Alpharetta Pediatrics

...where kids are special

Laura M. Bleekrode, M.D.

PATIENT INFORMATION SHEET

PATIENT NAME:_____

(LAST) (FIRST) (MIDDLE)

NICKNAME:_____ DATE OF BIRTH:_____

(CIRCLE ONE) SEX: M F ADOPTED: Y N

HOME PHONE: _____ CELL PHONE:_____ (MOM / DAD)

EMAIL ADDRESS:_____ (MOM / DAD)

HOME ADDRESS:

_____

_____

BILLING ADDRESS: (if different from home address)

_____

_____

PHARMACY: Name and Number: _____

SIBLINGS: Name and Birthday:

1)_____ 2)_____

3)_____ 4)_____

EMERGENCY CONTACT:

_____

(NAME AND CONTACT NUMBER - PLEASE CIRCLE ONE: CELL HOME WORK)

PARENT MARITAL STATUS: MARRIED DIVORCED SEPARATED OTHER_____

FATHER INFORMATION	MOTHER INFORMATION
FULL NAME:_____	_____
DOB:_____	_____
EMPLOYER:_____	_____
OCCUPATION:_____	_____
WORK PH:_____	_____
SOCIAL SECURITY #_____	_____

MOTHER'S MAIDEN NAME: _____

SIGNATURE:_____ DATE:_____

1100 Northmeadow Pkwy • Suite 108 • Roswell, Georgia 30076 • (770) 664-4430 • Fax (770) 664-7836
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ALPHARETTA PEDIATRICS

MEDICAL INFORMATION

Patient Name:			Name Called:	
Birthdate:	Age:	Sex:	Birth Weight:	Adopted ? Y N

Describe any complications of pregnancy, delivery, or following the birth in the hospital:

Has your child had any of the following illnesses?

_____ Rheumatic Fever _____ Meningitis _____ Pneumonia _____ Kidney Infections _____ Asthma

_____ Convulsions _____ Heart Murmur _____ Anemia _____ Bone Fractures (including skull)

Other: _____

Has your child had any surgeries? Please list with dates.

Please indicate any blood relatives that have or have had a significant illness and the approximate age the illness began.

(eg: diabetes, seizure disorder, cancer, heart disease, high blood pressure...)

Does your child have any known allergies to drugs , foods , or medications? _____ Yes _____No ____ Don't Know

If " YES " please specify: _____

Do you have your child's IMMUNIZATION RECORDS ? _____ Yes _____ No

If "NO", you must get them BEFORE your first check up with our office OR prior to any form completion by our office.

Any additional information we need to know about your child to better serve his / her needs or the needs of the family?

_____

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MANAGED CARE ACKNOWLEDGMENT

By my signature below, I acknowledge that I have been informed of the following information:

1. Many insurance plan requires that all health care be directed through this office. Therefore, I must see my primary care physician or one of her associates in the office to discuss any concerns or issues before any referral will be given. **It is my responsibility to check with my insurance company to see if a written referral is required.** If so, this office will handle all the necessary paperwork.

2. Referrals must be received or confirmed prior to visiting a specialist's office. Failure to obtain a referral may result in my insurance carrier failing to pay for the care and I can be held financially responsible for the service.

3. Most referrals will be handled **within 14 days** of the request. This is within the guidelines of the bulk of managed care health plans. Post-dated or same-day referrals are only completed with the approval of the physician or office manager.

4. I must notify this office following a visit to the emergency room or an urgent care facility within 48 hours of the service. **I should not assume that CHOA, the nurse advice line, or the physician on call will notify the office.**

5. If my child must see a specialist for any follow-up from an ER visit or urgent care facility visit, I must notify my PCP to obtain a referral. **I should not assume that the ER or urgent care facility has notified my physician.**

_____ _____

Signature of Parent or Guardian Date

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HIPPA ACKNOWLEDGEMENT FORM

Family or Patient consent

I. **I have been given the opportunity to read and understand the NOTICE OF PRIVACY PRACTICES of ALPHARETTA PEDIATRICS. I understand that I have rights outlined in this notice and can request a copy of this notice for my own personal records. I accept this notice as a protection of the patient's medical information.**

II. **Additionally, I give my permission for any routine results to be left as a message on the following phone number(s): YES _____**
Please enter numbers below:

_____

Decline permission: NO _____ (please initial to decline)

_____ _____

Signature of Parent / Guardian / Patient (if over 18yrs of age) **Date**

_____

Print Name for Accurate Reference

Children this Acknowledgement Protects:

_____

_____

_____

_____

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GENERAL FINANCIAL AGREEMENT

1) We require 24 hours notification for cancellations of any scheduled appointment. Failure to provide this notification will result in **a $25.00 fee for sick appointments and a $50.00 fee for well appointments.**

2) There is a **$20.00 fee** for all returned checks.

3) We submit claims to your insurance company as a courtesy to our clients. We will collect the copay and any co-insurance at the time of service. **Any balance we are unable to collect from the insurance company, after appropriate contractual adjustments are applied, will be your financial responsibility**.

4) In cases of divorce or multiple parent financial obligations, the following rules will apply:

   - **The parent who brings the child to the office is responsible to pay the full amount of the copay or coinsurance due at the time of service.** If the financial responsibility is shared in any way, it is your obligation to collect it from the other party. We will not split the bill or be responsible for collecting from a party that is not present. We will supply you with a duplicate copy or any copies necessary free of charge.
   - **We will send out one bill per family.** If the financial responsibility is shared than it is your responsibility to collect from the second party. We will print you a duplicate copy of any bills for you to send to the other party free of charge.

5) Every insurance policy is different and we are unable to provide you with the specifics of your policy. Any tests or procedures we perform are based on our evaluation of your child's needs at the time of service. **Some procedures may not be covered by your insurance company even though they are medically necessary for the appropriate care of your child. You will be financially responsible for payment of these procedures unless other payment arrangements are made, in writing, PRIOR to treatment.**

6) There is a **$5.00 fee** charged for any form completed outside of an office visit. Please make sure to ask for any forms at the time of service.

7) Our office policy is to **keep a copy of your credit card on file** to handle any outstanding balance. After properly submitting your claim to the insurance, **we will charge any balance indicated as patient responsibility by your insurance company to your credit card**. A duplicate invoice will then be sent to you detailing the transaction.

The office reserves the right to change these policies at any time. Your signature below represents your agreement to abide by these policies. Please feel free to speak with our billing department or the office manager regarding any questions about these policies.

I have read and fully understand the above information.

_____ _____

Signature Date

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OUTSIDE LAB: Agreement and Results Notification

A) Please be advised that the practitioners in our office MAY REQUEST that further laboratory evaluation for the most accurate diagnosis and treatment to be determined. We utilize the following LABS:

- PathGroup
- Diatherix
- Lab Corp
- Quest / Solstas

Please select the LAB required by your Insurance Company: _____

- If none selected, we will DEFAULT to PATHGROUP at this time.

Parent Name: _____

Insurance Company: _____

B) We cannot guarantee that the labs performed will be covered 100% by your insurance.

C) We do all that we can to work within the parameters of your insurance**. If your card states a specific lab for us to work with PLEASE MAKE THE SELECTION ABOVE.** However, every policy is different and we are not responsible to understand your individual plan. If you feel it is necessary to contact your plan prior to any labs being sent out, please notify the nurse. You may contact them and relay any necessary information to our staff.

D) We REQUIRE that you set up a follow up appointment to review the results of any LABS performed outside of a routine well check up. On occasion, an appointment for routine lab results is required as well.

If you would like to allow us to leave a message concerning any routine lab results received, please INITIAL and leave us the appropriate phone numbers: YES _____ NO _____

Phone number for message: _____

_____ _____

Signature Date

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INSURANCE INFORMATION SHEET

ASSIGNMENT OF BENEFITS:

I hereby authorize payment of medical benefits directly to the physician's office. I further authorize the physician and/or practitioner to release any information required to process the insurance claims.

I understand the above information to be correct and it is my responsibility to inform the office of any changes.

I understand that failure to do so may adversely affect the offices ability to collect from my insurance company and that I will be responsible to reimburse the office for those services.

I understand that all services provided to my child are ultimately my financial responsibility.

**** COPY OF INSURANCE CARD IS REQUIRED PRIOR TO SUBMISSION OF ANY CLAIMS ****

INSURANCE COMPANY: _____

PRIMARY INSURED: _____

PRIMARY INSURED DATE OF BIRTH: _____

PRIMARY INSURED SOCIAL SECURITY: _____

PRIMARY INSURED RELATIONSHIP TO PATIENT:

MOTHER **FATHER** **GRANDPARENT** **STEP-PARENT**

LEGAL GUARDIAN **OTHER:** _____

MEMBER ID NUMBER: _____

GROUP NUMBER: _____

EFFECTIVE DATE: _____

CLAIM SUBMISSION ADDRESS:

_____

CONTACT NUMBER: _____

SIGNATURE:_____ **DATE:**_____

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PRESCRIPTION AUTHORIZATION PROTOCOL

If it becomes necessary for your child to receive any type of routine prescriptions or maintenance medications while under our care, there are certain protocols in place that must be followed.

A) Any patient that is on a continual or routine medication is **required to have a yearly physical** in our office. This includes both controlled and non-controlled substances.

B) **Some medications require additional office visits**, outside of a yearly exam, to monitor weight and blood pressure. These appointments must be maintained as well per instructions by the physician.

C) Please **allow 3-5 business days for all medication refills**. This is especially important for CONTROLLED SUBSTANCES (ie: Concerta, Vyvanse, Ritalin etc.) since these require a Physician's signature prior to release of the script.

D) Any requests for dosage change while on a medication will require an office visit and can not be made over the phone.

_____ _____

Signature of Parent or Guardian **Date**

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AVAILITY # _____

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ALPHARETTA PEDIATRICS CREDIT CARD INFORMATION AGREEMENT

CREDIT CARD NUMBER: _____

EXPIRATION DATE:_____BILLING ZIP CODE _____

NAME ON CARD:_____

TYPE OF CARD: VISA MASTERCARD DISCOVER AMERICAN EXPRESS _____

I authorize Alpharetta Pediatrics to charge any account balance deemed ***patient responsibility*** including co-pays, by my insurance company to the card listed above. I understand that this amount will be taken from an ***explanation of benefits*** provided by my insurance company to Alpharetta Pediatrics. It will not include any balance deemed ***doctor responsibility*** by my insurance company or a ***negotiated discount*** taken by my insurance company. My signature below will serve as my authorization to charge my account when necessary. If I wish to revoke this authorization, I must provide Alpharetta Pediatrics notification in writing.

_____ _____

Signature Date

Please check one:

____ No approval necessary – please mail receipt to me

____ No approval necessary if under $100 – please mail receipt to me

____ Contact me before running charges - Phone # _____

____ I do not wish to place a card on file

Children Covered Under this Agreement – <u>List Name and Birth Date</u>

_____

_____

_____

_____

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