

Atlanta Pediatric Partners Patient Registration Form

Patient Information:

Patient Name	Last Firs	st Midd	lle	Date of Birth		Gender (Cir M	cle One) F
Street Apt.				Patient's Social Security Number			
City	State	Zip		Home Phone N	umber		
Parent l	nformation:	Child li	ves with ?				_
Mother's Name	Last	First	Middle	Father's Name	Last	First	Middle
Mother's l	Date or Birth	Mother's	SS#	Father's Date of	f Birth	Father's SS#	
Employer				Employer			
Business N	Number			Business Number			
Mobile Nu	ımber			Mobile Number			
Mother's Email Address			Father's Email Address				
Referred By:							
Name				Other			
Emerge	ncy Contact:						
Name Phone Number							
Primary	Insurance:						
Insurance Company Name:							
Claims Address:							
Name of F	Policy Holder:						
Member Identification Number							

Group Number	
Who should correspondence regarding bills go to? Mot l authorize the release to my Insurance Company of any is claims. Research, chart reviews and quality control.	
Signature(Guarantor, if minor)	Date
(Guarantor, ir ininior)	
I hereby assign payment directly to Atlanta Pediatric Part for these services. Although covered by insurance, I und unless covered by a managed care plan, Medicaid/Peach	erstand I am responsible for all charges
Signature_	Date
As a responsible party for the above named patient, I authorize the or medical information required to provide continuing an	e release of any personal, demographic
Signature	Date



I have agreed to allow certain individuals participate in the discussion and decisions to my child/children's medical care. Therefore, I hereby give my permission for Atlanta Pediatric Partners, PC to disclose my personal medial information to the following individual (s).

Name:		Relationship to Parent
Name:		Relationship to Parent
Name:		Relationship to Parent
Conditions	s for Disclosure (Check the item(s) that a	oply):
	☐ The practice may disclose my personal health information to the individual(s) above only in my presence.	
	1 ,	information to the individual(s) above in discussions physically present, including disclosures by
	Other conditions of disclosure:	
I understar	nd that this consent may be revoked at an	y time by written notice to the practice.
Patient Signature:		Date Sunder the age of 18 years old)
	(Parent's signature, if child is	s under the age of 18 years old)
Witnessed	l by:	Title/Position:
Print name	e of Witness:	Date:

Revised 03/17/2020



Billing Guidelines

Atlanta Pediatric Partners, PC billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the practice manager if you have any questions regarding this information.

Co-Pays

It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.

Co-Insurance/Deductibles

Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

Billing

As a courtesy, Atlanta Pediatric Partners bills your health insurance provider on your behalf, with the following guidelines/exceptions:

- Insurance Card: It is critical that the most current insurance card is brought to every **appointment.** We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
- Secondary Insurance: Atlanta Pediatric Partners bills Tricare and Medicaid from the secondary governmental plans

Combined Visits (well child exam and a sick visit)

If you are scheduled for a well child exam and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly.

• After Business Hours and Holiday Surcharge

Some health insurance providers bill a surcharge if you see your pediatrician after normal business hours or on a holiday.

Administrative Fees

Atlanta Pediatric partners charges various fees for the following items, which require personnel and resources to address:

- Copies of medical records
- Completion of additional school physical forms
- Special request completion of camp or sports physical forms (free during visit)
- Completion of FMLA paperwork
- Returned check (for insufficient funds): \$25.00
- "No-show" Fee: Assessed if you do not show up for a scheduled appointment and we do not receive a call at least 24 hours prior to the scheduled time: \$25.00

Medical Record Copies		
Copying cost per page (1-20)	\$0.97	
Copying cost per page (21-100+)	\$0.83	
Copying cost per page (100+)	\$0.66	

-Maximum charge of \$30.00 per individual plus postage costs. -Maxi

imum charge of \$75.00 per family plus postage cost.	
Revision Date: 3/17/2020	



No Show Policy:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Atlanta Pediatric Partners, P.C. sends text messages, email reminders, as well as voice call to our patients in advance of their scheduled appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule, and accommodate those patients who are waiting for an appointment. As courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least a 24 hour notification, you will incur a \$25.00 "No Show" service charge to your account. This "No Show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no show to your appointment, our practice may decide to terminate its relationship with you.

I understand the "No Show" policy of Atlanta Pediatric Partners, P.C. and understand should I
not give at least 24 hours' notice then my account will be charged \$25.00 per appointment. I
understand I must cancel or reschedule at 24 hours in advance in order to avoid a potential "No
Show" charge to my account.

Signature of Parent/Patient	Date	
Printed name of responsible party		



The Doctors and Staff of Atlanta Pediatric Partners want you to know how we will protect your private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, since April 14, 2003, new regulations became effective under a federal law called Health insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other healthcare providers, health insurance companies and their claim processing staff. In general, HIPAA enacted to establish national standards to:

Give patients more <u>control</u> over their health information;

Set boundaries for the use and release of health records;

Establish <u>safeguards</u> that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;

Hold violators accountable, with civil & criminal penalties; and

Try to balance need for individual privacy with requirement for <u>public responsibility</u> that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients that we see after April 14, 2003 with the attached Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below confirming that a full version of the policy is readily available in the waiting room for review. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Private Practices, please feel free to contact our (Office Manager/Privacy Officer).

Thank you for your cooperation.

I acknowledge that a copy of the Atlanta Pediatric Partners Notice of Privacy Practices policy is available, if requested, and have been given an opportunity to ask questions.

Patient Name:	
Signature of Patient or Personal Representative:	
	Date:



Financial Policy

Thank you for choosing Atlanta Pediatric Partners (APP) for your child's healthcare. APP is committed to keeping your insurance and other financial arrangement made with us as simple as possible. To assist in meeting this goal, please read and follow the guidelines below.

For Patient with Insurance:

APP is a provider of medical services. We are not party to the contract made between you and your employer and/or your insurance company. Therefore, we encourage you to contact your insurance carrier personally, in order to remain informed of your benefits. **Please bring your insurance card to each visit.**

If APP is not a participating provider listed on your insurance plan, then payment in full is due today. (See APP's Self –Pay Discount Policy). Since insurance plans cannot guarantee all eligibility or benefits, APP does not guarantee eligibility benefits. In those situations where the services APP provides are not covered by your insurance carrier, you will be responsible for any and all services over and above your insurance limits, as well as all non-covered medical services.

Co-payments or co-insurances: specified by your insurance carrier is expected at the time of services are rendered. Past due balances must be cleared prior to being seen by the physician. Cash, Checks, money orders, credit/debit cards are all acceptable forms of payment. Instamed is a secure and convenient option for patients to manage their healthcare payments.

The responsible party, the induvials named on the permission form (whether single, divorced or legally separated, friend or relative) accompanying the child at the time of his/her medical visit is the person responsible for making the co-payment and payment of past due balances, regardless of who provides the insurance coverage.

Bills and bill related correspondence are sent to the responsible party named on the insurance card. Please notify APP's billing office at (404) 699-1339, in advance, if someone other than this person should receive copies of bills/correspondences. APP will process and file your insurance claims for medical services performed at our clinic at no cost to you. Any outstanding claims not paid by your insurance company within 60 days of billing will be due by the patient's responsible party.

For Patient without Insurance:

Any balance over 90 days old is considered delinquent and will be turned over to an outside collection agency. In the event your account is turned over to collection, you will be billed and are responsible for paying the balance, plus a \$30 service charge. Once an account has been turned over to collection, your account must be paid in full before any future services are rendered.

Returned checks are subject to a handling fee of \$30.00.

If you have any questions about APP's Financial Policy, please discuss with our business office, (404) 699-1339. Thank you. I have read, understand and agree to my financial responsibilities under this policy.

Parent/Guardian/Responsible Party

Date



Atlanta Pediatric Partners, P.C 4579 S. Cobb Dr. SE, Suite 300 Smyrna, GA 30080 404/699-1339 Office 404/699-1380 Fax

Patient Name:	
Doctor/Facility:	
Patient DOB:	_
Fax:	
Γelephone:	
hereby authorize you to use or disclose the specific informulso described below.	rmation described below, only for the purpose and parties
Description of the specific information to be used or discl	osed:
_	

Person or entity requesting the information and authorized to make the requested use or disclosure:

Atlanta Pediatric Partners, P.C. 4579 S. Cobb Dr SE, Suite 300, Smyrna GA 30080

Continuation of Medical Care

This authorization shall remain in effect from the date signed below and for up to 90 days thereafter.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for the research-related treatment)
- If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Signature:	Relationship to Patient
Date:	· · · · · · · · · · · · · · · · · · ·