YEARLY UPDATE

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: _____

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 _____

How would you like to be reminded of appointments?

☐ Voice Mail ☐ Text Message ☐ E-mail

Name of Insurance Policy Holder: _____ DOB: _____

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.

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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.