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Patient: Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_

DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Gender M F Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Reminders:

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (other than parents):

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Information: Mother Father Foster Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Parent /Legal Guardian Information: Mother Father Foster Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Information:

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Information (only if the policy holder is not parent/legal guardian):

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient(s) Family History

Information about your child(ren):

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Mother:

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

Medical Problem(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father:

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_

Medical Problem(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a family history (including child’s parents, siblings, grandparents, aunts, uncles ) of any of the following?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Allergies  Asthma/Wheezing  Birth Defects  Bleeding Tendencies  Convulsions  Diabetes | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO | Early Heart Attacks  Emotional Problems  Epilepsy  High Blood Pressure  High Cholesterol  Hip Disorders in Infancy | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO | Kidney Disease  Mental Problems  Thyroid Disease  Tuberculosis  Lazy Eye  Other Heart Disease  Other Illness | YES NO  YES NO  YES NO  YES NO  YES NO  YES NO  YES NO |

If you answered YES to any of the above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History:

Do you and your family have a religious preference? YES NO If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status of parents: Married Single

Has there been separation, divorce, or death? Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has been the attitude of your child to this situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, acupuncture or herbal medicine? YES NO If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a gun in your home? YES NO

Are there pets in your home? YES NO

Does anyone in your home smoke? YES NO

Are there family disagreements on how to raise the child(ren)? YES NO

List all siblings, step siblings or any other child(ren) that live with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the person complete the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient’s Medical History

Child’s Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy History with Child

Did you take drugs during pregnancy? YES NO

Did you smoke during pregnancy? YES NO

Did you drink any alcoholic beverages during pregnance? YES NO

Birth History of Child

*Please circle one:* Full Term Pregnance Premature birth: at \_\_\_\_\_\_\_\_\_ weeks \_\_\_\_\_\_\_\_ days

Adopted at what age? \_\_\_\_\_\_\_\_\_\_ Has he/she been told their adopted? YES NO

Type of delivery? Vaginal or C-section Obstetrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight: \_\_\_\_\_lbs. \_\_\_\_\_\_\_oz. Length: \_\_\_\_\_\_inches

*Please circle one:*  Brest fed Bottle fed

Any problems at birth? YES NO If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Development

*Please list age of child when the following milestones were reached:*

Sat alone: \_\_\_\_\_\_\_\_\_mos. Walked: \_\_\_\_\_\_\_mos. Words: \_\_\_\_\_\_\_\_mos. Sentences: \_\_\_\_\_\_\_mos.

First teeth: \_\_\_\_\_\_\_\_mos. Bladder trained: \_\_\_\_\_\_\_\_\_mos. Bowel trained: \_\_\_\_\_\_\_\_mos.

Does the child have any handicap? YES NO If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any bed wetting problem? YES NO Is there a family history of bed wetting? YES NO

School Performance

School Performance: Academic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been in special education class(es)? YES NO

Has the child had a learning problem? YES NO If yes, please specify what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Illness

*Please mark date or frequency of illness or specify causing allergy:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Asthma |  | Pneumonia |  | Allergic to Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergic to Foods:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergic to Insect Bites: |
| Chicken Pox |  | Roseola |  |
| Colds |  | Rubella(German Mealses |  |
| Convulsions |  | Tonsillitis |  |
| Ear Infections |  | Scarlet Fever |  |
| Mumps |  | Urniary Tract Infection |  |

Operations and Hospitalizations *Please specify date or reason:*

Appendectomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tonsils and Adenoids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ear Tubes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications

Is the child taking any medications on a regular basis? YES NO

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything about your child you feel we need to know to provide the best medical care for him/her?

Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the person completeing the form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Financial Policy

Thank you for choosing AGC Pediatrics, LLC as your health care provider. The following is a statement of our financial Policy, which we require you to read and sign prior to treatment. Please understand that payment of your bill is considered part of your care.

Due to frequesnt changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you are unable to provide preoof of insurance, are on a plan in which we do not participate, or have no insurance coverage, payment is required at the time of your visit.

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your superbill at each visit so you will be able to file your claim with your insurance company. If we are a participatient provider, we will routinely file a claim for services rendered although all co-pays and co-insurance amounts are due at the time of service. If you have a deductible portion of $75 (whichever is applicable) at the time of service will result in a $25 administrative fee.

If you are scheduled for a WCC (Well Child Check-up) and other health concerns are brought up that would typically require a separate sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly. Additionally, if it is determined that we need to treat a medical condition or must order additional test or labs at the WCC (Well Child Check-up), your bill will reflect all services rendered.

Should ther be a dispute with your insurance company, we will attempt to resolve it for you. During this time, a statement will be mailed to you each month showing your account balance due for all insurances other than HMO’s. If your insurance has not paid within 90 days the balance may be treandserred to your personal balance, which must be paid upon receipt. Your insurance policy is a ontract between you and your insurance company. Even though you have health insurance, you as the guarantor are responsible for payment of all services provided by AGC Pediatrics, LLC. Therefore, it is your repsonsibility to notify AGC Pediatrics, LLC immediately of any insurance change in order to ensure the correct insurance carrier is billed for services rendered. If there is a change in your insurance, please ensure that wer are listed as the PCP, if a PCP is required to receive payment.

Newborns It is important that you add your newborn to your insurance policy within the first 30 days of life to prevent any lapse in coverage. Please contact your employer (Human Resource Department) or insurance carrier to start the process and ensure all the proper paperwork has been submitted.

Vaccine for Children Program (VFC) Children who are insured but do not have vaccine coverage, are enrolled in Medicaid, or areeither American Indian or Natrive Alkaskan qualify for the VFC Program. The vaccins are provided free of charge, but there is an administration fee, which is your responsibility. You must qulify in order to receive the VFC vaccines.

Intetest, Late Fees, and Collections Fee We reserve the right to charge interest in the amount of 1.5% monthly (18% annually), as provided by the state law, on all past due account balances. A late fee of $25.00 is applied to any item unpaid after insurance has adjusted the clain (or 60 days from the date of service, whichever is less). Any delinquent account referred to collections will have a $150.00 collections charge applied. In addition, you are responsible for all legal fees, attorney fees, collection costs, and any miscellaneous expenses related to the collection delinquent accounts.

Divorce, Separation, and Custody Agreements AGC Pediatrics, LLC will not be partial to custodial, serparation, or financal disputes relating to individuals with regard to minor children to whom services are provided. The individual who requests the medical services and signs the financial agreement is responsible for any balance due. All co-pays, co-insurances, and deductible, if applicalbe, will be collected at the time services are rendered from the individual requesting the medical services for the minor child(ren). We will not call the other parent for consent. The providers will discuss the minor’s medical information with the accompanying parent at the time of the visit. AGC Pediatrics, LLC will provide a copy of any medical records requested, although we reserve the right to charge a fee. Both parents have access to the minor child’s medical records, unless there is a court order that specificall mandates only one of the parents to have the right to authorize medical treatment and release of the monor’s medical records. We reserve the right to discharge any patient form AGC Pediatrics, LLC if an issue comes between the divorced/seperated parents which would disrupt our practice. We maintain that divorce, separation, and custody agreemnts should not enter into the medical care of a child; such matters should remain between the parents.

Retrun check fees A $30 processing fee will be charged for checks returned as insufficient funsds, stop payment on an issued check, or checks drawn on a closed account. The charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action. Any family that has a history of more than 2 returned checks for insufficent funds will requrie cash or approved credit card payments for all visits thereafter.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Missed Appointments Missed appointments are very disruptive to our office. The also deprive others from an appointment to see the provider. A $35 fee will be charged for all no-shows or appointments cancelled in less than 24 hours in advance. If you repeatedly miss scheduled appointments, you may be asked to seek medical care elsewhere. *Please be courteous to those patients who need to be seen.*

Delinquent Accounts If a large bill is anticipated and financial arrangements need to be made, a payment program may be arrandged with our Billing/Insurance Department prior to your visit. Failure to resolve any past due accounts, including returned checks, will result in referral to a collection agency. Any family whose account is forwarded to a collection agency will be dismissed form our practice. If you are on a plan that requires you to be assigned a Primary Care Physician (PCP), then a copy of the dismissal letter will be sent to the insurance company so they will know to reassign you to another PCP.

Transferring of Medical Records Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to antoher physician’s office. A medical summary, list of immunizations, and growth charts(s) can be provided at no charge. Otherwise, there will be a $25.88 administration fee for each child’s record to be transferred.

Nurse fee Any procedures performed by the nurse (hearing, vision, lab work, allergy shots, vaccines etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in additon to the procedure performed. All appropriate co-pays will apply.

All patients are asked to please check-out before leaving the office. It is unlawful to intentionally walk out without satisfying your financial obligations after treatment has been rendered. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Cell Phones and Audio/Video Recording Policy When you step into our office, your child’s healthcare is our number one priority. That is why we ask that you please refrain from using your cell phone once you enter the office and for the remainder of your visit. If you must take a call or have important calls to make, please step outside to do so. **No audio or video recording of any kind for any reasonis allowed in the office.**

**Parents agree to turn off or silence all cell phones/equipment upon entering the clinical area and in exam rooms. Use of cellular equipment interferes with the wireless technology utilized within the office. The doctor/medical provider reserves the right to terminate the interaction if parent or legal guardian/patient uses their cell phone.**

**AGC Pediatrics, LLC has ZERO tolerance policy against aggressive behavior, unreasonable expectations, bullying, profanity, lying and verbal abuse towards our staff from our patients and their family members. Any display of this behavior will be subject to being terminated as a patient from this office.**

|  |
| --- |
| HMO or POS plans REQUIRE you to call your insurance carrier today (or prior to today) and have your PCP offically changed to the provider you are seeing at AGC Pediatrics, LLC. This will allow today’s charges to be covered by your insurance plan. |

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Parent/Patient Authorization Signtures

Patient Name(s):

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M F

*Please initial all applicable spaces. If a category does not apply to you, please write “N/A” in the space.*

Initials Financial Responsibility

I have received a copy of AGC Pediatrics, LLC Financial Policies statement. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that AGC Pediatrics, LLC is not responsible for knowing what services my plan covers and does not cover.

\_\_\_\_\_\_\_\_

Insurance Responsibility

I irrevocably assign and transfer to AGC Pediatrics, LLC all insurance benefits covered the AGC Pediatrics, LLC services for payment of services rendered. I understand that it is my responsibility for providing a current copy of my insurance card and notifying AGC Pediatrics, LLC of any changes/additions to a patient’s insurance coverage.

**\_\_\_\_\_\_\_\_**

Authorization for Release of Information

I hereby authorize AGC Pediatrics, LLC to release any necessary information for the following reason: to other physicians for continuing professional care, to any insurance company or their representatives, or otherwise as allowed by law. I release AGC Pediatrics, LLC from any liability for the release of information and I understand this release includes any and all blood and related teste, including HIV, HEP, and other diseases. This authorization is irrevocable and is not limited in time.

\_\_\_\_\_\_\_\_

Release of Data for e-Prescribing

I hereby authorize AGC Pediatrics, LLC to exchange prescription data with any/all prescription networks to facilitate the care of my child(ren) named above. This will include but not limited to medication history check, prescription eligibility coverage, generic vs. branded drug costs, and drug interaction verification. This authorization is not limited in time.

\_\_\_\_\_\_\_\_

Health Information Exchange

I understand that AGC Pediatrics, LLC will be participating in a health exchange. This allows AGC to quickly and accurately access information from another health care providers through secure, electronic means and could include information such as your child’s medications, allergies, test results and doctor’s notes. It would not include psychotherapy notes or other information that requires specific authorization to release under federal law. This helps our providers to make quick and accurate treatment decisions, especially in the case of an emergency or urgent situation.

\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

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Authorization for Care/Treatment

I am aware that my child(ren) may require medical treatment when I am not able to be present. In my absence, I give the individual(s) listed below my permission to authorize any and all medical treatment(s) for my child(ren) named above. Furthermore, in my absence, I give permission to AGC Pediatrics, LLC and its entire staff to examine and provide emergency treatment to my child(ren) listed above. In additional, the provider/clinic has my permission to refer my child(ren)’s emergent care and treatment to the appropriate service for the treatment of the illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child(ren)’s care whether or not services are covered by insurance. This authorization is not limited in time.

\_\_\_\_\_\_\_\_

Individual(s)Name Relationship to Patient

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHI Release

Who do you authorize to receive your child(ren)’s Personal Health Information (step-parents, babysitters, grandparents, etc….)? If a person, other than the parent/legal guardian, is not listed below, they will be unable to gain access to your child(ren)’s PHI, either written or verbal from AGC Pediatrics, LLC. This is for appointment scheduling, picking up paperwork, or prescriptions, reminders, requesting medication refills, test results, lab and x-ray results, referrals information, etc.; this does not include access to complete medical records.

\_\_\_\_\_\_\_\_

Individual(s) Name Relationship to Patient

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization. Information that is disclosed under this authoriztion may be disclosed again by the person or organization to which it is sent. This privacy of this information may not be protected under the federal privacy regulations.

Communication

We may contact you via phone, text, or email at the number(s) and address(es) provided for appointment reminders, health reminders, account related matters and other issues as needed. We may leave a voicemail or a message with whomever anwsers.

YES NO

If you answered No, please advise us on how we may best contact you for appointment changes, account related matters, and/or any health matters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

www.agcpediatrics.com

189 & 204 Professional Court, Calhoun, GA \* 7311 Fairmount Hwy., Calhoun, GA \* 5 Medical Drive, NE, Cartersville, GA

Authorization of Treatment and Assignment of Benefits:

I authorize AGC Pediatrics, LLC to treat my child, I futher authorize payment directly to AGC Pediatrics, LLC for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all of my insurance submissions. I permit a copy of this authorization to be used in place of the original.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chid Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Receipt of Notice of Privacy Practice:

Written Acknowledgement Form

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been made aware that a copy of the HIPAA is located in the lobby and waiting areas of AGC Pediatrics, LLC and am aware that I can request a printed copy.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chid Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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All God’s Children New Security Policy for Verbal Consents

I am aware that my child(ren) may require medical treatment when I am not able to be present and I may not have the person bringing them on the Authorization for Care/Treatment, a verbal consent may be needed. A verbal consent must come from the parent/legal guardian. In order to make sure our staff is speaking with the parent/legal guardian, a security question and answer will need to be provided. If the answer can not be given, to the question you have given us, then we can not allow the person your child is being brought in by to have your child seen for the visit scheduled. Please understand, this is for the safety of your child(ren). If you forget and can not remember your answers, then you must come in to fill out another form. We will not change security questions or answers over the phone. It will require parent/legal guardian to fill out New Security Policy for Verbal Consents.

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My security question is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Answer is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_