PATIENT REGISTRATION FORM

PATIENT (CHILD) INFORMATION

Name

Address

City, State, Zip

Home Telephone ( ) County

Date of Birth CHILD'S Social Security Number

Sex (Check One) ☐ M ☐ F

Race (Check One) ☐ Asian (A) ☐ Black (B) ☐ Caucasian (C) ☐ Hispanic (H) ☐ Native American (I) ☐ Other

Patient's Primary Language: English Spoken? ☐ Yes ☐ No

PARENTAL/BILLING INFORMATION

	MOTHER'S INFORMATION	FATHER'S INFORMATION	LEGAL GUARDIAN'S INFORMATION
Name			
Address			
City, State, Zip			
Home Telephone			
Social Security #			
Date of Birth			
Employer			
Employer's Address			
City, State, Zip			
Work Telephone			

Guarantor's primary language: English Spoken? ☐ Yes ☐ No

With whom does the patient reside? (Check One) ☐ Mother ☐ Father ☐ Both Parents ☐ Legal Guardian ☐ Other – please specify:

REFERRAL SOURCE (How did you hear about our practice?)

Name

INSURANCE INFORMATION

Insurance Company Name		
Group Name/Number		
Policy Number		
Policyholder Name (Subscriber)		
Patient Relationship to Policyholder		

☐ Please check this box if the patient has more than two forms of insurance and complete the same information as requested for the primary/secondary insurance on the back of this form. How will you be paying your portion today? ☐ Cash ☐ Check ☐ Credit Card

EMERGENCY CONTACT INFORMATION (Other than parent or legal guardian)

Name

Telephone Number ( ) Relationship to Patient

Have you ever applied for Medicaid? ☐ Yes ☐ No

Would you like to apply for Medicaid? ☐ Yes ☐ No

I authorize payment of medical benefits to Cartersville Pediatric Associates and I authorize the release of any medical information necessary to process insurance claims. I voluntarily consent to examination and treatment for myself and/or my dependents. I will be responsible for the full amount of the charges except those under Cartersville Pediatric Associates contractual arrangements with certain insurers.

Parent/Responsible Person: _____ Date: _____

In absence of Parent/Responsible Person, sign here: _____ Date: _____

CARTERSVILLE PEDIATRIC ASSOCIATES, P.C.
PATIENT HISTORY FORM

Patient's Name: _____ Date of Birth: _____
Birth Weight: _____ Birth Height: _____

Pregnancy History

1. Delivery Method: □ Vaginal □ C-Section Breech Yes___ No____
2. Baby was: □ Full Term □ Premature
3. List any illnesses Mother had during pregnancy: _____
   _____
4. List any medications Mother took during pregnancy (prescription & non-prescription): _____
   _____
5. List any problems during labor & delivery: _____
   _____
6. Did baby go home with Mother? □ Yes □ No If no, why? _____
   _____
7. List any problems that occurred in the first month of birth? _____
   _____

Child's History

1. List any **drug** allergies the child has: _____
2. List any **other** allergies the child has: _____
3. List all of the child's current medications: _____
4. List any significant injury or illness your child has had: _____
   _____
5. List any hospitalizations or surgeries the child has had: _____
   _____
6. List any other significant health concerns the provider should be aware of : _____
   _____

Family History

Has anyone in the child's immediate family had any of the following (Check all that apply):

- o Alcohol/Drug Use
- o Asthma/ Allergies
- o Behavioral Problems
- o Birth Defects
- o Blood Disorders/Sickle Cell
- o Other: _____
- o Cancer
- o Diabetes
- o Hearing/Vision Problems
- o Heart Disease/High Blood Pressure
- o Seizures/Epilepsy

Parent/Guardian Signature: _____ Date: _____

Internal Use Only

□ Cartersville Pediatric Associates
P.O. Box 200429
958A Joe Frank Harris Parkway, Suites 101 &105
Cartersville, GA 30120
Ph :(770) 386-3011 Fax: (770) 386-9451

□ Cartersville Pediatric Associates at Lake Pointe
3950 Cobb Parkway, N.W.
Suite 701
Acworth, GA 30101
Ph: (770) 974-1801 Fax: (770) 974-9807

CARTERSVILLE PEDIATRIC ASSOCIATES, PC
FINANCIAL POLICY

- Due to frequent changes in health insurance coverage, we require that you bring your insurance card to each visit and notify our office immediately of any insurance changes to ensure that the correct insurance carrier is billed for services rendered.
- All copays and outstanding balance from deductibles or co-insurance are due at the time of your visit unless other financial arrangements have been made in advance.
- Payment is due in full if you are unable to provide proof of insurance, have incorrect Primary Care Provider listed with your insurance carrier, or have no insurance coverage at the time of visit.
- Newborns should be added to your insurance policy within the first 30 days of life to prevent any lapse in coverage. Contact your employer or insurance carrier to start this process and ensure all necessary documents have been submitted.
- If your child is scheduled for a Well Child Checkup and other health concerns are brought up that would normally require a separate visit, your insurance company may consider this two separate visits. In this case, you could be billed for your co-pay, co-insurance or charges applied toward your yearly deductible.
- We will attempt to resolve any issues with your insurance that you bring to our attention. If your insurance has not paid within 90 days the balance will be transferred to your responsibility and will be due upon receipt of your statement.
- Cartersville Pediatrics will not be party to custodial, separation or financial disputes regarding minor children to whom services are provided. The individual who requests medical services and signs the financial agreement is responsible for any balance due. Both parents will have access to the child's medical records, unless there is a court order on file that specifically states otherwise. We reserve the right to discharge any patient from Cartersville Pediatric Associates if any issues arise regarding divorced or separated parents which could disrupt our practice.
- If you are unable to pay your balance in full please contact our office immediately to set up payment arrangements. Failure to resolve any past due outstanding balances could result in further collection activity or dismissal from the practice (including all family members).
- Although we do not charge a fee for missed appointments we ask that you notify our office within 24 hours of your scheduled appointment. Repeat no-show appointments could result in dismissal from the practice (including all family members).

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Parent/Legal Guardian Date

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CARTERSVILLE PEDIATRIC ASSOCIATES, PC
AUTHORIZATION OF TREATMENT

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Patient confidentiality is important at Cartersville Pediatric Associates. Therefore, we ask that you provide us with the following information:

Please list names of any family members or other parties that you authorize to seek medical attention (over the phone or at a scheduled office appointment), speak to nurses, schedule appointments, pick up prescriptions or forms, and/or receive personal health information concerning your child:

_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient

** Any party **NOT** listed above will **NOT** be able access any of your child's protected health information (including bringing child to appointment or picking up prescriptions or forms) until this authorization is updated by the parent or legal guardian.*

**Photo I.D. will be required from all parties listed above when bringing patient to scheduled appointment or when picking up prescriptions or forms from Cartersville Pediatric Associates*

In the event that I am unable to be reached at the primary phone number listed in my child's record, Cartersville Pediatric Associates may leave the following information on my voicemail (check all that apply):

□ Appointment Reminders □ Test Results □ Referral/Test Information □ Financial Information

By signing below, I understand that a written request must be submitted in order to make changes to, revoke or terminate this authorization.

_____ Signature of Parent/Legal Guardian	_____ Date
_____ Witness Signature	_____ Date

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Date: _____ Provider/Physician: CARTERSVILLE PEDIATRIC ASSOCIATES, P.C.
MM/DD/YYYY

Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: _____ **Date of Birth:** _____
Last Name First Name MI MM/DD/YYYY

Parent/Guardian: _____
Last Name First Name MI

INELIGIBLE FOR STATE-SUPPLIED VACCINE *(Check if applicable)*

☐ The child has insurance that pays for immunizations. (*Fully-insured / Private Pay*)

ELIGIBLE FOR STATE-SUPPLIED VACCINE
This child qualifies for vaccination with state-supplied vaccine because (*check only one box*):

☐ The child is enrolled in Medicaid
☐ The child is American Indian or Alaskan Native
☐ The child does not have health insurance (*Not Insured*)
☐ The child has health insurance that does not pay for vaccines (*Underinsured*)
☐ The child is enrolled in PeachCare for Kids

Note To Providers:
A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. ***While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.***

SCREENING UPDATES

DATE SCREENED	VFC ELIGIBILITY* (Check only one category)					NOT ELIGIBLE
	PEACHCARE FOR KIDS	MEDICAID ENROLLED	UNINSURED	AMERICAN INDIAN OR ALASKAN NATIVE	UNDER-INSURED	INSURANCE COVERS VACCINATIONS**

*This form should be retained in the child's medical record for at least three (3) years and updated at each visit during which an immunization is provided. Further documentation of VFC eligibility is not required.
** Children with insurance that has coverage for immunizations are not eligible to receive VFC vaccines.

CARTERSVILLE PEDIATRIC ASSOCIATES, PC

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that CARTERSVILLE PEDIATRIC ASSOCIATES may use or disclose my protected health information for treatment, payment or health care operations; which means for providing health care to me, the patient, handling billing and payment, and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

CARTERSVILLE PEDIATRIC ASSOCIATES has a detailed document called the ***"Notice of Privacy Practices."*** It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *"Notice of Privacy Practices"* before signing this agreement. If I ask, CARTERSVILLE PEDIATRIC ASSOCIATES will provide me with the most current *"Notice of Privacy Practices."*

My signature below indicates that I have been given the chance to review such copy of the *"Notice of Privacy Practices."* My signature means that I agree to allow CARTERSVILLE PEDIATRIC ASSOCIATES to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that CARTERSVILLE PEDIATRIC ASSOCIATES has taken action relying on consent.

_____ _____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN **DATE**

_____

RELATIONSHIP *(if not patient)*

Office Location

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