PATIENT REGISTRATION FORM

PATIENT INFORMATION

[ ] New Patient [ ] Update

Children's Names	Preferred Name	Adopted (Yes or No)	Male or Female	Birthdate	Weeks of Pregnancy	Pt. Social Sec
____________________	__________	Y / N	M / F	___/___/____	_______	________
____________________	__________	Y / N	M / F	___/___/____	_______	________
____________________	__________	Y / N	M / F	___/___/____	_______	________
____________________	__________	Y / N	M / F	___/___/____	_______	________
____________________	__________	Y / N	M / F	___/___/____	_______	________

Primary Language: ______________________________ Ethnicity: [ ] Hispanic [ ] Non-Hispanic
[ ] Refuse to Report

Race: [ ] American Indian [ ] Asian [ ] Black/African American [ ] Hispanic [ ] Native Hawaiian/Pacific Islander

[ ] White [ ] Other [ ] Refuse to Report

Preferred Pharmacy: ______________________________ Address: ______________________________
City: ________________

FAMILY INFORMATION

Mother's Name: ________________________________ Preferred Name: ________________
Birthdate: ____/____/_____

Home Address: ____ City: _______________ State: __________ Zip: ___________

Telephone: Home: __________________________ Work: __________________________ Cell: __________________________

Employer: ____ Position: _________________________________

E-mail Address: ____ Social Security #: _______________________

Father's Name: ________________________________ Preferred Name: ________________
Birthdate: ____/____/_____

Home Address: ____ City: _______________ State: __________ Zip: ___________

Telephone: Home: __________________________ Work: __________________________ Cell: __________________________

Employer: ____ Position: __________________________________

E-mail Address: ____ Social Security #: _______________________

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Name: ____ Preferred Name: _________________ Birthdate: ____/____/_____

Home Address: ____ City: _______________ State: __________ Zip: ___________

Telephone: Home: __________________________ Work: __________________________ Cell: __________________________

Employer: ____ Position: _________________________________

Employer Address: _____________________________________ City: _______________ State: __________ Zip: __________

E-mail Address: ____ Social Security #: _______________________

PRIMARY INSURANCE

[ ] No Insurance / Self Insured

Insurance Company Name: ____ Effective Date: _____/_____/______

Policyholder Name: ____ Birthdate: _____/_____/______

Social Security #: ____________________________ Relationship to Patient: ____________________________

Employer Name: ____ Group #: ___________________________________

Policy/ID #: ____________________________________ Co-pay Amount: $ ________ or _________ % of visit

SECONDARY INSURANCE

Insurance Company Name: ____ Effective

Date: _____/_____/______

Policyholder Name: ____
Birthdate: _____/_____/______

Social Security #: _______________________ Relationship to Patient:
____

Employer Name: _______________________________________ Group #:
____

Policy/ID #: ______________________________ Co-pay Amount: $ ______ or _______
% of visit

ADDITIONAL INFORMATION (if applicable)

Name of Male step-parent: _______________________________

Legal Male Guardian: ___________________________________ Relationship to Patient:
____

Name of Female step-parent: _____________________________

Legal Male Guardian: ___________________________________ Relationship to Patient:
____

EMERGENCY CONTACT INFORMATION

Whom to call in case of an emergency (Other than parents/guardian)

1. Name: ____ Relationship to Patient:
____

Telephone: Home: ___________________ Work: ___________________ Cell:
____

2. Name: ____ Relationship to Patient:
____

Telephone: Home: ___________________ Work: ___________________ Cell:
____

3. Name: ____ Relationship to Patient:
____

Telephone: Home: ___________________ Work: ___________________ Cell:
____

4. Name: ____ Relationship to Patient:
____

Telephone: Home: ___________________ Work: ___________________ Cell:
____

SIGNATURE REQUIRED

I hereby authorize SOUTHEAST GEORGIA PEDIATRICS (SGP) to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by SGP health care providers and hereby direct my insurance carrier or its intermediaries to issue payment directly to Southeast Georgia Pediatrics on behalf of such rendered services. I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I further certify that I have received, read and agree with the SGP Privacy Policy document and the SGP Financial document.

____

____

Signature *Date*

HEALTH HISTORY

Patient Name: ____ Date of Birth: ______/______/_______

Did mother have any infectious illness during the pregnancy? (For example: German measles (rubella), flu, bladder or kidney infection)

Type of Infection: ____ Month of Pregnancy: _____________

Medication Given: ____

Did mother take any medications during pregnancy?

___ Vitamins ___ Laxatives ___ Iron ___ Antibiotics ___X-Rays ___ Aspirin/Tylenol
___Cigarettes ___ Alcoholic Beverages ___ Prescriptions ___ Birth Control Pills
___ Other Over-the-Counter Drugs ___ Marijuana or Other Drugs

Were there any complications of the pregnancy? (such as diabetes, thyroid disease, toxemia, excessive bleeding)____

Were there any complications of the labor or delivery? (such as prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breathe)
____

Birth Weight: __________ Length: _________ Did the infant stay longer than the mother? ___________
If so, why? ____

Hospital of Birth: ____ City: _________________ State: _______

Obstetrician: ____ City: _________________ State: ________

Check box ONLY if your CHILD has or has ever had any of the following:

	Abdominal pain (frequent)		Diabetes		Menstrual period problems (for girls
	Alcohol or drug use		Diarrhea		Nausea / vomiting
	Allergies		Earache		Nosebleeds
	Anemia or a bleeding problem		Ear infections		Rectal bleeding
	Asthma, bronchitis, bronchiolitis, or pneumonia		Ear or hearing problems		Rheumatic fever
	Bed-wetting (after age 5)		Epilepsy		RSV
	Blood transfusion		Eye or vision problems		Sinus problems
	Breathing difficulties		Headaches (frequent)		Skin conditions (chronic) – i.e. Ecze
	Broken bones or sprains		Heart problem or murmur		Sore throat, strep throat
	Chickenpox		Hepatitis		Stomachache (frequent)
	Constipation		Measles, Rubella, Mumps		Thyroid or endocrine problem
	Cough (persistent)		Menstrual periods started (for girls)		Urinary tract infection

	Any other significant problem: ____

FAMILY HISTORY

[ ] Pt. was adopted
**Please circle or write in AND list relationship to child: Medical conditions in biological mother, father, siblings,
maternal/paternal aunts, maternal/paternal uncles, and maternal/paternal grandparents.

Skin: eczema, psoriasis, ichthyosis, other: ____

Eyes: blindness, cataracts, lazy eye, other: ____

Ears: deafness, ear infections, deformities, other: ____

Nose/Throat: sinus problems, lack of sense of smell, tonsillitis, other: ____

Mouth: cleft palate, cleft lip, other: ____

Glands: thyroid trouble, diabetes (adult), diabetes (juvenile), other: ____

Lungs: asthma, cystic fibrosis, other: ____

Heart: murmurs, heart attacks, congenital abnormalities, high blood pressure, other: ____

Stomach/Bowel: ulcers, colitis, lactose intolerant, other: ____

Kidney/Bladder: congenital abnormalities, infections, kidney stones, other: ____

Bone or Joint Disease: osteoarthritis, rheumatoid arthritis, osteogensis imperfect, other: ____

Neurological Problems: seizures, paralysis, strokes, other: ____

Cancer: ____

Development Problems: ____

Psychiatric Conditions: manic depressive (bipolar) disorder, schizophrenia, other: ____

Other: ____

____ ___________________________

Signature
Date

Permission to Create a *Health Exchange record* and Share My Medical In with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Healt defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). T your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with o healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this docume the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this t

______________________ *Printed Name of Patient* ______________ *Patient Date of Birth* ______________ *Printed Name of Repre*

______________________ *Signature of Patient or Representative* ______________ *Date Signed*

AUTHORITY OF REPRESENTATIVE:

I, ______________________, do hereby state that I am authorized to sign this permi of the patient on the following basis (Relationship to Patient): ______________________

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healt CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access yo *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the pu this document. The Health Information may include, but is not limited to the following: Information contained in medical records; p surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; patholo or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of c abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nu intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concer examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be sub However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to pro security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agree *Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the follo disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of an quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia He is available at the CGHE website (https://www.CGHE.net) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange,MSC 98 7 Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on th permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but no participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors Offices) through the *Central Georgia He*

07212011

NOTICE OF PRIVACY PRACTICES

Please Review It Carefully

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. In addition, we may tell your health plan about a treatment you are going to receive in order to obtain necessary approval or to determine coverage of the treatment.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. We may disclose medical information about you to all doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you.

Who Will Follow This Notice?

- Any health care professional authorized to enter information into your medical chart.
- All department employees, staff, and other personnel at Southeast Georgia Pediatrics.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION

This notice will inform you about the different ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
The law requires us to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Individual Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process to evaluate its use of medical information in order to balance the research needs with patient’s need for privacy. Before we use or disclose medical for research, the project will have been approved through this research approval process. We will almost always ask for your specific permission fi the researcher obtains access to your name, address or other information that reveals who you are.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Treatment Alternatives: We may use and disclose medical information to inform you about, recommend possible treatment options or alternatives that may be of interest to you.

LESS FREQUENT USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION INCLUDE:

- **Coroners, Medical Examiners and Funeral Directors:** We may release medical information to a coroner, medical examiner, or funeral director to identify a deceased person, determine the cause of death, or to carry out their services.
- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure so that the government can monitor the health care system, government programs and compliance with civil rights laws.
- **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official,

we may release medical information about you to the correction institution or law enforcement official: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Military and Veterans:** We may release medical information about you as required by military commands authorities.
- **National Security and Intelligence Activities:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Organ and Tissue Donation:** We may release medical information to for organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Protective Services for the President and Others:** We may disclose medical information about you to authorize federal officials so they may provide protection to the President, other authorized persons, and foreign heads of states or conduct special investigations.

Public Health Risks: We may disclose medical information about you for public health activities including, but not limited to:

- Preventing or controlling disease, injury or disability;
- Reporting births and deaths;
- Reporting child abuse or neglect;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may be using;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- Notifying the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Workers Compensation: We may release medical information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

NOTICE OF INDIVIDUAL RIGHTS

- **Right to an Accounting of Disclosures:** This is a list of the disclosures we made of medical information about you. You must submit your request in writing to Southeast Georgia Pediatrics. You must state a time period, which may not be longer than six years and may not include dates before February 26, 2003. Indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You may request an amendment for as long as the information is kept by us. Submit your request in writing to Southeast Georgia Pediatrics stating a reason that supports your request. We may deny your request for an amendment if it is not in writing, does not include a reason to support the request, asks us to amend information that was not created by us (unless the person or entity that created the information is no longer available to make the amendment), is not part of the medical information kept by us, is not information which you would be permitted to inspect and copy, or the information is accurate and complete.
- **Right to Inspect and Copy:** You have the right to inspect and copy medical information that may be used to make decisions about your care, including medical and billing records. You must submit your request in writing to Southeast Georgia Pediatrics. If you request a copy of the information, we are entitled to charge a fee for the costs of copying, mailing and other supplies certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice, even if you have agreed to receive this notice electronically. To obtain a paper copy of this notice contact Southeast Georgia Pediatrics.
- **Right to Request Confidential Communication:** To request confidential communications, you must make your request in writing in to Southeast Georgia Pediatrics. We will not ask you the reason for the request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical

information disclose for treatment, payment or health care operations or to those who are involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Make your request in writing to Southeast Georgia Pediatrics. You must tell us: (1) what information you want to limit; (2) whether you want to limit our use disclosure or both; and (3) to whom you want the limits to apply.

Principles of Medical Practice

I, as a medical professional, subscribe to a body of ethical standards primarily for the benefit of my patients. I recognize my responsibility not only to patients, but to society, to other health professional, and to myself. The following is my standard of conduct which defines the essentials of honorable behavior for a physician. A physician shall:

1. be dedicated to providing competent medical services with compassion and respect for human dignity.
2. deal honestly with patients and colleagues, and strive to expose those physicians deficit in character or competence, or who engage in fraud or deception. Sexual harassment of patients or staff, or sexual activity between staff, and patient or their family members is unethical, will not be tolerated, and should be reported to our practice manager, Megan Brantley, immediately.
3. respect the laws and also recognize a responsibility to seek changes in those requirements that are contrary to the best interest of their patients.
4. respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. continue to study, apply an advanced scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and the use of the talents of other health professional when indicated.
6. in the provision of appropriate patient care, except in emergency, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. recognize their responsibility to participate in activities contributing to an improved community.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint, contact our office at 912-387-0445 and speak with our HIPAA Policy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you. If you have any questions about this notice, please contact our HIPAA Officer at 770-977-0094.

OFFICE INFORMATION

Southeast Georgia Pediatrics
1701 D Boulevard Sq.
Waycross, GA 31501
Our office hours are Monday – Friday 8:00 am – 12:00 noon & 1:30 pm – 5:00 pm.
Phone number: 912-387-0445
Afterhours phone number: 912-387-0445
Fax number: 912-226-3513
E-mail: megan@southeastgapeds.com

We reserve the right to change this notice and to make the revised notice effective for medical information we already have about you as well as nay information we receive in the future. We will have available a copy of the current notice. The effective date will be in the lower left-hand corner of the last page.

FINANCIAL POLICY

Southeast Georgia Pediatrics is dedicated to providing the best possible medical care for your child in a warm and friendly atmosphere. With this in mind, we have provided you with our financial policy in order to avoid any misunderstanding or disagreement concerning payment for services rendered to your child.

Insurance Coverage:

We accept most insurance plans. If you are not certain whether we accept your insurance, please call your

insurance carrier to inquire. **You must present <u>your child's</u> insurance card at every visit.**

It is very important that you have a complete understanding of your benefits. For example, some plans may not cover well-visits after a certain age. It is **your** responsibility as the insurance owner to understand the limitations of your coverage.

If we have a contract with your insurance company**, your co-payment, if applicable, is due at the time of service, prior to being seen, and cannot be waived.** We will not bill for co-payments. Failure to pay your co-payment at the time of visit will result in a **$30 surcharge**.

As a courtesy to you, we will routinely file all claims with your insurance company. Some of the services we provide may not be covered by your insurance; and you will be responsible for these charges, and any deductibles or co-insurance that may apply. If we've verified that your claim has not been received, and payment has not been remitted within 45 days by your insurance company, the balance will be transferred to you. Payment in full will be expected within 30 days. **Disputed claims are contractual issues between you and your insurance carrier.**

If we are not contracted with your insurance carrier and you self-file, or you have no insurance and are self-paying, your charges must be paid in full at the time of the service. We will be happy to provide self-file patients with a copy of your charges and will reimburse you when we receive a payment from your insurance company.

<u>New parents please note that it may take several weeks for your insurance plan to activate coverage for your baby. Please be sure that your paperwork has been received by your insurer so that coverage will be in place before your baby's one month check to avoid paying out of pocket for the visit.</u>

<u>Change of Information:</u>
We will ask you to update your information yearly. However, it is very important that you inform us of any changes in address, phone numbers, or insurance during the year also. Any changes will directly affect payment of services as well as the ability of our staff to contact you.

We will routinely ask you for your current insurance information. However, if you have a change of insurance, please notify the billing office at least 48 hours before your child's next appointment so that we may verify your child's coverage.

<u>Payments of Services:</u>
For your convenience, we accept personal checks, cash, Visa, MasterCard, Discover, and American Express. **Or make payment online by visiting our website, www.southeastgapeds.com, and creating a family account.**

Co-payments and other out-of-pocket expenses are due at check-in. The adult accompanying the child to the appointment is responsible for the co-payments.

You will receive statements for any balances applied to you by your insurance company. Balances must be paid within 30 days. Patients with delinquent balances will not be permitted to schedule routine well exams for their children until their delinquent balance is paid in full. Balances over 90 days will be transferred to an outside collections firm. At this point we will send you a notification of intent to dismiss you from our practice. If payment in full is not received in 14 days, you will receive a dismissal letter. We will treat your child for 30 days for acute illnesses until another medical provider can be found.

In the case of divorced or separated parents, the custodial parent is responsible for all co-payments, deductibles, co-insurances, and any other out-of-pocket expenses. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the custodial parent's responsibility to collect from the other parent.

We understand that our families occasionally have financial problems. Our billing department is always available to help you and will be happy to work with you on a payment plan. Please call Megan at 912-387-0445 as soon as possible if you need to make payment arrangements.

<u>Returned Checks:</u>

There is a $25 fee for every returned check. After 2 returned checks we will ask that all future payments be made in cash.

Missed Appointments:

Southeast Georgia Pediatrics makes every effort to schedule your child at your convenience. We do ask that if you must cancel an appointment that you call no less than 24 hours before your appointment to let us know. Please remember that an appointment that you cannot keep might be used for another child who is in need of treatment. Families neglecting to cancel appointments on three occasions or more may be asked to leave the practice.