next to your preferred contact number
☐ Home_____ ☐ Cell_____ ☐ Work_____
How do you prefer appointment reminders? ☐ Text ☐ Call
Email_____ *May we sign you up for our patient portal?* ☐ Yes ☐ No
Employer Name_____ Occupation_____

Primary Insurance_____ Policy Holder_____
Secondary Insurance_____ Policy Holder_____

Emergency Contact_____
Emergency Contact Phone Numbers_____
Who may we thank for referring you to Chattahoochee Pediatrics?_____

(*) Indicates optional information requested under the Affordable Care Act, including Ethnicity and Race.
Chattahoochee Pediatrics does not discriminate on the basis of race, ethnicity, ancestry, religion, gender, gender identity or expression, sexual orientation, age, disability, national origin, citizenship, marital/parental status, or military status.

I understand and agree to permit Chattahoochee Pediatrics to render medical services for my child(ren). I authorize the release of any information necessary for the filing of insurance claims and authorize payment from my insurance company to be sent directly to Vaishali B Kute, MD, LLC dba Chattahoochee Pediatrics. I understand that unless a preexisting agreement exists between my insurance company and this office, I will be responsible for any unpaid balance not covered by insurance.

Signature of Parent/Legal Guardian_____ Date_____

CHATTAHOOCHEE PEDIATRICS POLICIES

Information Privacy **INITIAL_____**

Vaishali B. Kute, MD LLC has prepared a detailed NOTICE OF PRIVACY PRACTICES to help me better understand how health information is used and shared. Vaishali B. Kute, MD LLC will use and disclose my personal health information to treat me, to receive payment for the care they provide, and for other health care operations. I understand that Vaishali B. Kute, MD LLC has the right to change this notice at any time. The current notice will be posted in the offices. My signature below acknowledges that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Insurance and Payments **INITIAL_____**

You are responsible for providing us with accurate insurance information before the visit. This includes secondary insurance information if applicable. We participate with several major insurance carriers and file your claims as a courtesy. Our office policy concerning the HSA/HRA & Deductible Plans are as follows:

Patients are responsible for their coinsurance, deductibles, and copays in full. Payment is due at the time of service and is based on the patient's insurance company's contracted rates. Late payments will incur a $30 late fee per month.

Late Arrivals **INITIAL_____**

We will try to accommodate late-comers as best as possible. Late arrivals will be fit back into the schedule if time allows or may be asked to reschedule to avoid delays.

Canceling Appointments, No-Shows (Missed Appointments) **INITIAL_____**

Chattahoochee Pediatrics kindly requests that parents/guardians/patients call the office at least 24 hours in advance to give notice of canceling and/or rescheduling an appointment. Any missed appointment in which the office was not notified in advance will be considered a "No-Call/No-Show." A No-Call/No-Show may be charged a $30 fee, and multiple No–Show appointments can lead to dismissal from the practice.

We understand there are emergencies and situations that will affect how soon you can provide us notice and we will give each case proper consideration when deciding a course of action.

Medications **INITIAL_____**

Medication refills will be happily taken care of by request. Routine, non-controlled medications can be filled with up-to-date well checks (yearly unless younger than 3 years old). Controlled medications and medications for mental health must have an up-to-date well check and "med checks" every six months.

We do not prescribe antibiotics over-the-phone. Antibiotics will be prescribed for your child if they are examined and diagnosed with a bacterial infection (ie: strep throat, sinusitis, otitis media, pneumonia, urinary tract infection, etc). Antibiotics do not cure viruses such as the common cold. Please understand that we are trying to protect your children from antibiotic-resistant infections.

Your signature below confirms that you understand these policies and agree to their terms and conditions.

Signature of Parent/Legal Guardian_____ Date_____