NEW PATIENT REGISTRATION

Patient Information (Please list all children in the family and use legal name)

Patient Name: _____ D.O.B. _____ Sex: Male / Female

Patient Name: _____ D.O.B. _____ Sex: Male / Female

Patient Name: _____ D.O.B. _____ Sex: Male / Female

Patient Name: _____ D.O.B. _____ Sex: Male/Female

Address: _____ City: _____ Zip: _____

How would you like to be reminded of appointments?

☐ Voice Mail _____ ☐ Text Message _____ ☐ E-mail _____

Parental/ Guardian information

Mother's Name _____ D.O.B. ____/____/____

Home# _____ Cell# _____ Email _____

Address (**If different from child**) _____

Place of Employment _____ Occupation/Title _____

Father's Name _____ D.O.B. ____/____/____

Home# _____ Cell# _____ Email _____

Address (**If different from child**) _____

Place of Employment _____ Occupation/Title _____

Emergency contact: (other than parents) Name: _____ phone: _____

Please select a pharmacy for us to electronically send your prescriptions when available:

☐ Walgreens	☐ CVS	☐ Kroger Shiloh Square	☐ Publix- Cobb Pkwy	☐ Other
2779 Cobb Pkwy	2782 N. Cobb Pkwy	3895 Cherokee St	2774 N. Cobb Pkwy	
Kennesaw 30152	Kennesaw 30144	Kennesaw 30144	Kennesaw 30152	
770-795-1838	770-420-1092	770-218-7033	770-426-3246	

Primary Insurance information

Name (**Policy Holder**) _____ D.O.B. (**Policy Holder**) _____

Address of policy holder if other than listed above _____

*Relationship to Patient _____ Insurance company _____

Secondary Insurance Yes No

- Financial/Privacy Policies (HIPAA) By Signing Below I Authorize Each Of The Following:
- I authorize East Cobb Pediatrics and Adolescent Medicine to treat the above named child.
- I authorize release of medical and billing information to the insurance company so that payment for charges can be processed.
- I authorize and direct the insurance company to pay the portion of charges due to EC Pediatrics.
- I acknowledge that a copy of the East Cobb Pediatrics and Adolescent Medicine Financial Policy and Privacy Policies have been made available.

FORM COMPLETED BY: ☐ MOM ☐ STEP-MOM ☐ DAD ☐ STEP-DAD OTHER _____

Signature _____ Date ____/____/____

PRINT NAME _____

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

Who has physical 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 explain and provide a copy of any legal paperwork that supports this restriction.

_____

In order to provide the best care for your child/children, we will at some visits ask you to fill out questionnaires on your child's development/behavior/symptoms. These forms are screening tools. These screenings may or may not be completely covered by your insurance company. If they are not covered, the cost would be minimal. They are necessary for us to provide adequate care.

****

Internal Use Only: Parent/Guardian refused to complete profile. Presented on (date&time): _____ by (name) _____

Consent for Protected Health Information

Patient Name: _____DOB_____

Patient Name: _____DOB_____

Patient Name: _____DOB_____

Patient Name: _____DOB_____

Please check the appropriate box below concerning protected health information. I am consenting to East Cobb Pediatrics leaving protected health information on the listed forms of unsecure communication. (Protected health information examples may include - emailed copies of physical/camp/sports forms, copies of behavioral/mental health- at your request, and other records, texts corresponding with providers, etc.) This consent applies to correspondence being sent or received by East Cobb Pediatrics. This consent does not expire unless you request a change in writing.

☐ Voice Mail _____

☐ Text Message _____

☐ E-mail_____

☐ I only wish to receive and send information through a secure email.

Signature: _____Date:_____

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

We now offer electronic statements!

Look out for our new statements! They will now have a code that allows you to do quick pay. With quick pay you can easily go online, without setting up an account, and pay your bill. If you take a couple seconds longer and set up an account, you will also be able to select electronic statements, as well as have your payment history at your fingertips. It makes getting year end statements a breeze. We hope you will take advantage of this great new service.

INITIAL HISTORY

EAST COBB PEDIATRICS &
ADOLESCENT MEDICINE

PATIENT NAME:_____
DATE OF BIRTH:_____
FORM COMPLETED BY:_____
PARENT SIGNATURE:_____

Birth History ☐ **Do not know birth history** ☐ **Adopted**

Birth weight_____ Were there any prenatal or neonatal complications? _____
If yes, explain _____
Was the delivery ☐Vaginal ☐Cesarean If cesarean, why?_____
_____

Did you deny any medical treatment at the hospital? ☐Yes ☐No If yes, explain _____
_____

During pregnancy, did mother:
Use tobacco ☐Yes ☐No Drink alcohol ☐Yes ☐No
Use drugs or medications ☐Yes ☐No IF answered yes, what drugs/medications were used:
_____

General **DK = Don't Know**

Do you consider your child to be in good health? ☐Yes ☐No ☐DK
Explain_____
_____

Does you child have any serious illnesses or medical conditions? ☐Yes ☐No ☐DK
Explain_____
Has your child had any surgery? ☐Yes ☐No ☐DK
Explain_____
_____

Has your child ever been hospitalized? ☐Yes ☐No ☐DK Explain_____
_____

Is your child allergic to any medications? ☐Yes ☐No ☐DK
Explain_____
_____

Past History **DK = Do not know**

Does your child have, or has your child ever had: Patient Name: _____

Chickenpox	☐ Yes ☐ No ☐ DK	When _____
Frequent ear infections	☐ Yes ☐ No ☐ DK	Explain _____
Problems with ears or hearing	☐ Yes ☐ No ☐ DK	Explain _____
Allergies (Other than medications)	☐ Yes ☐ No ☐ DK	Explain _____
Problems with eyes or vision	☐ Yes ☐ No ☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No ☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes ☐ No ☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes ☐ No ☐ DK	Explain _____
Blood transfusion	☐ Yes ☐ No ☐ DK	Explain _____
HIV	☐ Yes ☐ No ☐ DK	Explain _____
Organ transplant	☐ Yes ☐ No ☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes ☐ No ☐ DK	Explain _____
Chemotherapy	☐ Yes ☐ No ☐ DK	Explain _____
Frequent abdominal pain	☐ Yes ☐ No ☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes ☐ No ☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes ☐ No ☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes ☐ No ☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes ☐ No ☐ DK	Explain _____
Cancer	☐ Yes ☐ No ☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes ☐ No ☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes ☐ No ☐ DK	Explain _____
Sleep problems: snoring	☐ Yes ☐ No ☐ DK	Explain _____
Chronic or recurrent skin problems (acne, eczema)	☐ Yes ☐ No ☐ DK	Explain _____
Frequent headaches	☐ Yes ☐ No ☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes ☐ No ☐ DK	Explain _____
Obesity	☐ Yes ☐ No ☐ DK	Explain _____
Diabetes	☐ Yes ☐ No ☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes ☐ No ☐ DK	Explain _____
High blood pressure	☐ Yes ☐ No ☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes ☐ No ☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes ☐ No ☐ DK	Explain _____
Tobacco use	☐ Yes ☐ No ☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes ☐ No ☐ DK	Explain _____
Developmental delay	☐ Yes ☐ No ☐ DK	Explain _____
Dental decay	☐ Yes ☐ No ☐ DK	Explain _____
History of family violence	☐ Yes ☐ No ☐ DK	Explain _____
Sexually transmitted infections	☐ Yes ☐ No ☐ DK	Explain _____
Pregnancy	☐ Yes ☐ No ☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes ☐ No ☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age at first period _____

Any other significant problem _____

_____

East Cobb Pediatrics
Please complete this family history form for your children

Patient Name:_____ DOB:_____
TODAYS DATE: _____

Put an X for all of your children's biological relatives who have the condition.

CONDITION	Child's Mother	Child's Father	Child's Sister	Child's Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Child's Aunt	Child's Uncle	Child's Cousin
ADHD/ADD											
Asthma											
Autism spectrum disorder, PDD Aspergers											
Birth Defect											
Bleeding or clotting disorder											
Cancer before age 50											
Born with an eye/vision problem											
Born with hearing loss											
Born with a heart problem											
Diabetes											
Early heart disease (<55 in men, <65 in women											
Genetic syndrome or condition											
High blood pressure											
High cholesterol or triglycerides											
Kidney Disease											
Mental or mood disorder											
Obesity											
Seizures											
Sudden cardiac death											
Other condition that affects 2 or more family members											
No information about this relative											
Thyroid Disorders											

East Cobb Pediatrics and Adolescent Medicine
Financial Agreement

East Cobb Pediatrics and Adolescent Medicine 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 agreement in order to avoid any misunderstanding concerning payment for the care provided to your child.

INSURANCE COVERAGE

We accept most insurance plans except Kaiser HMO and PPO plans, Peach State, Ambetter, and Amerigroup. If you are not certain if we participate with your plan, please call your insurance carrier. **You must present your child's insurance card at every visit.**

Patients must know their insurance plan benefits. For example, some plans may not cover well-visits after a certain age. It is **your** responsibility as the insured to understand the limitations of your coverage.

Co-payments are collected when you check in. Co-payments are collected for sick visits, follow up visits, and well visits if required by your plan. **Co-payments cannot be waived.** We will not bill for co-payments. Failure to pay your co-payment at the time of your visit will result in a **$30 surcharge.**

If we are contracted with your insurance company, we will routinely file all claims. **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 been received, and payment has not been sent within 30 days by your insurance company, the balance will be transferred to you. Payment in full will be expected within 30 days. **If you disagree with how your claim was processed, please call your insurance company.**

A $50 deposit is collected for high deductible plans.

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

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.

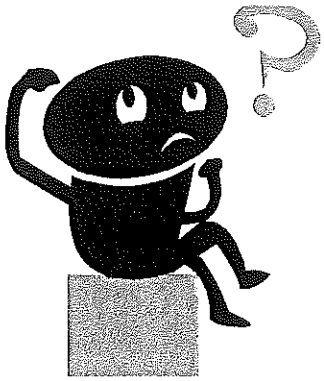
NEED ASSISTANCE WITH YOUR INSURANCE?

Our business office is available Monday through Friday during regular office hours. For assistance, please call 770-977-0094 and speak to: **Jessica Hill ext. 138** (Aetna Plans, Cigna Plans, United Healthcare, Humana, Kaiser PHCS, Tricare and Coventry); Charlotte **Cato ext. 146** (Patient Balances); **Wynette Davis ext.130** (MediCaid, CareSource, WellCare, Blue Cross Plans, PHCS, Southcare, and all other commercial plans).To contact the Business Office Manager, please call **Carole Sterling at ext. 141,** or send your e-mail to: csterling@eastcobbpeds.com

CHANGE OF INFORMATION

Yearly updates are required by law. However, it is very important that you inform us of any changes in address, phone numbers, or insurance during the year. Any changes can directly affect payment of services as well as the ability of our staff to contact you.

We will routinely ask for your current insurance information. 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. If we cannot verify coverage, you will be asked to pay in full on the day of service.



I was charged for that?????

Parents are often surprised to learn that a procedure or service that they assumed was routine well care or part of the office visit was actually a separate charge. Depending on your particular insurance plan, some or all of the charge for these services may be patient responsibility.

Below is a list of our <u>most common</u> services and procedures that are billed in addition to your office visit:

Newborn well child visits begin at one month of age. Until then, we will see your baby at scheduled newborn follow up visits. If the visit is focused on breast feeding counseling or a medical issue that must be addressed, your insurance may process the claim with copay or toward your deductible.

At a newborn follow-up visit, there may be a charge for:
A blood draw (if a repeat PKU is needed); frenotomy (tongue clip); foreskin manipulation for penile adhesion; silver nitrate cauterizations of the navel. If there is a medical problem such as jaundice, or if extensive nursing/newborn counseling is provided, your insurance company may not consider this visit routine.

At your child's well visit, there are separate charges for:
Urinalysis, CBC, blood draws, vaccine administrations, developmental screenings, hearing evaluation, vision screening, ADHD, depression, anxiety disorder, and substance abuse screenings, or any medically necessary services provided beyond usual well child care.

** If your child is has an acute illness and needs treatment at the time of your routine well visit, it may be necessary to charge for the additional sick visit**

At sick visits, there may be separate charges for:
Urinalysis, CBC, blood draws, strep tests, flu tests, RSV tests, mono tests, any medications given, administration of an injection, removal of wax (cerumen) in the ear, removal of any foreign object in the ears, nose, or skin, nebulizer treatments, spirometry, pulse ox, nitric oxide test, drainage of an abscess, burn dressings, treatment of nursemaid's elbow, application of splints, and wart removal.

If your child has been prescribed an inhaled medication, there may be a charge to teach the proper use of the inhaler so that your child receives the full benefit of the medication.

If you're not sure if your insurance covers these procedures and services, please call the customer service number on your insurance card.

There is a $10 charge for all camp, sports, and school forms that are not presented at the time of your child's physical. All forms have a 48 hour turnaround. If you request your camp form to be completed same day, the charge is $20.0

We hope that making our parents aware of these additional charges will help to clarify our billing process and avoid any misunderstanding.

Thank you!