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Dear Parent,

Welcome to ABC Pediatrics, Fayetteville.

We look forward to providing pediatric medical care to your child.

The forms enclosed in this mailing need to be completed in full and returned to us prior to your appointment or, if you bring them to the first appointment, please plan to arrive ten minutes early.
Most of our policies are published on the ABC Pediatrics website www.myabcpediatrics.com. Please read through them. The two that impact your visits to our practice the most are the Late policy and the No-Show policy.

Our electronic medical record system allows us to set aside appropriate time slots for different ages of children as well as allows for you to have electronic access to confirm appointment times. Arriving even a few minutes late, will wipe out all our hard work and good intentions. Please plan to arrive about 4 to 5 minutes ahead of your scheduled time. If you are running late, call before you come so we can check for another available time slot. If you arrive late, you will need to be rescheduled.

We have enclosed the entire No-Show policy and a summary of the Financial Policy (the entire policy is on the website) for you to read and sign.

Remember, you need to bring your child's insurance card, the appropriate co-pay, or self-pay, and a list of the child's current medications to every visit.

While this may sound like a lot of rules, they are for your child's and your benefit. We do not want any of our patients to have 1 to 2 hour waiting times! Our current patients say they like the difference in how smoothly our practice runs and how short the wait times are and we hope you will appreciate all our efforts as well.

The Providers and staff of ABC Pediatrics.

Patient Registration Form

(Please print and complete all sections)

Patient's Information	*Patient's Information*
Child #1: DOB: M/F	**Child #2:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____	Child's Race (circle one): White, Black, Hispanic, Other _____
Child's Primary Language (circle one): English, Spanish, Other _____	Child's Primary Language (circle one): English, Spanish, Other _____
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Child #3: DOB: M/F	**Child #4:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____	Child's Race (circle one): White, Black, Hispanic, Other _____
Child's Primary Language (circle one): English, Spanish, Other _____	Child's Primary Language (circle one): English, Spanish, Other _____
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Mother's Information	*Father's Information*
Name: DOB:	Name: DOB:
Primary/Day Phone#: WK/HM/CELL	Primary/Day Phone#: WK/HM/CELL
Secondary Phone#: WK/HM/CELL	Secondary Phone#: WK/HM/CELL
Address Apt#	Address Apt#
City State Zip	City State Zip

Preferred Daytime Phone Number: _____ Preferred Email Address: _____

Would You Like Access to Patient Portal For Appointment Reminders, Lab Results, Referral Requests, Etc? Yes No

Authorize Text Notifications: Yes No Authorize Email Notifications: Yes No

Medicaid Information

Medicaid ID Number: **Child #1:** _____

Amerigroup/Medicaid/Peachstate/Wellcare/Peachcare (circle one)

Child #2: _____

Amerigroup/Medicaid/Peachstate/Wellcare/Peachcare (circle one)

Child #3: _____

Amerigroup/Medicaid/Peachstate/Wellcare/Peachcare (circle one)

Child #4: _____

Amerigroup/Medicaid/Peachstate/Wellcare/Peachcare (circle one)

I acknowledge the above information provided is correct. I authorize treatment and payment for all medical services rendered by the medical providers and staff of ABC Pediatrics, PC.

Please sign and date: Guarantor/Responsible Guardian _____

Relationship to Patient _____ Date_____

ABC Pediatrics

Patient Request for Transfer of Medical Records

Name of Patient_____ DOB_____

I authorize_____ to send the
(Name of provider, practice, or institution to release information)

following information about my child to ABC Pediatrics. (Specifically describe the information to be disclosed, such as Full Medical Records, Immunization Records, Discharge Summary, Medical Summary, etc.)

_____
(Please list description here)

Previous Provider's Phone Number _____

Previous Provider's Fax Number _____

The information will be used for the following purpose:

_____
(May be listed as "at request of parent")

This authorization will expire on _____
(Expiration date or defined event)

Signature of Parent/Legal Guardian _____

Print Name of Parent/Legal Guardian _____

Date _____

ABC Pediatrics
735 South Glynn Street
Fayetteville, Georgia 30214
Phone: 770-461-4126
Fax: 770-461-8852
www.myabcpediatrics.com

ABC Pediatrics

Authorization for Release/Use of and Disclosure of Protected Health Information

Name of Child_____ DOB_____

This authorization permits **ABC Pediatrics** to use and/or disclose the following individually identifiable heath information about my child. Please indicate below:

Full Medical Records – Yes / No	Medical Summary – Yes / No
Immunization Records – Yes / No	

This information will be used for the following purpose:

_____

(Ex. Transferring to Another Practice, At the Request of the Parent, Etc.)

Release information to _____

(Name, address, phone/fax number)

This authorization will expire on _____

(Expiration Date or Defined Event)

The Practice will not charge for copies of Immunizations Records or a Medical Summary. We charge $5.00 for 3231, 3300, 3189, School Medication Authorization and $10.00 for forms that require a doctor's review such as: sports, camp, college, or physical forms. We charge $30.00 for full medical records for the first request and $20.00 for each additional request not exceeding $70.00 per family. In each instance, it must be payable on the day this form is signed.

I do not have to sign this authorization in order to receive treatment form **ABC Pediatrics.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: **ABC Pediatrics**, 735 Glynn Street South, Fayetteville, Georgia 30214. For your convenience, call us at 770-461-4126. Fax: 770-461-8852.

Signed by _____ _____

Signature of Parent/Legal Guardian — Date

_____ _____

Print Name of Parent/Legal Guardian — Relationship to Patient

Annual Immunization Consent Form

Patient Name:_____ Patient DOB_____

I understand that it is medically recommended that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule, and American Academy of Pediatrics guidelines.

I understand that each vaccine will be discussed with me prior to administration. I will be given the Vaccine Information Statement for each vaccine and will be given the opportunity to ask questions.

The Vaccine Information Sheet(s) (VIS) from the Centers for Disease Control (CDC) explain the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the need for the recommended vaccine(s)
- The **risks and benefits** of the recommended vaccine(s)
- If my child does not receive the vaccine(s), **the consequences** may include:
  - contracting the illness the vaccine should prevent (the outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well)
  - transmitting the disease to others
  - requiring my child to stay out of child care or school during disease outbreaks
- My child's doctor or nurse, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations

I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC Immunization Schedule, including the influenza vaccine. ***I will be consulted on each vaccine given prior to administration and I will have the opportunity to decline the vaccination if I choose to do so.*** While I will be given specific information for each immunization, I will not need to sign individual consents for each vaccine. This consent will be renewed each year.

I understand that I may address this issue with my child's doctor or nurse at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature_____ Date_____

Witness_____ Date_____

Immunization Consent in the Absence of Parent or Guardian

I understand that this consent covers all routine, recommended immunizations, unless otherwise specified by me. This includes visits during which my child is not accompanied by a legal guardian. The Vaccine Information Sheet will be given to be taken home.

Parent/Guardian Signature_____ Date_____

Witness_____ Date_____

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

In my absence, I _____, who has legal custody of my child, _____ and whose date of birth is _____ authorize _____ to provide consent to ABC Pediatrics to render care under the supervision and advice of a licensed medical care professional. I understand that it may be necessary to perform diagnostic testing and/or to administer vaccinations in the course of the visit.

I consent to all medically services rendered during the visit for example, physical examination, hearing and vision testing, immunizations, treatment for illness, referrals to a specialist, etc. The above named person may also receive any tests results and any additional medical information pertinent to the care and treatment of the minor child.

I do not consent to the following services:

_____.

This written consent is valid for the time period of: _____ to _____.

After a period of one year, a new consent form would need to be completed. This consent may be revoked by me at any time in writing.

_____ _____

Parent or Legal Guardian's Name Date

_____ _____

Parent or Legal Guardian's Signature Date

_____

Phone Number Where Parent or Guardian Can Be Reached

Standing Consent to Access External Prescription History

I, _____, whose signature appears below, authorizes ABC Pediatrics, PC and it's medical providers and staff to view external history via eClinicalWorks/RxHub software for the patient(s) listed below.

_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth

I understand that prescription history is from other unaffiliated medical providers, insurance companies and pharmacy benefit managers and that it may be viewable by the providers and staff of ABC Pediatrics. The external history made include prescription history for several years.

Please sign only after you have read and understand the above statements.

_____	_____	_____
Parent/Guardian's Signature	Relationship to the Patient	Date Signed

_____	_____
Witness Signature	Date Signed

ABC Pediatrics

No-Show Policy

Due to the frequency of patients failing to show up for scheduled appointments, it is the policy of ABC Pediatrics to assess a No-Show fee anytime the patient/responsible party fails to notify ABC Pediatrics in advance of a cancellation or change in a scheduled appointment.

The No-Show fee is $50.00 for failure to cancel or change a Well Child Visit (Physical) 24 hours in advance of the cancellation or change in this type of appointment. The No-Show fee is $30.00 any time a patient/responsible party fails to notify ABC Pediatrics 1 hour prior to a sick or recheck appointment. This allows the scheduling department to try to give the appointment to another patient. **To cancel an appointment before or after office hours or on weekends, please call the answering service at 404-935-6730.**

It is the policy of ABC Pediatrics to mail as few patient statements as possible, in an effort to reduce healthcare costs. When a no show fee is incurred, responsible parties are encouraged to mail the payment directly to ABC Pediatrics. It is the policy of ABC Pediatrics to mail one statement in an effort to collect the no show fee. If 30 days after the generation of the first statement it is necessary for ABC Pediatrics to mail a second statement because no payment has been received, an interest charge of a flat 12% of the balance, but not less than $5, will be added to the account. If no payment is received 10 business days after the mail date of the third statement, the account will be reviewed and turned over to the collection agency. **All accounts turned over to the collection agency will also be responsible for the collection agency fees**.

Child's Name: _____ Child's DOB: _____

Signature of parent/responsible party: _____

Date: _____

ABC Pediatrics

Summary of Financial Policy and Authorization

Thank you for choosing ABC Pediatrics as the provider of your child(s) healthcare needs. Please read the following summary of our financial policy and sign where indicated. You may also ask for a copy of the ABC Pediatrics' detailed financial policy or review it on our website at www.myabcpediatrics.com

PAYMENT POLICY

Payment is expected at the time of service. We accept cash, check, and credit cards- American Express, MasterCard, Visa, and Discover.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers, and will file insurance claims on your behalf. CO-PAYMENTS, any ESTIMATED CO-INSURANCE and/or your DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE. In the event you do not have insurance coverage, payment is expected in full at the time of service. We do offer a payment plan provided you have a positive credit history with ABC Pediatrics and have submitted your request in advance of treatment.

Charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore it is your responsibility to know your benefits. We ask that you contact to your insurance carrier prior to any visit and that you follow-up with your insurance company in the event of any dispute or issues with a claim.

DELINQUENT AND COLLECTION ACCOUNTS

You will receive up to three patient statements for any balances on your account after the insurance payments and adjustments have been applied. Any unpaid delinquent debt (no payment received after 90 days of services rendered), including no-show fees, owed to ABC Pediatrics will be referred to an outside collection service and will be reflected on your personal credit report.

You will be responsible for all additional collection agency expenses incurred by ABC Pediatrics in the course of obtaining payment, and the family on the account will be permanently dismissed from ABC Pediatrics. The collection agency expense is currently 30% of outstanding balance.

AUTHORIZATION

- I hereby certify that the information I have provided regarding my (child's) insurance, our address and phone numbers is correct.
- I understand that fees charged are due at the time of service and charges are ultimately my responsibility, regardless of my insurance.
- I hereby authorize ABC Pediatrics to apply for benefits on my (child's) behalf for covered services rendered. I request payment from my insurance carrier be made directly to ABC Pediatrics.
- I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time by submitting a request to ABC Pediatrics in writing.
- I acknowledge by my signature that I have read and do understand this financial policy and authorization. I also acknowledge that I will be responsible for payment of services, co-pays, co-insurances, deductibles, or non-covered services by my insurance company.

Print Child's Name: _____Date of Birth _____

Parent/Guardian Signature:_____ Date_____

Revised Date: May 2014