

Date: _____

Name: _____

Birth Date: _____

**MEDICAL HISTORY
(Ages 5 Years and Older)**

FAMILY HISTORY

Mother: _____ Birth Date: _____

Health: _____

Father: _____ Birth Date: _____

Health: _____

Siblings (Name/Date of birth/Health): _____

Family Health Problems (Check appropriate items):

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart attack or stroke at age less than 60 | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |

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"/> Pneumonia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Bronchiolitis/Bronchitis | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Frequent Abdominal Pains |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Bed Wetting |

Other: _____

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

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

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

NORTH FULTON PEDIATRICS - FORM PACKET FOR AGES 5 YEARS AND OLDER

PATIENT INFORMATION

PATIENT _____

TODAY'S DATE _____

ADDRESS _____

BIRTHDATE _____

S.S. # _____

PHONE # _____

PARENT INFORMATION

FATHER'S NAME _____

MOTHER'S NAME _____

S.S. # _____

S.S. # _____

ADDRESS (CHECK IF SAME AS PATIENT ____)

ADDRESS (CHECK IF SAME AS PATIENT ____)

HOME PHONE # _____

HOME PHONE # _____

WORK PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

CELL PHONE # _____

EMPLOYER _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S ADDRESS _____

INSURANCE CO. _____

INSURED'S NAME _____

I.D. # (S.S. #) _____

CLAIM ADDRESS _____

GROUP # _____

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 authorize payment of medical benefits to North Fulton Pediatrics, P.C. for services rendered and agree to the below stated method of payment and terms 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 _____

YELLOW PAGES _____ INSURANCE COMPANY _____ OTHER _____

METHOD OF PAYMENT: CASH _____ CHECK _____ OTHER _____ MEDICAID _____

WE RESERVE THE RIGHT TO CHARGE INTEREST IN THE AMOUNT OF 1.5% MONTHLY (18% ANNUALLY) AS PROVIDED BY THE STATE LAW ON ALL ACCOUNTS UNPAID 60 DAYS AFTER SERVICE IS PROVIDED.

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NORTH FULTON PEDIATRICS, P. C. 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

Participation forms for camp, school, and sports, etc. will be charged a \$10.00 processing fee payable in advance. Any 2nd request for state forms will be charged a \$10.00 fee payable in advance.

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