Pediatric Partners OF AUGUSTA

PATIENT REGISTRATION FORM

The primary caregiver who holds the primary insurance is responsible for the payment of all charges not paid for by the policyholder's insurance (for example: co –pay amounts, deductibles, any services not covered by the insurance company. It is the responsibility of the caregiver bringing the child(ren) to pay all applicable co-payments.

In the event of divorce or separation, it is the mutual responsibility of both caregivers to work together to ensure that all charges not paid by the appropriate insurance company are paid in a timely manner. Pediatric Partners will NOT become involved in how these charges and payments are allocated, if applicable, among parents/guardians.

Patient _____

DOB _____ Social Security # _____ Sex ◯ M ◯ F

Address _____

Primary Caregiver(s)/Who does child(ren) live with**?** _____

Parent#1 _____ Social Security # _____ Marital Status S M D

Relationship to patient _____ Date of Birth _____ ◯ ◯ ◯

Address _____

Preferred Phone # _____ Work Phone # _____

Can confidential messages be left on your voice mail? ☐ Yes ☐ No Email address _____

Parent#2 _____ Social Security # _____ Marital Status S M D

Relationship to patient _____ Date of Birth _____ ◯ ◯ ◯

Address _____

Preferred Phone # _____ Work Phone # _____

Can confidential messages be left on your voice mail? ☐ Yes ☐ No Email address _____

Race American Indian ◯ Asian ◯ Black/African American ◯ White ◯ Native Hawaiian ◯ More than One Race ◯

Preferred Language English ◯ Spanish ◯ Other ◯

Ethnicity Hispanic/Latino ◯ Not Spanish/Latino ◯

Primary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder's DOB _____ Social Security #_____

Secondary Insurance Company _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder's DOB _____ Social Security #_____

_____ _____

Responsible Party Date

Patient Name _____ **DOB**_____

Website – _____

PEDIATRIC PARTNERS OF AUGUSTA, LLC

CONSENT FOR VACCINATION FORM

Patient _____ Date of Birth _____

I understand that Pediatric Partners of Augusta, LLC will furnish information to me about the risks/benefits of each vaccine and of the appropriate diseases prior to giving the vaccination(s) to my child/ren. I also understand that I will have the opportunity to ask any questions and have them fully answered to my satisfaction before the administration of any immunization(s).

My signature below indicates that I will decide based upon the information provided to me and upon my understanding of the risks and benefits of each vaccine and will give my verbal and/or written permission prior to the administration of each vaccine to be given to my child/ren or the person(s) named above for whom I am authorized to make this decision.

_____
Signature of parent or guardian

_____
Date

No Show Policy

We want to thank you for choosing us as your children's healthcare provider. We are committed to providing your children with the best possible medical care.

Your clear understanding of our practice's general policies are important to our physician-patient relationship. We make every effort to keep our quality high while providing excellent service.

Missing Appointments

We understand that scheduling conflicts occur from time to time. If you are unable to keep your scheduled appointment, we request that you contact our office at least two hours in advance. If we are not notified that you will be unable to keep your appointment, you may be charged a fee. Most insurance companies will NOT cover this charge.

We have developed this policy in an effort to better serve our patients by providing same day appointments for those who are sick and need to be seen that day. If a schedule is made and the appointment not kept, we have lost an available time that could have been used to see a sick child.

Excessive missed appointments will result in your family being dismissed from the practice. If you have 3 missed appointments in a calendar year you will not be allowed to schedule another appointment and will need to find another provider. We will provide you with a warning after your 2nd missed appointment.

My signature below indicates that I have read and understand this no show policy.

_____

Signature of parent or guardian

_____

Date

POLICIES AND PROCEDURES

Your clear understanding of our practice's general and financial policies are important to our physician-patient relationship. We make every effort to keep our quality high and our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

BILLING

We file your insurance claims as a courtesy to you. Even though a claim to your insurance company may have been filed, you will receive a statement reflecting your current balance. This balance is your responsibility. After 90 days, this balance reflecting patient responsibility becomes PAST DUE. At this time, we may use an outside collection agency to assist us in collecting these past due balances. If this occurs, an additional charge of up to $100 will be added to your account for the additional cost to collect the overdue balance. If your overdue account is turned over to an external collection agency, we will NOT be able to schedule any preventive, well child examinations or school/sports physicals for all children on that account. If you have financial situations which cause your children's medical expenses to be a burden, please call our billing office to speak with our financial counselors.

FINANCIAL POLICIES

You are financially responsible for the cost of your child(ren)'s medical care. If you have medical insurance coverage, this is a contract between you and your insurance company. If you have insurance coverage, the determination as to whether your insurance company will cover any services your child receives is entirely up to them.

Insurance companies typically do NOT cover all medical costs. Some pay fixed allowances for each office visit, while others pay only a percentage. Procedures, labs, and diagnostic testing may have a higher co-payment or fall under the plan's deductible.

We depend on you to provide us with the correct and current insurance information so that we may file your claim appropriately. It is your responsibility to know and to inform us if your insurance company requires a co-pay amount, and if you are required to use a specific hospital, laboratory or radiology facility. If you do not provide us with the correct information at the time of your child's visit, and your insurance company denies payment, you will be responsible for all the resulting charges.

Insurance co-payment amounts are due at the time of service. If not collected at the time of your child(ren)'s visit, we will charge the responsible party an additional $15.00. This additional amount will not be covered by your insurance company and will be your responsibility.

If your insurance company will not cover the services your child needs, or if you have no insurance, payment in full is expected at the time of service. We offer a discount for full cash payments.

I hereby authorize the physicians of Pediatric Partners of Augusta, LLC, to administer/perform any medical and/or surgical procedures deemed necessary and authorize release of information necessary to secure payment. I authorize all benefits paid by my insurance company to be paid directly to Pediatric Partners of Augusta, LLC.

Signature of Insurance Policyholder_____ Date_____

DIVORCE, CUSTODY AND SEPARATION ISSUES:

It is imperative that in cases of divorce or separation that PPA be notified as soon as possible as to who responsibility as designated by the court as the primary custodian and who has final decision making authority, and whom has responsibility for holding insurance for the child(ren). It is imperative that we obtain a copy of the appropriate documentation outlining these issues for inclusion in your children's medical records. PPA will look to the person(s) with primary responsibility and/or the designated primary custodial parent to be responsible for the payment of all charges not covered by the insurance company. It is the parent's responsibility to work together to ensure that all charges not paid by the insurance company are paid to PPA in a timely manner. PPA will NOT become involved in how appropriate non covered services are allocated amongst the parents.

NOTICE OF PATIENT PRIVACY

I hereby acknowledge that Pediatric Partners of Augusta, LLC may share my child(ren)'s medical information as permitted under appropriate federal law (HIPAA) and Georgia State law with other health care providers through a Health Information Exchange.

We may make your child(ren)'s medical information available electronically through state, regional or national medical information exchange services which will help make your child's medical information readily available to other health care providers who may need access in order to treat your child(ren). Participation in Health Exchange Services also provides that we may receive medical information about your child(ren) from other health care providers.

In addition granting permission to participation in the Health Information Exchange, I have had the opportunity to read, review and to receive if requested a copy of Pediatric Partners of Augusta, LLC Notice of Privacy Practices which details how my child(ren)'s health information may be used and disclosed under Federal and State laws.

LABORATORY AND RADIOLOGY SERVICES

Your PPA provider may order laboratory and/or radiology studies to assist them in the evaluation and treatment of your child(ren). I understand and agree that it is my responsibility to know and to communicate to Pediatric Partners of Augusta, LLC which laboratory/radiology provider ("In Network Provider") my insurance plan requires me to use in order for my child(ren)'s diagnostic studies to be reimbursed by my insurance company. I understand and fully agree that I am fully responsible for all charges incurred for laboratory/radiology services rendered that were not covered by my insurance plan(s). In Network Laboratory _____ In Network Radiology_____

OTHER

- Immunization records are generally prepared within 48 hours and are provided free of charge
- Physical Examination forms (school sports, etc.) are generally prepared within 48 hours and are provided free of charge provided that your child has been seen within the past 12 months or otherwise noted.
- Visits to our After Hours Clinic have an additional after hours fee of $25.00. Not all insurance plans cover this cost.
- If we are unable to verify your insurance coverage within 24 hours of your scheduled appointment, we will re-schedule your appointment and notify you as appropriate.
- If payment is made by a check that is returned as unpaid/insufficient funds by the bank, your child(ren)'s account will be charged $35.00 bank processing fee.
- All patients who receive controlled substance medications (ADD/ADHD, pain medications) are required to pick up the printed prescription at the appropriate office location and sign the necessary documentation.

I have read, accepted and agree to the above.

Responsibile Party _____ Date _____

Pediatric Partners Representative_____

NOTICE OF PRIVACY PRACTICES

This notice describes how protected health information may be used and disclosed and how you may have access to this information. Please review it carefully.

We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they related to your protected health information.

Understanding your Health Record Information

Each time you visit Pediatric Partners of Augusta, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment and a plan for future care or treatment. This information serves as a:

-Basis for planning your care and treatment
-Means of communicating among the many health professionals who may contribute to your care
-Legal document outlining the care you received
-Means by which you or a third party may verify that the services billed were actually provided
-Tool to educate other health professionals
-Source of information for Public Health officials charged with monitoring and improving the health of this state and the nation
-Source of data from which PPA can plan for the future care delivery strategies
-Tool by which we can assess and continually strive to improve the care we provide to our patients and the resulting outcomes

Having a better understanding of what your health information is and how it is used will help you to: ensure its accuracy, make more informed decisions when authorizing disclosure to others, and better understand both who and why others may access your health information.

Your Rights:

Although your health record is the property of Pediatric Partners of Augusta, LLC, the information contained herein belongs to you. You have the right to:

-Request a paper or electronic copy of this notice of Privacy Practices upon request.
-Inspect and copy your health record.
-Request that your health record be amended.
-Obtain an accounting of disclosures of your health information. To accomplish this, please contact the Administrator.
-Request that restrictions be places upon the use or disclosure of your health information
-Revoke your authorizations to use or disclose your health information.
-Request that we not submit your health information to your health insurance carrier if you have paid for the service in full yourself.
-Request an electronic copy of your health record.
-Restrict specific disclosures to your health insurance carrier if you have paid for the service in full yourself.

Our Responsibilities

Pediatric Partners of Augusta, LLC is required to:

-Maintain the privacy of your health information
-Provide you with this notice of our Privacy Practices
-Abide by the terms and condition so f this Agreement
-Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
-Notify you of a breach of unsecured health information

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please contact the Administrator in writing. If you have questions and would like additional information, please contact the Administrator at 706.854.2517.

If you believe your privacy rights have been violated, you can either file a complaint with the Administrator or with the Office of Civil Rights, US Department of Health and Human Services. There will no retaliation against you or your children for filing a complaint to either party.

The address for the OCR is:

Office for Civil Rights
Us Department of Health and Human Services
200 Independence Avenue, SW
Room 509 HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Healthcare Operations

We will use your health information for treatment

For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your electronic health record and used to determine the course of treatment that the provider would work best for you. Your physician will document in your health his or her expectations of the other members of your health care team who will participate in your care. These members will then record the actions they took and their observations. By examining these, your physician will assess how you are responding to treatment.

We will share your medical information as permitted under federal law (HIPAA) and Georgia state law, with healthcare providers through a statewide Health Information Exchange.

We will use your health information for payment

For example: A bill for services rendered may be sent to you or a third party payor. The information accompanying this bill may include information that will identify you,, your diagnosis procedures and supplies used.

We will use your health information for regular health operations

For example: Our providers, clinical staff or other members of the quality improvement team may use information in your health record to assess the care rendered, and the outcomes achieved in both your and similar cases. This information will then be used in a continuous effort to improve the quality and effectiveness of the healthcare and services we provide.

Notification: We may use or disclose information to notify or assist in notifying a family member, other relative, or any other person responsible for your care that you so identify your care and your general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, or any other person that you so identify health information relevant to that person's involvement in your care of payment related to your care.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Reminders: We may contact you to provide appointment reminders or information about treatment alternatives of other health related services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and/or product defects, or post marketing surveillance information to enable product recalls, repairs or replacement

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing disease, injury or disability.

Law Enforcement: We may disclose health information as required by law for law enforcement purposes or in response to a valid subpoena

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member of business associate believes in good faith that weave engaged in unlawful conduct or have otherwise violated professional or clinical standards that are potentially endangering one or more patients, workers or the general public.

_____ _____

Signature of Responsible Party Date