PLEASE FILL OUT THE FOLLOWING INFORMATION IN ITS ENTIRETY				
Whose name is on the insurance policy? (Circle one) Mother Father Other:				
Insured DOB:				
Insurance Company Name:				
Policy ID # Group #				
Parent Marital Status (circle one) Single Married Divorced				
If divorced, who does the child live with: (circle one) Mother Dad				
Parent "A" (**Insurance Policy Holder**)				
Address:				
City: State: Zip Code:				
Mobile Number:				
Email Address:				
Employer's Name:				
Parent "B"				
Address:				
City: State: Zip Code:				
Mobile Number:				
Email Address:				
Employer's Name:				
Referred by:				
Your Child's Full Name	**M/F**		**Date of Birth**	**Preferred Name**

ASSIGNMENT, RELEASE, AND PAYMENT: I hereby authorize my insurance benefits be paid directly to Pediatric Associates of North Atlanta, P.C. I accept financial responsibility for co-pays, co-insurance, cancellation fees and non-covered services at the time of service. I hereby authorize Pediatric Associates of North Atlanta, P.C. to release medical to referring and family physician, my insurance company and/or other medical or educational institutions as per my instructions. I hereby understand that past due accounts may be sent to collections and that I will be responsible for an administrative fee in addition to the outstanding balance.

Signature	Date:

FINANCIAL POLICY

Pediatric Associates of North Atlanta's primary goal is to provide superior medical care for each child in our practice. In reaching this goal, we must be able to communicate openly and effectively with our patients and their caregivers. Please read the financial information below.

As a courtesy to our patients, we want to assist you in using your insurance correctly. In order to accommodate the needs and requests of our patients, we are enrolled in numerous insurance programs. We will verify coverage when new insurance is presented at the time of the visit. Because of the frequency in coverage changes these days, you as the policyholder are required to present the ***patient's*** insurance card whenever requested to ensure proper insurance filing information.

Responsibility of Patient	**Administrative Service Fee (ASF)**
1. Be prepared to present the current insurance card at each visit. 2. Co-pays, co-insurance and non-covered service fees, as verified with your insurance company by our staff prior to your child's visit to our office, will be the patient's responsibility. 3. Patients with applicable plans must designate one of our physicians as the PCP prior to your child's visit. 4. Patients with HMO and some POS plans must contact our office before seeing any specialist for a referral. Primary care physicians cannot give you a referral after the visit. 5. Know your insurance company's requirements for pre-certification, as well as any benefit limitations, make the front office aware of restrictions AT check-in. 6. Yearly wellness exams will be filed to your insurance company with the expectation that they will be covered at 100%. If any portion of the visit is not considered to be part of your wellness plan, the patient will be responsible for the amount designated by your insurance company.	As a courtesy to our patients, we will complete any required forms as a free service during a patient's well-child office visit. Forms included but not limited to: School registration forms 3231 and 3300 Insurance Applications Over-the-counter medication prescription requests (FSA) F.M.L.A. forms Camp Forms School Medication Auth. School Physical forms Boy-scout or Girl-scout forms Katie Beckett forms Computer generated account reports Any other necessary forms **There is a fee for all forms outside the well exam**. You may pay an annual fee of $20.00 for the current year or $15 per form.

After-Hours Calls

After-hours calls to the CHOA nurse line or to physician on call will incur a fee of $15 per call. We encourage you to call our P.A.N.A. phone nurses during routine office hours with your questions at no charge, and reserve after-hours calls for emergencies only.

Cancellations and Missed Appointments

We require 24 hours cancellation notice for checkup appointments. Failure to cancel will result in a **$50 fee**. If you miss your child's sick appointment and do not call to cancel prior to the appointment time, you will incur a $25 fee. Cancellation fees are payable before or at your next office visit.

Collections Policy

Should an overdue bill go without payment after significant efforts have been made by PANA, we will forward the claim to a collections agency. Once a patient's account has gone into collections we will not be able to schedule future appointments or order prescriptions until payment has been made. If an account remains in collections without payment made, we will have no other option but to discharge the patient from our practice.

Self Pay Patients

Patients paying out of pocket will be given a discount on services, which must be paid in full at checkout. Any services performed in the office must be paid for at the time of service. **Any outside labs or cultures ordered will be billed separately by the lab performing those services, at a later date.**

Please sign below to acknowledge that you have read and agree to this financial policy, and agree to accept the responsibilities as described above. This form will remain valid until office policies change, at which time a new form will be given to sign.

Signed_____ **Date** _____

Pediatric Associates of North Atlanta, P.C.
5185 Peachtree Parkway • Suite 330
Peachtree Corners, GA 30092 • Phone (770) 476-9885

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their **protected health information (PHI)**. The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

____ **Primary Telephone # _____**
- **____** May leave message with detailed Information
- ____ May mail to my home address
- ____ Leave message with call back number only
- **____** May leave message with detailed Information

____ Secondary Telephone # _____
- ____ May leave message with detailed information
- ____ Leave message with call back number only
- ____ Leave message with call back number only
- **____** May leave message with detailed Information

____ Written Communication
- ____ May mail to my home address

____ Electronic Mail Communication
- ____ May use these email addresses

_____
_____

The Privacy Rule (TPO) generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as adequate records. **NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.**

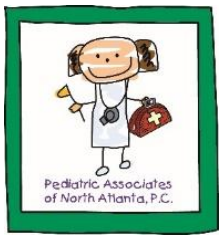
_____

IF THE PATIENT IS OVER 18 YEARS OLD THIS SECTION MUST BE COMPLETED

□ **I authorized PANA to release ANY protected health information (PHI) to the following individuals:**
_____

□ **My personal phone number is: _____. This should be used if no other individual may receive my PHI.**

Signed_____ **Date:** _____



Authorization-Non-Parent/Guardian
To Accompany Patient Periodically

There may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren).

The person bringing your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, give authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Pediatric Associates of North Atlanta (PANA) and to discuss and share medical information about my child. I further authorize them to see them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the PANA provider.

I also give them authority to make more serious or urgent health care decision in the event of an emergency.

Parent/Guardian Cell Phone Number: _____
Parent/Guardian Cell Phone Number: _____

Child's Name: _____DOB: _____
Child's Name: _____DOB: _____
Child's Name: _____DOB: _____
Child's Name: _____DOB: _____
Child's Name: _____DOB: _____

_____	_____	_____
Name of Person (allowed to bring child)	Relationship	Contact Number
_____	_____	_____
Name of Person (allowed to bring child)	Relationship	Contact Number
_____	_____	_____
Name of Person (allowed to bring child)	Relationship	Contact Number

*****This authorization will not expire, please update this form accordingly*****

_____ _____
Signature of Parent/Guardian Date