Welcome to Barrow Pediatrics – New Patient

Patient Information (PLEASE PRINT):

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 and Financial Policies

Please carefully read each section below and initial if you agree with the terms:

_____ I declare that I am the Parent or Legal Guardian for the above-named Patient.

_____ 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.

_____ 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 treatment plan may result in the refusal of further care from Barrow Pediatrics.
I authorize 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 my child's medical care.

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Office and Financial Policies (Cont.)

Please carefully read each section below and initial if you agree with the terms:

_____ I authorize and request that my insurance company assign payment directly to Barrow Pediatrics for services rendered to my child. This assignment will remain in effect until revoked by me in writing. *I understand that I am ultimately responsible for payment of all charges incurred for my child's care, regardless of insurance coverage.* I realize it is my responsibility to verify covered benefits with my insurer, obtain proper referrals, and pay the treating physician co-payment, deductible and co-insurance amounts.

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

_____ I have read and understand the 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 Barrow Pediatrics, along with your child's individual rights and our legal duties with respect to your child's protected health information.

_____ For your convenience, we accept most major credit cards as payment for services. Since we are charged a *credit-card processing fee* when using this service, we assess a $1.95 fee for credit-card charges up to $35; and a $2.95 fee for charges over $35. We also accept personal checks for payment. If your check is not honored by your bank, you agree to pay a $30 NSF (non-sufficient funds) fee, in addition to the check's face value.

_____ If unable to keep your child's appointment, please call and *cancel* the appointment at least 24 hours before the scheduled time. This will allow another child to use that appointment slot. A FEE OF $25.00 WILL BE CHARGED FOR ANY APPOINTMENT THAT IS MISSED AND NOT CANCELLED AT LEAST 24 HOURS BEFORE THE APPOINTMENT TIME. After missing three (3) appointments, your child will be dismissed from the practice at which time you will have 30 days to find a new physician outside of Barrow Pediatrics.

_____ If your account becomes **past due**, we will take steps to collect the balance owed. However, if we must refer your account to a Collection Agency, in addition to your past-due balance, you agree to pay all collection fees (25% of the past-due amount). If we need 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.***

Thank you! We look forward to working with you to achieve your child's healthcare goals.

If you agree with all the above terms, please sign and date below:

Patient Name ____ *DOB*___________

(Please Print)

*Parent / Legal Guardian Sign*____________________________ *Date*___________