Primary Care Pediatrics

Please Check:

New Patient ____

Update on Current Patient ____

Pediatric Patient Demographics

Patient Information:

Full Name (First, Middle, Last): _____

Nickname: _____ **Gender:** _____ Male _____ Female **Date of Birth:** _____/_____/_____

Patient's Residing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Best Phone #: _____

Siblings: _____

Family Email: _____

Preferred Pharmacy: _____ **Phone #:** _____

Parent/Guardian Information:

Father/Guardian:

Name: _____

Address: _____

_____

DOB: _____/_____/_____

Cell #: _____

Employer: _____

Mother/Guardian:

Name: _____

Address: _____

_____

DOB: _____/_____/_____

Cell #: _____

Employer: _____

Authorizations:

- **I hereby authorize and request the medical treatment necessary for the care of the above named patient.**
- **I authorize the release of all medical records to the referring and family physicians and to my insurance company. If applicable, I allow the fax transmittal of my medic records if necessary.**
- **I acknowledge full financial responsibility for services rendered by Primary Care Pediatrics, PC. I understand payment is due at the time of service unless other defini financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.**
- **I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insuranc authorizes and to inform the staff of Primary Care Pediatrics, PC as to which laboratory my insurance covers.**
- **I further authorize and request that insurance payments be made directly to Primary Care Pediatrics, PC for services rendered.**

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Patient/Parent or Guardian Signature **Please Print Patient/Parent or Guardian Name** **Date**

HIPAA Patient Acknowledge

I have read and understand the Notice of Privacy Practices of Primary Care Pediatrics. I understand that I have the rights outlined in this notice and can request a copy of this notice for my own personal records. I accept this notice as a protection of my child's medical information.

_____ _____

Signature of Parent or Guardian Date

Insurance Information

Insurance Name: _____

Policy/ID #: _____

Group #: _____ Copay: _____

Subscriber Full Name: _____

Relation to Patient: _____

Subscriber Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber DOB: _____/_____/_____ Subscriber Best Phone #: _____

Effective Date of Policy: _____/_____/_____ Current Email: _____

INSURANCE PREFFERED LAB : (If no choice is made, it will be your responsibility for none covered lab cost)

QUEST_____ LABCORP _____ INITIALS: _____

Primary Care Pediatrics

763 Peachtree Pkwy, Suite 2
Cumming, Ga 30041
Phone: 678-208-2050 Fax: 678-208-2051

Margaret M. Boudreaux, M.D., FAAP

Patient: _____

DOB: _____

Policy for Individual Vaccine Schedule

We are happy to work with parents who wish to stagger the amount of vaccines or the type of vaccine your child is to receive at their routine well check visit. Please put an X on the item that fits closest to your vaccine schedule.

_____ I am following the Georgia CDC recommended vaccine schedule for school entry.

_____ I will follow an alternative vaccine schedule discussed with my healthcare provider.

_____ I am choosing not to vaccinate my child/children at this time. I have discussed the benefits of vaccinating my child/children with my healthcare provider and I am aware of the risks of not vaccinating.

_____ I have not made a decision at this time to follow any of these choices above. I understand a decision must be made by my next appointment.

Please be advised, once you decide on a vaccine schedule with the doctor/practitioner, we expect you to do your best to abide by that schedule and plan ahead for your appointments. If you miss two or more visits for vaccines and your child will be entering school shortly, we may not be able to accommodate last minute catch ups. If you miss your scheduled appointment, there will be a $25 **NO SHOW** fee.

It is **Your Responsibility to consult your insurance for coverage and benefits. **Some insurance companies do not cover vaccinations given outside of your annual Wellness Visit. Call your insurance before your vaccine appointment and ask if they cover vaccines given outside of your annual Wellness Visits.

By signing below, you are acknowledging that you have read, understand, and agree to the terms stated above.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Printed Name Date

_____

Physician/Healthcare Provider Signature

REVISED 7-2-2018

Vaccine Discussion:

I have been provided the opportunity to read the VIS (Vaccine Information Sheet) for the vaccines recommended at today's visit. I have discussed the risks and benefits for recommended vaccines with the provider. I have indicated the reasons why I do not wish to vaccinate my child. I know that if my child does not receive the vaccination(s) according to the medically accepted schedule, the consequences may include:

- Contracting the illness the vaccine is designed to prevent (the outcome of these illnesses may include one or more of the following: certain types of cancer, pneumonia, illness requiring hospitalization, death, brain damage, paralysis, meningitis, seizures, and deafness: other severe and permanent effects from these vaccine-preventable diseases are possible as well)
- Transmitting the disease to others(including those too young to be vaccinated or those with immune problems) possibly requiring the child to stay out of child care or school and requiring someone to miss work to stay home with the child during disease outbreak.

_____

Patient Name

_____ _____ _____

Signature of Parent/Guardian | Please Print Name of Parent/ Guardian | Date

General Financial Information

1. We require 24 hours notification for cancellation of any scheduled appointment. Failure to provide proper notification will result in a $25 non-cancellation fee for sick visits and a **$50 non-cancellation fee for well check** appointments.

2. There is a $20.00 fee for all returned checks.

3. We submit claims to the insurance company as a courtesy to our clients. We reserve the right to collect the co-pay and any co-insurance at the time of service. Any balance we are unable to collect from the insurance company will be your financial responsibility.

Patients will be given a 30 day grace period to pay any outstanding balance. After this time, a late fee of $1.5% will be charges to your account for unpaid balances.

4. Every insurance policy is different and we are unable to provide you with specifics of your policy. Any tests or procedures we perform are based on our evaluation of your child's needs at the time. **Some procedures are not always covered by the insurance company even though they are medically necessary.** You will be responsible for payment of these procedures unless otherwise stated by you prior to treatment of your child.

5. If you are moving or choose to leave our practice, there is a $35.00 charge for a complete copy of the medical chart. Some information can be provided for free as detailed on the request form.

6. All our billing is done through a 3rd party billing company, MTBC. Their contact information is located at the bottom lower left of your bill.

Primary Care Pediatrics will make every effort to notify you of any policy changes in the future. Your signature below represents your agreement to abide by these policies. Please feel free to speak with our business office regarding any questions with the above policies.

I have read and fully understand the above information.

_____ Date_____

Revised: 10/03/2017

PRIMARY CARE PEDIATRICS
763 Peachtree Parkway, Suite 2
Cumming, GA 30041
Telephone (678)208-2050
Fax (678)208-2051

MANAGED CARE ACKNOWLEDGEMENT

By my signature below, I acknowledge that I have been informed of the following information:

1. Many insurance plans require that all health care be directed through this office. Therefore, I must see my primary care physician or one of her associates in the Office to discuss any concerns or issues before any referral will be given. ***It is my responsibility to check with my insurance company to see if a written referral is required***. If so, this office will handle all the necessary paperwork.

2. Referrals must be received or confirmed prior to visiting a specialist's office. Failure to obtain a referral may result in my insurance carrier failing to pay for the care and I can be held financially responsible for the service.

3. Most referrals will be handled ***within 14 days*** of the request. This is within the guidelines of the bulk of managed care health plans. Post-dated or same-day referrals are only completed with the approval of the physician or office manager.

4. I must notify this office following a visit to the emergency room or an urgent care facility within 48 hours of the service. ***I should not assume that Children's Healthcare of Atlanta, the nurse advice line, or the physician on call will notify the office.***

5. If my child must see a specialist for any follow-up from an ER visit or urgent care facility visit, I must notify my Primary Care Provider to obtain a referral. ***I should not assume that the ER or urgent care facility has notified my physician***.

_____ _____
Signature of Parent or Guardian Date

6/15/10

PRIMARY CARE PEDIATRICS
763 Peachtree Pkwy, Suite 2
Cumming, GA 30097
678-208-2050
Fax 678-208-2051

Authorization for Treatment

Patient Name: _____

Date of Birth: _____

The following people are authorized to bring my child for any necessary treatment and may sign informed consent forms in my absence. Please have them bring identification (drivers license or ID card) to present at time of visit. **Also, co-pays are due at the time of visit. Please send in payment with authorized person.**

Name	Relationship to Patient

I realize that it is my responsibility to give updates of this form to **Primary Care Pediatrics** if there are any changes.

_____
Signature of Parent or Legal Guardian

_____
Date

NOTICE OF PRIVACY PRACTICES OF PRIMARY CARE PEDIATRICS

This notice describes how medical information about your child/children will be used and disclosed, and how you can obtain access to this information.

If you have any questions about this notice, please contact **Jerome Boudreaux.**

WHO WILL FOLLOW THIS NOTICE:

All Primary Care employees, staff, and other personnel

Any Business Associates of the practice who may have access to your child's medical information during their routine work for the practice.

MEDICAL INFORMATION PLEDGE:

We are required by law to: To keep private all medical information pertaining to your child, provide you this notice of our legal duties and privacy practices with respect to medical information about your child, and follow the terms of the notice currently in effect.

This notice will describe both how we may use and disclose medical information about your child and your rights regarding the use and disclosure of this medical information. It will also outline any obligations we have regarding the use and disclosure of any medical information.

DEFINITIONS:

"MEDICAL INFORMATION" about your child/children includes: medical history, physical findings, test results, diagnoses, and treatments. It also includes medical information about your family that has relevance to your child's/children's healthcare. In addition to actual medical information, it may include social information about your family and lifestyle that is relevant to your child's/children's healthcare.

The term "THE PRACTICE" will refer to Primary Care Pediatrics and all it's employees.

HOW WE MAY USE AND DISCLOSE MEDICAL INFROMATION ABOUT YOUR CHILD:

The following categories describe different ways that we use and disclose medical information. We will try to explain within each category what we mean and possibly give and example. All the way we are permitted to use your information will be described in one of the following categories.

1) For Treatment: Medical information concerning your child/children may be disclosed to doctors, nurses, medical assistants, lab technicians, medical students, and any other personnel of the Practice who are involved with the care of your child. In an as needed basis, we will disclose information to the front office personnel to coordinate needed services such as appointments, referrals, prescriptions, or outside lab work or x-rays. We may discuss health information with other doctors and their staff who are involved in the medical treatment of your child/children. Others outside the Practice such as your child's family members, clergy, etc. may receive information if it does not violate any legal document we have stating otherwise in the child's chart (this includes parental divorce decrees and adoption papers.) These others must show they have direct activity in the child's care.

2) For Payment: Medical information will be disclosed so that treatment and services received at the Practice may be billed to and payment may be collected from you, and insurance company, or third party. We may also need to use medical information to obtain prior authorization for a treatment or service from an insurance company or third party.

3) For Healthcare Operation: We may use and disclose medical information about your child to maintain and operate our practice. These uses and disclosures are necessary to run the Practice on a day to day basis as well as to assure the overall quality of care your child receives. These activities include but are not limited to reviews of our treatments and services; reviews of our personnel; or reviews of our billing systems. We may also combine your medical information other patient's information to evaluate our quality of care and services and identify areas which may need improvements, adjustments, or deletions. In these cases, if possible all information which directly identifies your child will be removed.

4) Reminders: Medical information may be used to contact you as a reminder that your child has an

appointment at our office. It may also be used if we have to contact you to remind you about prescription pickup, form pickup, referrals, or any other item requested by you or a practitioner for your child.

5) Treatment Alternatives: We may use and disclose medical information to tell you about possible treatment options or alternatives that may be of interest to you.

6) Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

7) Individuals Involved in Your Child's Care or Payment of Your Child's Care: We may disclose medical information about your child to a friend or family member who is clearly involved in your child's medical care. We may also give information to someone or some agency which is helping to pay for you child's healthcare.

8) Research: We do not routinely involve ourselves in research. Anyone preparing to conduct a research project will always be required to sign a pledge (a legal commitment) to honor the confidential nature of your child's medical information. We will also notify you about the research prior to its beginning.

9) Business Associates: There are some services provided by our office that are actually contracted out to other entities, such as our claims clearinghouse and our answering service. When these services are utilized, your child's medical information may be disclosed so that they can perform their jobs appropriately. We do require these agencies to sign and honor a Business Associates Agreement which requires them to appropriately safeguard your child's information.

10) As Required by Law: We will use and disclose medical information about your child when required to do so by federal, state, or local law.

11) To Avoid A Serious Threat To Health or Safety: We may use and disclose medical information about your child when necessary to prevent a serious threat to your child's health and /or safety or the health and /or safety of the public or another person. Any disclosure would only be to individuals who are able to help prevent the threat.

SPECIAL SITUATIONS

12) Hospital Co-ordination: We may use and disclose your child's medical information when coordinating services between our office and any agency based at one of the hospitals of which we are on staff or an agency working in relation to a hospital of which we are on staff. These activities include but are not limited to neonatal care; lactation consultants; universal metabolic testing agencies; organ, tissue, or cord blood donation; or any other such organization that may be utilized to better serve your child's medical needs.

13) Military and Veterans: If you are a member of the armed forces, we may release medical information about your child as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- 14) Public Health Risks: We may disclose medical information about your child for public health activities. These activities generally include the following:
- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or maybe at risk for contracting or spreading a disease or condition:
- To notify the appropriate government authority if we believe a patient has been the victim of abuse,

neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

15) Health Oversight Agencies: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include but are not limited to audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

16) Lawsuits and Disputes: If you or you child is involved in a lawsuit or a dispute, we may disclose medical information about your child in response to a court or administrative order. We may also disclose information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

17) Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if we are unable to obtain the person's agreement;
- About a death we believe may be the result of a crime;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of a crime or victims; or to report the identity, description or location of the person who committed the crime.

18) Coroners, Medical Examiners and Funeral Directors: We may release medical information to these professionals in order for them to properly perform their job, for example, to identify a deceased person or determine the cause of death.

19) National Security, Intelligence Activities, Protective Services for Elective Officials and Foreign Dignitaries: We may release medical information about your child to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. These activities may include but are not limited to providing protection to the President, Foreign Heads of State, or other authorized persons conducting special investigations.

20) Inmates: If your child is an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about your child to the correctional institution or law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOUR CHILD:

You have the following rights regarding medical information we maintain about your child:

1) Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your child's care. Usually, this includes medical and billing records but does not include any notes made as a result of a confidential visit by an adolescent if :

- You have approved this confidential visit or
- The law otherwise protects the confidentiality of this visit.

To inspect and copy medical information that may be used to make a decisions about your child, you must submit your request in writing to the office manager listed on the last page of this notice. If you request a copy of the information, we charge a fee for the costs of copying, mailing, or any other supplies or time associated with your request.

We may deny your request to inspect or copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the

person who initially denied your request. The Practice will comply with the outcome of the review.

2) Right to Amend: If you feel that medical information we have about your child is incorrect or incomplete, you may ask us o amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice.

To request an amendment, your request must be made in writing and submitted to our privacy officer listed on the last page of this notice to be presented to our doctors. In addition, you must provide a reason that supports you request.

We may deny your request for an amendment if it is not in writing or fails to provide a reason for the amendment. We may also deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is without question accurate and complete.

3) Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about your child. EXCEPTION: Disclosures to individuals made as a result of the activities describe in numbers 1-7 and number 9 in the section HOW WE MAY USE AND DISCLOSE MEDICAL INFORMAITONABOUT YOUR CHILD are not tracked and therefore will not be included in the counting provided to you.

To request this list, you must submit it in writing to the office manager. Your request must state a time period which may not be longer than six years. You must state in what form you would like the list and all efforts will be made to provide in that manner. The first list you request in a twelve month period, will be free. Additional lists may incur a fee for the time and supplies to withdraw or modify your request before any fees are incurred.

4) Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about your child for treatment, payment, or health operations. You also have the right to request a limit on the medical payment for your child. For example, you could ask that we do not disclose information about a surgery your child had to a specific family member. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide your child emergency treatment.

To request restrictions, you must make your request in writing to our privacy officer. In this request, you must state:

- What information your want limited;
- Whether you want to limit our use, disclosure, or both;
- To whom you want the limits to apply; and
- For how long the limits are in effect.

5) Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain manner or at a certain location. For example, you may request that we only contact you at work.

To request confidential communications, you must state it in writing to our office manager. We will not ask you the reason for your request and we will accommodate all reasonable requests. Your request must specifically state how an/or where you wish to be contacted.

6) Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Please submit your request to any front desk personnel.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice without prior notification. We reserve the right to make the changed or revised notice immediately effective for medical information we already have and that information which we will receive in the future about your child. We will make available a copy of the current notice at each practice site. The notice will always contain an effective date on the front page. In addition, a copy of the current notice will be clearly posted in each office and will be available for you inspection and review with each visit.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the Practice through the Privacy Officer(listed below) or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to the privacy officer. We wan to hear if any violations have occurred so that we may better protect and serve your child's medical needs. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission, you may revoke that permission, in writing, at any time. If you revoke your permission, you must understand that we are unable to take back any disclosures we have already made with your permission. We are required to retain all our records of the care that we provided to you.

PRIVACY OF FAMILY PHOTOS:

We appreciate receiving your family photos. Upon receipt, you are authorizing Primary Care Pediatrics to display them. **If you do not wish to have them displayed, please inform us when you send them.**

PRIVACY OFFICER:

Margaret Boudreaux: 763 Peachtree Parkway Suite 2
Cumming, GA 30041
Phone (678) 208-2050
Fax(678)208-2051

BUSINESS MANAGER:
Jerome Boudreaux : address same as above

7/6/2010