BARROW PEDIATRICS - Information *(Please Print)*

Patient Information:

Patient Name:_____
Address:_____ City:_____ State:____ Zip:_____
Phone #:_____ DOB:_____ Age:_____Sex: M F
Allergies:_____ Preferred Language:_____
Mother's Maiden Name:_____ Patient lives with: _____
Other Children Seen In Office:_____

Parent / Legal Guardian and Emergency Contact Information:

Parent/Legal Guardian #1:_____ Marital Status: M S D
Address:_____ City:_____ State:____ Zip:_____
Phone #:_____
Insurance Policy Holder's SSN:_____

Parent/Legal Guardian #2:_____ Marital Status: M S D
Address:_____ City:_____ State:____ Zip:_____
Phone #:_____
Insurance Policy Holder's SSN:_____

How May We Contact You For Appointment Reminders (Please Check)? ____ Text ____ Phone ____ E-Mail
E-Mail Address: _____

Office & Financial Policies Agreement

I declare that I am the Parent or Legal Guardian for the above-named Patient. My signature below acknowledges I have read and agree to Barrow Pediatrics' Office & Financial Policies Agreement as follows:

A FEE OF $25.00 WILL BE CHARGED FOR ANY APPOINTMENT THAT IS MISSED AND NOT CANCELLED BEFORE THE APPOINTMENT TIME. INSURANCE WILL NOT PAY THIS FEE! After missing three (3) appointments, you will be dismissed from the practice at which time you will have 30 days to find a new physician outside of Barrow Pediatrics. I acknowledge that I have read the Notice of Privacy Practices displayed in the office of Barrow Pediatrics. Co–pays and payments for services are due at the time services are rendered. This document can, and if necessary, will be used in a court of law. A photocopy of this agreement is considered as valid as an original. If fees are incurred in order to collect any delinquent accounts, those fees will be the responsibility of the parent / legal guardian. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby assign all medical and/or surgical benefits, to include medical major benefits to which the patient is entitled, private insurance and any other health plan to Barrow Pediatrics. This assignment will remain in effect until revoked by me in writing. I authorize Barrow Pediatrics to release any information necessary to secure payment for services rendered.

*Parent / Legal Guardian Sign*_____ *Date*_____

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Office & Financial Policies Agreement (Continued)

I hereby consent to today's visit and all subsequent visits for examination and treatment by Barrow Pediatrics' staff. I authorize all routine office procedures and services, treatment, examination, and diagnostic procedures, including but not limited to laboratory testing, drugs, or other procedures deemed necessary by the Doctor. I certify that no guarantees have been made regarding the results or outcomes that may be obtained from this treatment.

By signing below, I give consent to my child's treatment by Barrow Pediatrics with the understanding that I will cooperate when referred to other physicians or medical facilities for examination or testing of my child. I understand that non-compliance with my child's plan of treatment may result in the refusal of further care from Barrow Pediatrics. My signature below also authorizes Barrow Pediatrics to release any health-related information acquired during my child's evaluation or treatment necessary for processing health-care insurance claims for services rendered and/or referrals to other physicians or medical facilities for the purpose of my child's medical care.

I authorize and request that my insurance company assign payment directly to Barrow Pediatrics for services rendered to my dependent. I understand that I am responsible for all charges regardless of insurance coverage. I understand that it is my responsibility to verify covered benefits with my carrier, obtain proper referrals, and pay the treating physician co-payment, deductible and co-insurance amounts.

Due to our contractual agreements with insurance companies and State Law, all co-pays **MUST** be collected at the time of service. All deductibles **must** also be collected after filing with your insurance. All deductibles will be collected at the time of service if we are not a participating provider with your insurance company.

I have read and understand this practice's Notice of Privacy Practices located on the wall in the waiting room. This notice provides in detail the uses and disclosures of your child's protected health information that may be made by this practice, your child's individual rights and the practice's legal duties with respect to your child's protected health information.

For your convenience, we will accept your personal check for payment of services. In the event that this check is not honored by your bank, we reserve the right to collect the check electronically for the face value of the check, plus a $30 processing fee.

If your account becomes past due, we will take necessary steps to collect this debt. Your delinquent account will be reported to credit bureaus. If we have to refer your account to a collection agency, you agree to pay all of the collection costs (40% of the past-due amount). If we have to refer collection of the balance to a lawyer, you agree to pay all legal fees incurred plus all court costs. In the case of a suit, you agree the venue shall be Barrow County, Georgia.

No future appointments will be scheduled until fees are paid in full.

By signing and dating below, you are agreeing to all of the above terms. Thank you. We look forward to working with you to achieve your child's healthcare goals!

*Parent / Legal Guardian Sign*_____ *Date*_____