# Patient Information Sheet

**Patient Information:**

**CHILD'S** Name (First, Middle, Last) ______________________________ Birthdate: ____________

Address: ______________________________ City: ____________________ State: __________ Zip __________

Language ____________ Race: ______________ Ethnicity: Hispanic/Latino Non-Hispanic/Latino Sex: Male or Female
(Please circle one of the above)

Emergency Contact (other than parent): ____________________ Relationship: ______________ Phone: ________________

Referred by: Hospital/O.B. PAL Website Insurance Co. Other (name): ______________
(Please circle one of the above)

**Parent / Guardian Information:**

**MOTHER'S** Name (First, Middle, Last): ________________________________________________

Address: ______________________________ City: ____________________ State: __________ Zip __________

Home Phone Number: __________________ Mobile Phone Number: __________________ Mobile Carrier: ______________

Work Phone Number: ______________ SS#: ____________________ Birth date: ________________

Preferred Method of Contact: Phone: _____ Email: _____ Text: _____

**FATHER'S** Name (First, Middle, Last): ________________________________________________

Address: ______________________________ City: ____________________ State: __________ Zip __________

Home Phone Number: __________________ Mobile Phone Number: __________________ Mobile Carrier: ______________

Work Phone Number: ____________________ SS#: ______________ Birth date: ________________

Preferred Method of Contact: Phone: _____ Email: _____ Text: _____

**INSURANCE Information:**

Name of person who carries the insurance coverage (the primary cardholder): ______________________________

Primary Insurance: ______________________________ Secondary: ______________________________

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PEDIATRIC ASSOCIATES OF LAWRENCEVILL, LLC AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFROMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT OF MYSELF/OR MY DEPENDENTS. I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGES EXCEPT THOSE UNDER THE CONTRACTUAL ARRANGEMENTS WITH CERTAIN INSURERS OF PEDIATRIC ASSOCIATIES OF LAWRENCEVILLE, LLC.

I GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO ACCOMPANY MY CHILD FOR MEDICAL TREATMENT AND TO MAKE MEDICAL DECISIONS IN MY ABSENCE:

1. ______________________________
2. ______________________________
3. ______________________________

**Signature of Patient, Parent or Guardian:** ______________________________ Date: ________________

**PLEASE FILL IN FORM COMPLETELY, FAILURE TO DO SO WILL RESULT IN DELAY OF YOUR APPOINTMENT**

PEDIATRIC ASSOCIATES OF LAWRENCEVILLE

Birth History:

Delivery: Birth Weight:______________ Length:_____________
______Vaginal _____C-Section ______Full Term ______Premature

Mother's Illness during Pregnancy:_______________________________________________

Problems during or around Delivery:______________________________________________

Do you think your child's development is: _______On Target _________Delayed
If delayed, please explain:_____________________________________________________

Has your child ever been hospitalized or had surgery:_____Yes ______No
If yes, please explain:_________________________________________________________

Any recurring/major illnesses or injuries: _________Yes ______No
If yes, please explain:_________________________________________________________

School problems/issues: __________Yes ______No
If yes, please explain:_________________________________________________________

Other Concerns:_______________________________________________________________

______________________________________________________________________________

Allergies:
______Drug ______Insects _____Food ______Environmental
Please explain:_______________________________________________________________

Family History:
Has anyone in your Child's family had any of the following diseases?
Please check all that apply:

______Alcohol / Drug Use ______Blood Disorder/Sickle Cell

______Asthma/Allergies _______Cancer

_______Behavior Problems ______ Diabetes

______ Hearing/Vision Problems _______Seizures/Epilepsy

_______Birth Defects ______ HIV/AIDS

Has anyone in your child's family had any of the following?
______ High Cholesterol ______ High Blood Pressure ______ Obesity
______ Early Heart Attack(s) – less than 40 years of age

# Office Policies and Procedures

Child's name___________________________________

Please Initial

________ ● **PHONE SYSTEM**: When you call our office, the phone system will be answered by our automated telephone system. Please listen carefully to the menu so that your call is directed to the appropriate department with little or no waiting time.

________ ● **CELL PHONES**: PLEASE TURN CELLULAR PHONES AND PAGERS OFF BEFORE ENTERING THE BUILDING

________ ● **WALK-INS**: If you walk in without an appointment, you may be directed to the Urgent Care Facility or the Emergency Room. We **work by appointment . There is a $20.00** convenience fee **in addition to your copay for walk ins**

________ ● **SICK VISITS**: If your child is sick, please make an appointment as early in the day as possible. We work by appointment only; no walk-ins. Patients arriving later than 20 minutes after the scheduled appointment time will have the option to reschedule or wait for the next available appointment that day. Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to another sick child.

________ ● **HEALTH CHECKS**: Try to schedule the health check appointment for your child in advance. This will enable us to accommodate your schedule and allow your child's physician to spend ample time answering your questions and evaluating your child. **Patients arriving late (20 minutes after scheduled appointment time) will need to reschedule**. We understand that situations arise where you cannot keep an appointment. Kindly notify us 24 hours in advance if you are unable to keep an appointment, or you will incur a missed appointment fee, **which your insurance does not** cover.

________ ● **IMMUNIZATIONS**: The Physicians of this practice have made it policy to immunize all patients of this practice. **If it is your choice not to immunize your child(ren), you will be asked to find a new pediatrician.**

________ ● **SATURDAY HOURS**: We provide Saturday morning hours in order to see your SICK child. Please call our office as early as possible to schedule an appointment. Phones are answered beginning at 9am. No walk-ins please.

________ ● **SIBLING POLICY**: If you have another child with you today who is ill and is not originally scheduled to see the doctor, please immediately notify the front desk so that we may try to accommodate your child. DO NOT wait to inform us after you have entered the exam room.

________ ● **NURSE PHONE CALLS**: The nurse line receives a high volume of calls. For your convenience, there is a voice mail system on this line. Please leave your name and phone number and spell your child's name and date of birth. One of our nurses will return your call as soon as possible. Morning calls are returned by 12:30pm, and afternoon calls by 5pm.

________ ● **PRESCRIPTION REFILLS**: For medication that cannot be called in, please notify us 48 hours in advance for picking up a prescription. The nurse will call in other medication refills as quickly as possible.

*(Please turn over to complete form)*

_________ ● **MEDICAL/IMMUNIZATION RECORDS**: Please give a minimum of <u>72 hours</u> notice for completion of school forms. This includes immunization records and physical forms. For a copy of the full chart, a medical record release form must be signed. Once we have the signed release form, there is a minimum of <u>72 hours</u> before these records become available. If a second release is requested a $15 charge will apply.

If you are a new patient <u>or</u> have changed pediatricians <u>or</u> have received immunizations from the Health Department, please check with our staff to make sure we have your child's immunization records on file. In the instance your child's immunization records are not found or are not shown "up-to-date", it is your responsibility to obtain the missing records. We highly recommend that you keep a personal copy of your child's immunization records – we would be happy to make a copy for you!

_________ ● **INSURANCE**: To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card <u>each time you visit our office</u>. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, **if you provide us with incorrect insurance information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing** fee.

- It is your responsibility to contact your insurance company and find out whether or not our doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors may participate in only one of these areas, not in all.

- It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy.

- The following circumstances may result in you being billed directly:

  ~ we are not participating physicians in your plan; insurance coverage is not in effect because of the date of visit
  ~ non-covered lab work is ordered/performed
  ~ or a non-covered service is performed or denied for the reason "not medically necessary"

- Co-payment is due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee. If someone other than the parent or guardian is bringing the patient, a **notice stating approval of the visit must be signed by the parent/guardian and presented at check-in**.

_________ ● **REFERRALS**: Referrals may be needed for specialists, emergency room visits, urgent care visits, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need <u>3 working days</u> to obtain a referral from your insurance.

_________ ● **LABS X-RAYS, OR OTHER AMBULATORY CARE SERVICES**: If labs, x-rays, or other ambulatory care services are required beyond your office visit, **it is your responsibility to know where your insurance company covers you to go for these services.** Each insurance company contracts with different companies.

I have read and understand the above mentioned policies, procedures, and notices.

Child's Name_______________________________________________________

Print Name_________________________________________________________

Relationship to Child_________________________________________________

Signature ______________________________________ Date _______________

# Pediatric Associates of Lawrenceville, LLC

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY PRACTICE**

By signing this authorization, I authorize Pediatric Associates of Lawrenceville, LLC (PAL) to use/or disclose certain protected health information (PHI) about____________________________________.
(Child's Name)

This authorization permits PAL to use and/or disclose the following individually identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purposes:
*Insurance information, further medical care, immunization forms to schools, daycare, college forms, camp forms ,sports physical forms, and to call prescriptions to pharmacy.*

*Other:*___________________________________________________________________________

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on (Choose One):
____ Child's 21st Birthday or _______________ (Expiration date or defined event)

The Practice ________ will ______X____ will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from PAL. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

755 Old Norcross Road
Lawrenceville, Georgia 30045

**I acknowledge receipt of the Notice of Privacy Practices of Pediatric Associates of Lawrenceville, LLC.**

Signed by:_________________________________ _______________________________
Signature of Patient or Legal Guardian Patient's Name

_________________________________ _______________________________
Print Name of Patient or Legal Guardian Date

As the personal representative, I have the authority to act for the Patient because I am the Patient's _____________________ *(relationship to Patient)*