SOUTHWEST GEORGIA PEDIATRICS

PATIENT INFORMATION

(Please complete all information)

DATE: _____ PRIMARY CARE PHYSICIAN: _____

Patient's Full Name _____
Last First Middle Name called

Birth Date _____ Sex _____ Patient's SS# _____

Home Telephone # _____ E-Mail _____ Patient's cell # _____
(if over 18)

Billing Address _____
Street City State Zip Code

Sibling's Names & DOB _____

Father's Name_____ SS # _____DOB _____Cell # _____

Father's Address _____

Father's employment & occupation _____Work #_____

Mother's name _____SS # _____DOB _____Cell # _____

Mother's address _____

Mother's employment & occupation _____Work #_____

Mother's maiden name _____

Name of Insurance Company _____Name of Insured _____

ID # of Insured _____ Policy of Group # _____

Name of Nearest Relative/friend _____ Relationship _____ Phone #_____
(not parent and local)

Pharmacy that your family uses _____ Location _____

I hereby assign all medical benefits to which I am entitled, including private insurance, and any other health plan to Southwest Georgia Pediatrics, P.C. A photocopy of this agreement is to be considered valid as an original. I hereby authorize said assignee to release all information to secure the payment**. I understand that I am personally responsible for any co-pays, deductibles, or non-covered services, and that I will be required to pay these at the time of service.**

I authorize Southwest Georgia Pediatrics to leave any information pertaining to my child's care on my answering machine. (This information may include but is not limited to: lab, x-ray and other test results as well as appointment information.)

_____ _____ _____
Responsible Party SS# Date

SOUTHWEST GEORGIA PEDIATRICS

1110 North Monroe Street
Albany, GA 31701
(229) 888-8121

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Parent/Guardian's Name: _____

In the event that a parent or legal guardian is unable to bring the above child I give permission for the following people to bring the child to the doctor, consent for medical care, and discuss the health issues with the staff of Southwest Georgia Pediatrics.

_____ Relationship to the child _____

_____ Relationship to the child _____

_____ Relationship to the child _____

_____ Relationship to the child _____

I give the following people permission to discuss the **medical bills** on my child in the event that I am unable to be reached or bring the child myself. I understand that if I have an **overdue balance** or a **returned check** the stall may ask for payment in full, up front, before my child is seen.

_____ Relationship to the child _____

_____ Relationship to the child _____

This form will be kept on file; the parent/guardian may change this information by updating the form, or by submitting a request in writing.

Please be aware that we are not accepting any new, or conversions to **Medicaid, Peach State, Wellcare or self pay patients**. Please initial showing that you have read this statement. _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, I consent to the use and release of all or any of the information obtained by Southwest Georgia Pediatrics, P.C. as part of medical services provided to me/my child for the purpose of:

- **Diagnosis, treatment, and care** to other physicians, including those at other medical practices, laboratories, diagnostic centers, hospitals, other health care professionals, facilities, and providers that may help in the treatment of the patient.
- **Obtaining payment for health care services**: Filing insurance claims, collections, etc.
- **Health care operations**: This is a term used in federal privacy protection legislation that relates to quality review, business operations, and general administrative purposes.

I understand that Southwest Georgia Pediatrics, P.C. assumes no responsibility for the use or misuse by others of my health information disclosed under this consent.

I have read/signed and received a copy of Southwest Georgia Pediatrics, P.C.'s Notice of Privacy Practices and I have discussed any concerns that I may have regarding the Privacy Notice.

Patient's Name _____ Date of Birth _____

Patient/Guardian Signature _____ Date _____

SOUTHWEST GEORGIA PEDIATRIC
ACCOUNT COLLECTION POLICY

1. All co-pays, deductibles, and non-covered services are to be paid at the time of service.

2. After the charges have been paid or denied by the insurance company, the patient is then mailed a bill. IF the patient/parent needs to set up a payment plan, it must be done at this time, not when the account is already in delinquent status.

3. If, after receiving 3 (three) bills the account is not paid in full, the collections clerk will call the account. If the collections clerk is unable to contact the patient/parent or the account is not paid within 10 days, the account will automatically be placed with the Credit Bureau.

4. Any account that is not paid, and is placed with the Credit Bureau, will automatically be changed a 54% collection fee, this is in addition to the amount already owed.

5. There is a $35.00 charge for check returned to us from the bank. All returned checks will be submitted to the bank a second time for payment, which means you will be changed a second NSF fee by the bank if funds are not available. If the check is returned a second time, you get 1 (one) call only before the account is placed with the Credit Bureau.

6. Any time an account is placed with the Credit Bureau, it could potentially affect your credit rating.

7. Any patient/parent having a history of delinquent accounts, returned checks, etc., and not paying their bills in a timely manner may be dismissed from the practice.

8. I understand that if I have an overdue balance or a returned check the staff may ask for the payment in full, up front, before my child is seen.

_____ _____

Signature Date

SOUTHWEST GEORGIA PEDIATRICS

OFFICE POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

APPOINTMENTS

1. We value the time we have set aside to see and treat your child. If you are unable to keep the appointment, we would appreciate 24-hour notice. **There is a charge of $35.00 for missed appointments.** If you miss three (3) appointments, you could potentially be dismissed from the practice.
2. If you are late for your appointment (> 15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit. Also check to be sure any vaccines that might be needed are covered by your plan.

Initial: _____

INSURANCE PLANS

Please understand

1. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit.**
2. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. For children younger than 2 years, there is sometimes a limit as to the number of allowable well visits, or a maximum dollar amount per year. If you exceed these, your insurance company will not pay; you will be responsible for payment.
3. It is your responsibility to know if a written referral or authorization is required to see a specialist, whether a preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

REFERRALS

1. Advanced notice is needed for all non-emergent referrals, typically 3-5 business days.
2. It is your responsibility to know if a selected specialist participates in your plan.
3. Remember, we must approve referrals before they are issued.

(over)

FORMS

1. There is no charge for a school/sports form presented at the time of your child's physical. This is considered part of the visit. **However**, should you lose your form, or forget to bring it, there will be a charge.
2. Any additional school, camp, or sports forms are subject to a $5.00 per form fee. Payment is due when the forms are dropped off. We require a 3 day turnaround time.

Initial: _____

PRESCRIPTION REFILLS

1. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

Initial: _____

DIVORCE, SEPARATION, AND CUSTODY AGREEMENTS

Southwest Georgia Pediatrics will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. The individual who requests the medical services and signs the financial agreement is responsible for any balance due. All co-pays, co-insurance, and deductible, if applicable, will be collected at the time services are rendered from the individual requesting the medical services for minor child/children. We will not call the other parent for consent. The physician will discuss the minor's medical information with the accompanied parent at the time of the visit. Southwest Georgia Pediatrics will provide a copy of any medical records requested, although we reserve the right to charge a fee. Both parents have access to the minor child's medical records, unless there is a court order that specifically mandates only one of the parents have the right to authorize medical treatment and release of the minor's medical records. We reserve the right to discharge any patient from Southwest Georgia Pediatrics if an issue comes between the (divorced/separated) parents which would disrupt our practice. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient name _____

Responsible Party Name _____ Relationship _____
Please print

Responsible Party Signature _____ Date _____