Pediatric Associates of North Atlanta, P.C.
5185 Peachtree Parkway, Suite 330, Peachtree Corners, GA 30092
Tel. 770-476-9885 Fax. 770-476-8482

PLACE BARCODE HERE

PLEASE FILL OUT THE FOLLOWING INFORMATION IN ITS ENTIRETY

Whose name is on the policy? (circle one)	Mother	Father	Child
Primary Email Address:		Insured DOB:	
Insurance Company Name:			
Patient ID #		Group #	
Parents' Marital Status (circle one)	Single	Married	Divorced
If divorced, who does the child live with: (circle one)	Mom	Dad	

Father's Name:					
Father's Home Address:					
City:		State:		Zip Code:	
Home #:		Cell #:			
Alternate Email Address:					
Employer's Name:		Work #:			
Employer's Address:					

Mother's Name:		Maiden Name:			
Mother's Home Address:					
City:		State:		Zip Code:	
Home #:		Cell #:			
Alternate Email Address:					
Employer's Name:		Work #:			
Employer's Address:					

Referred by:

Your Child's Full Name	M/F	Date of Birth	Primary Doctor	Preferred Name

ASSIGNMENT, RELEASE AND PAYMENT: I hereby authorize my insurance benefits be paid directly to Pediatric Associates of North Atlanta, P.C. I accept financial responsibility for co-pays, co-insurance, cancellation fees and non-covered services at the time of service. I hereby authorize Pediatric Associates of North Atlanta, P.C. to release medical records to referring and family physicians, my insurance company and/or other medical or educational institutions as per my instructions. I hereby understand that past due accounts may be sent to collections and that I will be responsible for an administrative fee in addition to the outstanding balance.

Signed:		Date:	

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FINANCIAL POLICY

Pediatric Associates of North Atlanta's primary goal is to provide superior medical care for each child in our practice. In reaching this goal, we must be able to communicate openly and effectively with our patients and their caregivers. This financial policy outlines some important changes that we would like to bring to your attention.

OUR POLICY ON INSURANCE

As a courtesy to our patients, we want to assist you in using your insurance correctly. In order to accommodate the needs and request of our patients, we are enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is imperative that we have your cooperation and understanding. We will verify coverage when new insurance is presented at the time of the visit. Because of the frequency in coverage changes these days, you as the policyholder are required to present the ***patient's*** insurance card at ***each visit.***

Responsibility of Patient

1. Present current insurance card at each visit.
2. Co-pays, co-insurance and non-covered service fees, as verified with your insurance company by our staff prior to your child's visit to our office, will be collected at the time of service.
3. Patients with HMO or POS plans must designate one of our physicians as the PCP prior to your child's visit.
4. Patients with HMO and some POS plans must contact our office before seeing any specialist for a referral. Primary care physicians cannot give you a referral after the visit.
5. Know your insurance company's requirements for pre-certification.
6. **Yearly wellness exams will be filed to your insurance company with the expectation that they will be covered at 100%. If any portion of the visit is not considered to be part of your wellness plan, the patient will be responsible for the amount designated by your insurance company.**

Administrative Service Fee (ASF)

As a courtesy to our patients, we will complete any required forms as a free service **during a patient's well-child office visit.**

Forms included but not limited to:

School registration forms	School Medication Auth.
3231 and 3300	School Physical forms
Insurance Applications	Boy-scout or Girl-scout forms
Over-the-counter medication	Katie Beckett forms
prescription requests (FSA)	Computer generated account
F.M.L.A. forms	reports
Camp Forms	Any other necessary forms

There is a fee for all forms outside the well exam. You may pay an annual ASF fee of $20.00 for the current year or $15 per form.

After Hours Telephone Calls

Our office has provided the services of the CHOA nurse advice line for after-hours calls at no cost to our patients. Due to significant increases in the rates of the nurse advice line, we are no longer able to absorb this cost. **After-hours calls to the CHOA nurse line or to physician on call will now incur a fee of $15 per call.** We encourage you to call our P.A.N.A. phone nurses during routine office hours with your questions, and reserve after-hours calls for emergencies only.

Cancellations and Missed Appointments

We require 24 hours cancellation notice for checkup appointments. Failure to cancel will result in a $50 fee. If you miss your child's sick appointment and do not call to cancel prior to the appointment time, you will incur a $25 fee. Cancellation fees are payable before or at your next office visit.

Collections Policy

To streamline the billing process, we will submit all claims to the insurance company on record. Should an overdue bill go without payment after significant efforts have been made by PANA, we will forward the claim to a collections agency. Once a patient's account has gone into collections we will not be able to schedule future appointments or order prescriptions until payment has been made. If an account remains in collections without payment made, we will have no other option but to discharge the patient from our practice.

Please sign below to acknowledge that you have read and agree to this financial policy, and agree to accept the responsibilities as described above.

Signed_____ **Date** _____

Pediatric Associates of North Atlanta, P.C.

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PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their **protected health information (PHI)**. The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

____ **Primary Telephone #** _____
____ May leave message with detailed Information
____ Leave message with call back number only

____ **Secondary Telephone #** _____
____ May leave message with detailed information
____ Leave message with call back number only

____ **Pharmacy #** _____
Rx will be called to this number

____ **Written Communication**
____ May mail to my home address
____ May mail to my office address
____ May fax to this number
fax # _____

____ **Electronic Mail Communication** ____ May use this email address
_____

The Privacy Rule (TPO) generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as adequate records.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

IF OLDER THAN 18 YEARS OLD, MY PHI MAY BE RELEASED TO:_____

By signing below I acknowledge having read the Patient Record of Disclosure, Patient Financial Policy and Informed Consent to Routine Procedures/Treatments. I have also been afforded a copy of our HIPAA Policy/Privacy Notice.

ACKNOWLEDGEMENT OF FINANCIAL POLICY: I have fully read the Patient Financial Policy and understand my financial responsibilities under this policy.
AUTHORIZATION FOR TREATMENT: I consent to examination, treatment, and any procedures including emergency treatment deemed necessary and ordered by our physician for my child and I am personally responsible for any charges.
AUTHORIZATION FOR INSURANCE: I authorize the release of any information concerning myself or child to my insurance company regarding treatment for services rendered.
AUTHORIZATION FOR INSURANCE BENEFITS: I authorize my insurance company to send payment directly to Pediatric Associates of North Atlanta, P.C. for services covered by my insurance plan.
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I hereby acknowledge that Pediatric Associates of North Atlanta, P.C. has provided me a copy of their Privacy Notice.
AUTHORIZATION TO CONTACT ME: I authorize Pediatric Associates of North Atlanta, P.C. to contact me by either phone, fax, electronic mail, or mail to provide a reminder appointment, gather demographic or insurance information, or to inform me of services or events offered at the facility.

READ ALL THE INFORMATION ABOVE BEFORE SIGNING BELOW
DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

SIGNED _____ DATE _____

PRINT _____ WITNESS _____

Authorization – Non-Parent/Guardian To Accompany Patient Periodically

There may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). **The person bringing your child will need to present a photo identification at time of service.**

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Pediatric Associates of North Atlanta (PANA) and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the PANA provider.

I also give them authority to make more serious or urgent health care decisions in the event of an emergency.

Parent/Guardian Cell Phone Number: _____
Parent/Guardian Cell Phone Number: _____

Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____
Child's Name: _____ DOB: _____

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

*****This authorization will not expire, please update this form accordingly*****

_____ _____
Signature of Parent/Guardian **Date**