



PATIENT INFORMATION

PATIENT _____

TODAY'S DATE _____

ADDRESS _____

BIRTHDATE _____

GENDER Female Male
RACE: Caucasian African-American Hispanic
 American Indian Other
ETHNICITY _____

PHONE # _____
PREFERRED LANGUAGE _____

PARENT INFORMATION

FATHER'S NAME _____

MOTHER'S NAME _____

S.S. # _____ DOB ___ / ___ / ___

S.S. # _____ DOB ___ / ___ / ___

ADDRESS (CHECK IF SAME AS PATIENT ___)

ADDRESS (CHECK IF SAME AS PATIENT ___)

HOME PHONE # _____

HOME PHONE # _____

WORK PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

CELL PHONE # _____

E-MAIL _____

E-MAIL _____

EMPLOYER _____

EMPLOYER _____

INSURANCE CO. _____

INSURED'S NAME _____

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorized payment of medical benefits to North Fulton Pediatrics, P.C. for services rendered and agree to the below stated method of payment and term of payment.

SIGNATURE OF INSURED _____ DATE _____

NEAREST RELATIVE OR PERSON TO CONTACT IN CASE OF AN EMERGENCY:

NAME _____ PHONE _____

ADDRESS _____

HOW DID YOU HEAR OF NORTH FULTON PEDIATRICS?

FRIEND _____ PHYSICIAN _____
 WEBSITE YELLOW PAGES INSURANCE COMPANY OTHER

1285 Hembree Road, Suite 100, Roswell, GA 30076 Phone: 770-442-1050 Fax: 770-475-1621

www.northfultonpediatrics.com



Today's Date: _____

Patient's Name: _____

Date of birth: _____

MEDICAL HISTORY

FAMILY HISTORY (Ages 5 Years and Older)

Mother: _____ Birth Date: _____
 Health: _____
 Father: _____ Birth Date: _____
 Health: _____

Child's Name	Relationship to child	Birth Date

Please list all children living in the child's home. Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

Family Health Problems (Check appropriate items):

<input type="checkbox"/> Allergies	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sickle cell disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Immune problem, HIV, AIDS	<input type="checkbox"/> Sudden death
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Heart attack/stroke < age 50	<input type="checkbox"/> Seizures	<input type="checkbox"/> _____

CHILD'S HEALTH HISTORY

Pregnancy and Birth Problems _____

Hospitalizations/ _____

Surgery: _____

Are immunizations up to date? _____ Allergies to medication: _____

Current medications: _____

Check appropriate items child has had in part:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Frequent sore throats
<input type="checkbox"/> Anemia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart murmur/problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Frequent abdominal pains	<input type="checkbox"/> Seizures
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/> Bronchiolitis/bronchitis	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Urinary infection
<input type="checkbox"/> Other: _____		

Has your child had any problems in his/her development?/Behavior concerns?: _____

School: _____ Grade: _____ School Performance/Problems?: _____

Former Pediatrician and other Specialists who have seen your child (name/location): _____



NORTH FULTON PEDIATRICS, PC FINANCIAL POLICY

Thank you for choosing North Fulton Pediatrics as your health care provider. Please understand that payment of your bill is considered a part of your care. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payments and deductibles are due at the time of service. These fees cannot be waived. For your convenience, we accept cash, check, Visa/MasterCard (including debit cards), American Express and Discover.

NON-CONTRACTUAL INSURANCE

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your bill, at each visit, so you will be able to file your claim with your insurance company.

CONTRACTUAL INSURANCE

If we are a participating provider, all co-pays and co-insurance amounts are due at the time of service. In the event that your insurance coverage changes to a plan for which we are not a participating provider, we will provide you with a bill so you will be able to file the claim with your insurance company. The full amount will then be due at the time of service.

Please be aware that some of the services provided may be non-covered services and not considered reimbursable under your insurance plan. You are personally responsible for these services.

We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company we will attempt to resolve it with you. During this time a statement will be mailed to you each month your account shows a balance due. For all insurance other than HMO's, if your insurance has not paid within 90 days; the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

VACCINES FOR CHILDREN (VFC) PROGRAM

Children who are not insured, or are insured but do not have vaccine coverage, are enrolled in Medicaid, or are American Indian or Native Alaskan qualify for the Vaccines For Children program. The vaccines are provided free of charge, but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC program, it is required that the nurse be told at the beginning of your child's visit. We cannot implement this program retroactively.

INTEREST

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) as provided by the state law on all past due account balances.

ADMINISTRATIVE FEE

For all forms filled out by this office, there will be a \$10.00 processing fee per form payable in advance. Some specialty forms (Katie Beckett) will have an additional fee. Any 2nd request for state forms will be charged a \$10.00 fee payable in advance.

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

All patients under the age of 18 years old must be accompanied by a parent or guardian. Only patients for emergency treatment will be seen without a parent or guardian.

RETURN CHECK FEES

A \$25.00 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check and checks drawn on a closed account. This charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action. Any family account that has a history of more than two returned checks for insufficient funds will require cash or approved credit card payments for all visits thereafter.

DELINQUENT ACCOUNTS

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator prior to your visit. Failure to resolve any past due accounts including any returned checks will result in referral to a collection agency. In the event your account is sent to a collection agency, a 30% collection fee will be added to your outstanding account balance.

North Fulton Pediatrics may need to disclose to a collection agency personal health information related to receiving payment for services rendered in the event your account is delinquent.

Any family whose account is forwarded to a collection agency will be dismissed from our practice. At this point, if you have a PCP assigned to you then you must contact your insurance company and request to be assigned to another office.

TRANSFERING OF MEDICAL RECORDS

Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for medical records be transferred. An immunization record, growth chart, and problem list can be provided at no charge. Otherwise, there will be an administration fee charged in accordance with the State regulations for the copying of medical records.

NURSE FEE

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in addition to the procedure performed. All appropriate co-payments will apply.

All patients are asked to please check out before leaving the office. It is unlawful to intentionally walk out without satisfying your financial obligations after treatment has been rendered.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand this Financial Policy.

Signature of Parent or Guardian

Date

Patient Name

North Fulton Pediatrics

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I, _____, have had the opportunity to review a copy of North Fulton Pediatrics Notice of Privacy Practices.

Signature of Patient/Parent/Guardian

Date

Relationship to patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____
Date

Initials

I hereby grant permission to North Fulton Pediatrics to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.

Personal or detailed information will not be left on an answering machine or voice mail.

Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____
Date

Initials