Covington Pediatrics patient registration

Patient Information

Patient Name: _____ DOB: ___/____/_____Gender: Male/ Female

Home Address: _____

City, State and Zip Code: _____

Ethnicity (please circle): Hispanic / Non-Hispanic / Unknown

Race (please circle): Asian / Black / Hawaiian / White

Phone Number for appointment reminders: _____

Email Address: _____

Primary Insurance Policy: Policy Holder's Name: _____ DOB: ___/____/___

Insurance Carrier: _____ ID and Group #: _____

Secondary Insurance Policy: Policy Holder's Name: _____ DOB: ___/____/____

Insurance Carrier: _____ ID and Group #: _____

Contact 1:

Name: _____ Relationship to patient_____

Lives with patient? (please circle) Yes / No DOB: ___/_____/_____ SS#: _____-____-_____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

Contact 2:

Name: _____ Relationship to patient_____

Lives with patient? (please circle) Yes / No DOB: ___/_____/_____ SS#: ____-___-_____

Work Phone: _____ Cell Phone: _____

Home Email: _____ Work Email: _____

Employer: _____ Occupation: _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointments, Reminders, Recall Notices, Billing Statement, General Practice Notices and Patient Portal Notifications list their preferences here: (work phone, cell phone, home email, or work email)

Emergency Contacts, other than parents:

Contact 1: _____ Relationship: _____

Phone Number: _____

Contact 2: : _____ Relationship: _____

Phone Number: _____

Who should receive billing statements? _____

May all contacts have access to the patients records electronically? Yes / No

If no, please explain and provide a copy of any legal paperwork that supports this restriction.

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please provide documentation.

COVINGTON PEDIATRICS , LLC

4181 HOSPITAL DRIVE SUITE 202
COVINGTON, GA 30014

Office Consent Form

Covington Pediatrics, LLC – consent is hereby given for staff and physicians to provide diagnostic procedures and to provide such treatment and care as in the opinion of treating provider may be necessary or appropriate. I understand that medicine is not an exact science, and no guarantee has been made as to the results of the treatment or care rendered.

By signing this form, I am consenting for Juliana Nahas, MD PC (dba: Covington Pediatrics) use and disclosures of any medical information deemed necessary without restrictions.

I authorize direct payment of medical benefits to Covington Pediatrics

PLEASE READ CAREFULLY:

- I understand that I am financially responsible for any balance not covered by insurance, including if services are rendered by a provider at Juliana Nahas, MD PC (dba Covington Pediatrics) who your carrier states is not a 'covered physician'.
- All accounts over 90 days past due will be reviewed for collections. In addition, if my Insurance, Medicaid, Peachstate, Amerigroup, Wellcare or Peachcare for Kids coverage is terminated during the time of my date of service, Covington Pediatrics, LLC will bill me and I will be financially responsible for this bill.
- Failure to pay may result in my appointments being cancelled or rescheduled until payment is made in full.
- If my account is turned over to a collection agency, I understand that all accounts and fees will be added to this account balance.

To the best of my knowledge, the questions on this form have been accurately answered.

I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES.

Please Print Patient Last/First Name	Please Print Guardian/Parent Last/First Name
Signature	Date

Acknowledgement of Notice of Privacy (HIPAA) and Consent to Use/Disclose Health Information

I acknowledge that I have received a copy of **Covington Pediatrics LLC** Notice of Privacy Practices. I understand that as part of my healthcare, **Covington Pediatrics LLC** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

APPOINTMENT MESSAGES		MEDICAL MESSAGES	
☐ Home	☐ Person	☐ Home	☐ Person
☐ Office	☐ Mail	☐ Office	☐ Mail
☐ Cell	☐ E-mail	☐ Cell	☐ E-mail

Before signing this form, you should understand the following:

- By signing this form, I authorize the use and/or disclosure of my protected health information
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected
- I authorize the release of any medical or other information necessary to process the insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and / or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I do have the right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.524).

Patient name and Date Of Birth: _____

Signature: _____ Date: _____

BILLING AND INSURANCE

We appreciate your selecting Covington Pediatrics to serve your child(rens') needs. We will do all we can to provide your child/children with the very best care possible. Our purpose is to provide our patients with expert, comprehensive and continuous medical care from birth through adolescence in the setting of a group practice.

Our fees are based on our cost of delivering quality care. All charges are to be paid at the time services are rendered. We accept cash, Mastercard, Visa and Discover.

If you are insured by one of the health plans in which we participate, we will gladly follow the contractual arrangements in the plan agreement. You must show your plan card at the time of each visit and be prepared to pay your co-pay, deductible or any non-covered service at the time of your visit. Please become familiar with your health benefits as many plans have restriction on certain services such as well childcare and immunizations. Also, please remember that your insurance contract is between you and your insurance carrier. If you have questions regarding your coverage, payment determination: or other details relating to your contract you should contact the insurance carrier directly.

***Please note we also reserve the right to charge for No- Show's. We ask that you kindly give us 24 hours of advanced notice if you need to cancel or reschedule an appointment. Also, if there are three (3) no shows for appointments, I understand that my child(ren) could be dismissed from the practice.

AUTHORIZATION TO RELEASE INFORMATION/PAY INSURANCE BENEFITS

I hereby authorize the physicians of Covington Pediatrics to release (PHI) required information to process claims. I hereby authorize payment to be made directly to Covington Pediatrics for all covered benefits under my insurance policy and I also understand that I am responsible for any unpaid portion not covered by my insurance.

_____ _____

Signature of Parent or Legal Guardian Date

INSURANCE STATEMENT/FINANCIAL RESPONSIBILTY

I understand that Covington Pediatrics will bill insurance companies for which they are providers, and verify the insurance information on those insurance plans which they are contracted, prior to services as allowed. My child(rens') insurance ID cards must be presented each and every visit. I am responsible for all balances my insurance carrier does not pay within 90 days. I am also aware that if my account becomes delinquent past 90 days it will be referred to a third party agency for collections effort. Our billing specialist will assist you if you have any billing or insurance questions. You can reach the business office at 770-787-7444 during the hours of 8:15am 5:00pm. If a check is returned on my account, I am aware that my account will be charged an additional $35.00 fee.

_____ _____

Signature of Parent or Legal Guardian Date

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

A parent or guardian must accompany all children/teens under the age of 18. The parent or guardian can designate another person to seek medical care for their minor by completing the information below.

I, _____, give the following person(s) permission to make medical decisions in my absence. They have permission to sign any appropriate documents related to my child _____
Date of birth: _____

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

The person(s) named above are allowed to:

_____ pickup prescriptions
_____ pickup forms
_____ pickup Medical records
_____ Speak to nurse for medical advice

Please list all siblings this may apply to:

_____ Date of Birth _____
_____ Date of Birth _____
_____ Date of Birth _____

Guardian Signature: _____ Relationship: _____

Print Name: _____ Date: _____

Covington Pediatrics
4181 Hospital Drive, Suite 202, Covington GA, 30014
Phone 770-787-7444, Fax 770-787-5050
www.covingtonpediatrics.com

Covington Pediatrics, LLC

5211 U.S. Highway 278 NE
Covington, Ga 30014

Patients Full Legal Name:_____ DOB:_____

Mothers Maiden Name:_____

Hospital Child Was Born In: _____

C-Section or Vaginal Birth:_____ Child's Birth Weight:_____

Child's Grade in School (if applicable):_____

INSTRUCTION: Put an (X) in the appropriate box for each question.

CHECK THE APPROPRIATE BOX FOR CHILD'S PARENTS:

[ ] Never married [ ] Living with partner [ ] Married now [ ] Separated
[ ] Divorced [ ] Widowed

CHECK THE APPROPRIATE BOX FOR YOUR CHILD

[ ] Multi Racial [ ] American Indian [ ] Hispanic [ ] Black; not of Hispanic origin
[ ] White; not of Hispanic origin [ ] Asian or Pacific

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Anemia (low blood count)	[ ]	[ ]	Arthritis	[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis or Pneumonia	[ ]	[ ]	Cancer	[ ]	[ ]	Chicken Pox
[ ]	[ ]	Dental Problems	[ ]	[ ]	Diabetes Mellitus	[ ]	[ ]	Ear Infection
[ ]	[ ]	Eczema	[ ]	[ ]	Epilepsy/Seizures	[ ]	[ ]	German Measles
[ ]	[ ]	Allergies or Hayfever	[ ]	[ ]	Hearing Problems	[ ]	[ ]	Heart Disease
[ ]	[ ]	HIV/AIDS	[ ]	[ ]	Learning Difficulties	[ ]	[ ]	Measles
[ ]	[ ]	Mental or Emotional Problems	[ ]	[ ]	Mononucleosis	[ ]	[ ]	Mumps
[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	Tonsillitis or Strep	[ ]	[ ]	Vision Problems
[ ]	[ ]	Weight Problems	[ ]	[ ]	Other (please list)_____			

_____

PLEASE ANSWER THE FOLLOWING QUESTION ABOUT YOUR CHILDS HISTORY:

YES	NO	
[ ]	[ ]	Were there and complications during the pregnancy?
[ ]	[ ]	Were there any complications during the birth and delivery?
[ ]	[ ]	Was the pregnancy full-term (9 months or 40 Wks)?
[ ]	[ ]	Did the child go home with mother after birth?
[ ]	[ ]	Did the child have any problems with jaundice?
[ ]	[ ]	Does the child have birth defects?
[ ]	[ ]	Has the child's growth and development been normal?
[ ]	[ ]	Are the child's immunization up to date? (please have immunization record available)
[ ]	[ ]	Does anyone in the child's home smoke?
[ ]	[ ]	Is your child exposed to sources of lead that you are aware of?

List any injuries

_____

List any Operations:

_____

List any hospitalizations (also age)

Child's Health History

List any non-prescription drugs your child is on

Prescription drugs child is on

List any drugs your child is allergic to

HAVE ANY OF YOUR CHILD'S RELATIVES EVER HAD ANY OF THE FOLLOWING?

[ ] Anemia [ ] Arthritis [ ] Birth Defects [ ] Bleeding tendency [ ] Cancer
[ ] Deafness [ ] Drinking or Drugs [ ] Eczema [ ] Epilepsy/Seizures [ ] Glaucma
[ ] Heart Attack or Heart Disease [ ] Mental or emotional Problems [ ] Nerve or muscle disease
[ ] Obesity [ ] Stroke [ ] Suicide or attempted suicide [ ] Tuberculosis [ ] Other (please list)

DO YOU OR YOUR FAMILY HAVE ANY CONCERNS WITH THE FOLLOWING?

[ ] Other family members [ ] Friends [ ]Housing or living arrangements [ ] Finances [ ] Education
[ ] Job or Employment [ ] Legal [ ] Transportation [ ] Recent loss of job or retirement
[ ] Mental o emotional difficulties [ ] Serious illness or disability [ ] Recent break-up, separation or divorce
[ ]Recent death of spouse, friend, or family member [ ] Neighborhood violence [ ] Family violence or abuse
[ ]Other (please list)

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE)

Name(s):	Male/Female:	DOB or Age:	Marital Status:	Living at home?

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS, OR INFORMATION ABOUT YOUR CHILD, YOU, OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW:

Signature (parent/guardian): Date: