Patient Registration Packet

Patient Information:

Patient Name: _____ ☐Male ☐Female D.O.B.: _____ Cell: _____ Email: _____
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Mailing Address: _____ _____ _____ _____
(Street or PO Box) (City) (State) (Zip code)

Sibling's Name: _____ ☐Male ☐Female D.O.B.: _____ Cell: _____ Email: _____
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Mailing Address: _____ _____ _____ _____
(Street or PO Box) (City) (State) (Zip code)

Sibling's Name: _____ ☐Male ☐Female D.O.B.: _____ Cell: _____ Email: _____
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Mailing Address: _____ _____ _____ _____
(Street or PO Box) (City) (State) (Zip code)

- *If you have additional children to register, please list them on the Medical Authorization for Treatment form (page 6)*

Referred By:

☐Hospital/OB: _____ ☐Our Website ☐Ins. Company ☐ Already Est. ☐Other (name) _____

Primary Contact: *Name*:_____ *Relation to Patient*: _____

For Family Medical History Reasons: Is this contact genetically related to the Child? ☐Yes / ☐No

Lives with patient? ☐Yes / ☐No *Date of Birth*: _____ *Social Security #*: _____

Work Phone: _____ *Cell Phone:*_____ *Home Phone*: _____ *Email*: _____

How would you ideally prefer to be contacted regarding (Check one for each category):

Medical Issues: ☐Home Phone / ☐Work Phone / ☐Cell Phone

Appointment Reminders: ☐Home Phone / ☐Cell Phone

General Practice Notices: ☐Home Address / ☐Home Phone / ☐Cell Phone / ☐Home Email

Secondary Contact: *Name*:_____ *Relation to Patient*: _____

For Family Medical History Reasons: Is this contact genetically related to the Child? ☐Yes / ☐NO

Lives with patient? ☐Yes / ☐ No *Date of Birth*: _____ *Social Security #*: _____

Work Phone: _____ *Cell Phone*: _____ *Home Phone*: _____ *Email*: _____

If this contact will need to be notified in addition to the primary contact for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:_____

_____

May all contacts have access to the patient's records? ☐Yes / ☐No

Patient Registration Packet

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

Who has 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.*

Emergency Contacts, other than parents: Name & Relationship

I GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO ACCOMPANY MY CHILD FOR MEDICAL TREATMENT AND TO MAKE MEDICAL DECISIONS IN MY ABSENCE:

1: _____ _____ *Phone*: _____
(Name) (Relationship)

2: _____ _____ *Phone*: _____
(Name) (Relationship)

Insurance: (*Legal notice: **All** active insurance carriers must be disclosed.)*

Primary: _____ *Policy Holder*: _____ Effective Date: _____

Policy/ID #: _____ Group #: _____

Claims Address: _____

Secondary: _____ *Policy Holder*: _____ Effective Date: _____

Policy/ID #: _____ Group #: _____

Claims Address: _____

AUTHORIZATION OF TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFTIS:

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO GRAYSON PEDIATRICS, LLC AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT OF MYSELF/OR MY DEPENDENTS. I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGES EXCEPT THOSE UNDER THE CONTRACTUAL ARRANGEMENTS WITH CERTAIN INSURERS OF GRAYSON PEDIATRICS, LLC.

Signature of Patient, Parent or Guardian: _____Date: _____

Relationship to Patient: _____

☐**I prefer to do my own insurance filing. Signature of Patient, Parent or Guardian**: _____ **Date**: _____

Pharmacy Information:

Preferred Pharmacy: _____ *Address:* _____ *Phone:* _____

☐ **I authorize Grayson Pediatrics, LLC to access my child(ren) electronic medicine prescription history**

Patient Registration Packet

Child's Name:_____

Household Information

Please list all those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems

What is the child's living situation?

☐ Lives with mother and father ☐Lives with adoptive parents ☐Joint custody ☐Single custody ☐Foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

_____

_____

BIRTH HISTORY

☐ **Birth History unknown**

☐Vaginal ☐C-Section ☐Full Term ☐Premature (if yes, weeks completed____) Birth Weight: _____ Length: _____

Were there any prenatal or neonatal complications? ☐Yes ☐No

Was a NICU stay required? ☐Yes ☐No (if yes please explain): _____

_____

GENERAL HISTORY

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

If no, please explain: _____

_____

Do you think your child's development is: ☐ On Target ☐Delayed

If delayed, please explain: _____

_____

Has your child ever been hospitalized or had surgery: ☐ Yes ☐No

If yes, please explain: _____

_____

Is your child allergic to medications or foods ☐Yes ☐No

If yes, please explain: _____

_____

Form Completed By:_____

Signature:_____ **Date:**_____

Grayson Pediatrics

Patient Registration Packet

Child's Name: _____

Patient Medical History

GENERAL HISTORY QUESTIONS	Yes	No	Unknown	When/explain
Has your child ever had an allergy to any medication, food or environmental? If so, which one(s)	☐	☐	☐	
Has your child ever wheezed or used an inhaler?	☐	☐	☐	
Has your child ever been hospitalized in the last year? If so, for what?	☐	☐	☐	
Has your child ever had a head injury requiring medical attention?	☐	☐	☐	
Has your child ever had surgery	☐	☐	☐	
Does your child have any ongoing medical problems?	☐	☐	☐	
Does your child have a special diet or vegetarian diet? If so, please describe diet	☐	☐	☐	
Has your child ever lived/spend time in an older building that has not been renovated since 1978?	☐	☐	☐	
Is there a gun kept in the place where your child lives?	☐	☐	☐	
If yes to the gun question, is the gun locked up/ammo separate?	☐	☐	☐	
HAS YOUR CHILD EVER HAD OR NOW HAVE	**Yes**	**No**	**Unknown**	**When/explain**
Eye/Vision problem	☐	☐	☐	
Ear/Hearing problem	☐	☐	☐	
Dental problems	☐	☐	☐	
Speech problems	☐	☐	☐	
Fainting spells	☐	☐	☐	
Urine/Kidney Infections	☐	☐	☐	
Wheezing or Asthma	☐	☐	☐	
Heart Condition/Heart murmur	☐	☐	☐	
Anemia/Blood problems	☐	☐	☐	
Bedwetting	☐	☐	☐	
Seizures/Convulsions	☐	☐	☐	
Recurrent skin rash/Eczema	☐	☐	☐	
Joint pain or swelling	☐	☐	☐	
Fractures/Bone problems	☐	☐	☐	
Lung, liver or blood infections	☐	☐	☐	
Tuberculosis or positive TB test	☐	☐	☐	
Other: please explain				
DOES CHILD	**Yes**	**No**	**Unknown**	**When/explain**
Have immunizations up-to-date	☐	☐	☐	
Take medicine regularly	☐	☐	☐	
See dentist regularly	☐	☐	☐	
HAS YOUR CHILD EVER HAD OR NOW HAVE	**Yes**	**No**	**Unknown**	**When/explain**
Frequent headaches	☐	☐	☐	
Discipline problems	☐	☐	☐	
Trouble getting along with others	☐	☐	☐	
Restlessness/Fidgety	☐	☐	☐	
Nervousness or Fearful	☐	☐	☐	
Persistently sad or depressed	☐	☐	☐	
Drug/Tobacco/Alcohol use	☐	☐	☐	
Sexual activity or Molestation	☐	☐	☐	
Trouble in school	☐	☐	☐	
Aggressive behavior	☐	☐	☐	
Eating problems/Eating too much/little	☐	☐	☐	
Other: please explain				

Patient Registration Packet

Child's Name: _____

Family Medical History

☐**Family history unknown; if so:** ☐**Adoption** ☐**Foster Care/DFCS**

The following information is of value in the complete examination of your child. Answering is optional and of course confidential.

Please check the boxes where the child's blood relatives have any of these problems?

	Father	Mother	Brother	Sister	Father's side	Mother's side	Please explain any checked box
Allergies (asthma, eczema, hay fever)	☐	☐	☐	☐	☐	☐	
Birth defects (cleft lip, club foot, hip dysplasia)	☐	☐	☐	☐	☐	☐	
Blood disorders (bleeding, sickle cell, anemia)	☐	☐	☐	☐	☐	☐	
Bone/Joint disorders (arthritis, gout)	☐	☐	☐	☐	☐	☐	
Cancer (Leukemia, breast cancer, tumors, Retinoblastoma)	☐	☐	☐	☐	☐	☐	
Cholesterol problems	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Eye problems (blindness, lazy eye, crossing eyes)	☐	☐	☐	☐	☐	☐	
Ear problems (deafness/hearing aids)	☐	☐	☐	☐	☐	☐	
Gastrointestinal disorders (ulcer, Crohn's, celiac, constipation)	☐	☐	☐	☐	☐	☐	
Genetic disorders (down syndrome, cystic fibrosis)	☐	☐	☐	☐	☐	☐	
Heart disease (heart attacks, high blood pressure, any birth defects)	☐	☐	☐	☐	☐	☐	
Immune problems	☐	☐	☐	☐	☐	☐	
Kidney disease (absent kidneys, cystic kidneys, UTI or kidney reflux)	☐	☐	☐	☐	☐	☐	
Liver disease	☐	☐	☐	☐	☐	☐	
Lung disorders (asthma, tuberculosis, pneumonia)	☐	☐	☐	☐	☐	☐	
Muscle disorders (Multiple Sclerosis, stiffness, arthritis, juvenile rheumatoid arthritis)	☐	☐	☐	☐	☐	☐	
Nervous disorders (migraines, seizures, epilepsy, sensory)	☐	☐	☐	☐	☐	☐	
Psychological disorders (ADHD, depression suicide, schizophrenia, Bipolar)	☐	☐	☐	☐	☐	☐	
Thyroid Problems (hyper, hypo, Hashimoto's)	☐	☐	☐	☐	☐	☐	
Alcoholism, drug dependency, abuse	☐	☐	☐	☐	☐	☐	
Regular smoker	☐	☐	☐	☐	☐	☐	
Developmental delays (speech, behavioral, Autism/Aspergers)							
Other:	☐	☐	☐	☐	☐	☐	

Medical Authorization for Treatment ***(Use this form only if you have more than one child to register)***

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO GRAYSON PEDIATRICS, LLC AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I VOLUNTARILY CONSENT TO EXAMINATION AND TREATMENT OF MYSELF/OR MY DEPENDENTS. I WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGES EXCEPT THOSE UNDER THE CONTRACTUAL ARRANGEMENTS WITH CERTAIN INSURERS OF GRAYSON PEDIATRICS, LLC.

Sibling's Name: __________________ ☐Male ☐Female D.O.B.: ____________ Cell: _____________ Email: ________________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: __________________ ☐Male ☐Female D.O.B.: ____________ Cell: _____________ Email: ________________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: __________________ ☐Male ☐Female D.O.B.: ____________ Cell: _____________ Email: ________________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: __________________ ☐Male ☐Female D.O.B.: ____________ Cell: _____________ Email: ________________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: __________________ ☐Male ☐Female D.O.B.: ____________ Cell: _____________ Email: ________________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

You will need to fill out an additional Patient Medical History and Household information, birth/general history forms for each child listed above.

Signature of Patient, Parent or Guardian: _________________________ **Date**: _________________

Relationship to Patient(s) listed above: _____________________________________

Office Policies and Procedures

Please Initial

_____ **PHONE SYSTEM**: We strive to answer our calls live, however, during times of heavy call volume, the phone system will be answered by our automated system. Please listen carefully to the menu so that your call is directed to the appropriate department with little or no waiting time. Leaving multiple messages on multiple lines will delay your call back.

_____ **CELL PHONES**: To set a good example for your children and to have a productive visit, please turn off your phone and Electronic devices when any staff member is in the room.

_____ **WALK-INS**: If you walk in without an appointment, you may be directed to the Urgent Care Facility or the Emergency Room**. We work by appointment only**. **There will be a $50.00 convenience fee in addition to your copay for walk ins. The convenience fee is separate from the actual appointment/insurance fees. This fee is due at the time of service and is not covered by your insurance.**

_____ **SICK VISITS**: If your child is sick, please make an appointment as early in the day as possible. We work by appointment only; *no walk-ins*. Patients arriving later than 20 minutes after the scheduled arrival time will have the option to reschedule or wait for the next available appointment that day. Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to another sick child.

_____ **HEALTH CHECKS**: Try to schedule the health check appointment for your child in advance. This will enable us to accommodate your schedule and allow your child's physician to spend ample time answering your questions and evaluating your child. **Patients arriving late (15 minutes after scheduled arrival time) will need to reschedule.** We understand that situations arise where you cannot keep an appointment. Kindly notify us 24 hours in advance if you are unable to keep an appointment, or you will incur a missed appointment fee of $50.

_____ **NO SHOW / MISSED APPOINTMENTS**: **Missed appointments will be charged a $50 "No Show Fee,"** These fees are not covered by your insurance. These fees are applied to all patients in accordance with CMS Federal guidelines. To avoid such fees please attend all scheduled appointments or call our appointment line at least 24 hours in advance to cancel the appointment.

_____ **DISMISSAL FROM THE PRACTICE**: Patients who No show/missed appointment three (3) or more times in a 12-month period may be dismissed from the practice. Additionally, patients who develop a history of late arrivals to their appointments may be dismissed from the practice.

_____ **IMMUNIZATIONS**: The Providers of this practice have made it policy to immunize ALL patients of this practice. **If it is your choice not to immunize your child(ren), you will be asked to find a new pediatrician.**

_____ **SIBLING POLICY**: If you have another child with you today who is ill and is not originally scheduled to see the doctor, please immediately notify the front desk on arrival so that we may try to accommodate your child. **DO NOT** wait to inform us after you have entered the exam room. If a sibling is added, the appointment time may need to be adjusted, and the family may experience a longer wait to see the provider. We understand that these scenarios do arise at the last minute, however, we strive to be on time to our scheduled appointments and please assist with this by notifying the office as soon as you are aware that the additional child(ren) need to be seen. These events may be subject to the walk-in fee.

_____ **ZERO TOLERANCE:** We strive to create a relationship of mutual respect with the families that we serve. Verbal abuse will result in immediate dismissal from our practice.

_____ **SureScripts Prescription History:** I consent for my provider to access my child's prescription history via the electronic data base.

_____ **NURSE PHONE CALLS**: The nurse line receives a high volume of calls. For your convenience, there is a voice mail system on this line. Please leave your name and phone number and spell your child's name and date of birth. One of our nurses will return your call as soon as possible. Morning calls are returned if possible by 12:30pm, and afternoon calls by 5-7pm. Phone calls after 4:00pm will be returned the next business day.

_____ **PRESCRIPTION REFILLS**: For medication that cannot be called in, please notify us at minimum of **72 business hours in advance by means of the patient portal or by calling the office.** We will electronically submit your prescription to the pharmacy you specified in your registration paperwork. You will receive a call or portal message from our office advising you your child's prescription has been sent to the pharmacy.

Patient Registration Packet

_____ **MEDICAL/IMMUNIZATION RECORDS**: Please give a minimum of **72 business hours** notice for completion of school forms. This includes immunization records and physical forms (see the financial policy for a list of administrative fees associated with specific forms). All form fees must be paid at the time the forms are dropped off at the office to be completed by the provider/staff. For a copy of the full chart, a medical record release form must be signed and a $25 administrative fee per chart paid at the time the request is made. Once we have the signed release form and payment, there is a minimum of **72 business hours** before these records become available. (CD versions are available)

If you are a new patient or have changed pediatricians or have received immunizations from the Health Department, please check with our staff to make sure we have your child's immunization records on file. In the instance your child's immunization records are not found or are not shown "up-to-date", **it is your responsibility to obtain the missing records**. We highly recommend that you keep a personal copy of your child's immunization records – we would be happy to make a copy for you!

_____ **INSURANCE**: To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card **each time you visit our office**. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, **if you provide us with incorrect insurance information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee.**

- It is your responsibility to contact your insurance company and find out whether or not our Doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our doctors may participate in only one of these areas, not in all.
- It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy.
- The following circumstances may result in you being billed directly:

~ we are not participating physicians in your plan; insurance coverage is not in effect because of the date of visit

~ non-covered lab work is ordered/performed

~ or a non-covered service is performed or denied for the reason "not medically necessary"

- Co-payments are collected up front and are due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee. If you have a deductible plan (especially high deductible plans), **a minimum of 80%** of the estimated insurance contract rate for the cost of the visit is due at the time of service.

_____ **BILLING STATEMENTS:** *Your billing statement is posted on your patient portal and is available 24/7*. You will NOT receive a hardcopy of your statement in the mail. Please ensure that you provide our staff with an active and well monitored email address to set up your child(ren)'s portal. You may make payment online via the patient portal and the link is found on our website, www.GraysonPediatrics.com, under the patient portal tab. Additionally, you may mail your payment to the office, or make a payment by phone by either calling the office at 678-381-2630 or our billing department at 469-863-8356 during business hours.

_____ **PERMISSION TO TREAT**: The child must be accompanied by an adult for the visit or we will be unable to treat the child. We must obtain a current copy of the accompanying adult's photo ID at each office visit. If someone other than the parent or guardian is bringing the patient and this person is not a listed contact in the child's chart, we require a written notice stating **approval of the visit, which must be signed by the parent/guardian and presented at check-in. Also, please ensure that you send payment for the visit with the accompanying adult for any co-pays or co-insurance deductibles required at check-in.**

_____ **REFERRALS**: Referrals may be needed for specialists, emergency room visits, urgent care visits, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need **3 business days** to obtain all referral data to facilitate the referral for you and your insurance company.

_____ **LABS, X-RAYS, OR OTHER AMBULATORY CARE SERVICES**: If labs, x-rays, or other ambulatory care services are required beyond your office visit, **it is your responsibility to know where your insurance company covers you to go for these services**. Each insurance company contracts with different companies. The bills you receive from these services are not managed by Grayson Pediatrics, LLC.

I have read and understand the above stated policies, procedures, and notices.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Patient's Name

_____ _____

Print Name of Patient or Legal Guardian — Date

Grayson Pediatrics, LLC

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY PRACTICE

By signing this authorization, I authorize Grayson Pediatrics, LLC to use/or disclose certain protected health information (PHI) about:

_____.

Child(ren)'s Name(s)

This authorization permits Grayson Pediatrics, LLC to use and/or disclose the following individually identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purposes:

Insurance information, further medical care, immunization forms to schools, daycare, college forms, camp forms, sports physical forms, and to call prescriptions to pharmacy.

*Other:*_____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in 365 days. At which point you will be asked to review and sign an updated copy.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Grayson Pediatrics, LLC. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

297 Cooper Road
Loganville, Georgia 30052

I acknowledge receipt of the Notice of Privacy Practices of Grayson Pediatrics, LLC.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Patient's Name

_____ _____

Print Name of Patient or Legal Guardian — Date

As the personal representative, I have the authority to act for the Patient because I am the Patient's _____

(relationship to Patient)

CONSENT FORM AND WAIVER

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION AND/OR IMAGE (PHOTOGRAPH OR VIDEOTAPE) FOR **MEDICAL PURPOSES ONLY**

I hereby give consent to Grayson Pediatric, LLC. (hereinafter "Grayson Pediatrics") to take and use images (photographs or videotape) or sounds recordings of me and/or the minor patient or person named below for whom I am giving consent, and disclose confidential patient information about me and/or the minor patient or person, to any medical facility as it pertains to the diagnoses and treatment of the minor patient or person named below form whom I am giving consent. (Most common picture examples: rashes, birthmarks, lacerations, skin lesions, pigmentation changes, etc.) (Most common sound/video recordings: cough, breathing patterns, pitch of voice/cry of child, muscle tone, etc)

I understand that confidential information to be disclosed may include information about the patient's treatment at Grayson Pediatrics obtained from interviews of the family, physicians and hospital personnel, or from the patient's medical records, including photographs, x-rays, videotapes and results of diagnostic studies, and I hereby waive the right to or interest in the confidentiality of this patient information or images taken and disclosed to the public, as contemplated in this release.

I hereby release and forever discharge Grayson Pediatrics (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in ad to such information and materials.

I have been informed that once this information is disclosed it may no longer be protected by federal privacy regulations. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying Grayson Pediatrics in writing at: 297 Cooper Road Loganville, GA 30052.

Name of Minor patient or person	D.O.B. of minor patient or person	Name of consenting individual, parent or legal guardian	Relationship to minor patient or person

_____ _____

Signature of Consenting Individual, Parent or Guardian Date

FINANCIAL POLICY

We are committed to providing our Grayson Pediatrics, LLC families with outstanding pediatric care. We have business office staff to address your billing and insurance questions. Our staff is available by phone 678-381-2630 or in person at 297 Cooper Road, Loganville, GA 30052. We are open Monday through Friday 8:30am to 5:00pm.

It is our goal to make sure you receive the maximum financial benefit from your insurance provider and to make sure that your account is handled in the most efficient manner possible. In order to accomplish this goal, it is important that we have your understanding and cooperation in adhering to our financial policies.

Account Responsibility - As the parent or guardian of a child registered with Grayson Pediatrics, LLC, you are agreeing to be responsible for all balances incurred on behalf of your child's medical care. All balances are due upon receipt of a statement from our offices. Your billing statements are posted to your child's patient portal, which may be found on our website, www.GraysonPediatrics.com, under the patient portal tab. If you feel your statement is incorrect or you are having financial difficulties, please contact our business office within 14 days. If your insurance company denies your claim or does not pay your claim within 45 days after we have filed the claim, the outstanding balance becomes your responsibility. Please contact us immediately if you are having a dispute with your insurance company or you think your claim has been denied in error.

Parent Payment Responsibility- The parent authorizing treatment for a child will be the parent responsible for those charges. If a divorce or custody decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent. If the non-custodial parent is responsible for medical treatment charges on behalf of the child, we advise that the non-custodial parent or guardian responsible for payment of charges for a child's medical treatment be present at the first patient visit of the child to sign the necessary papers. Otherwise, the parent authorizing the treatment will be responsible for those charges, until such time as the appropriate forms are signed by the parent responsible for medical treatment costs and such signed forms are delivered to our office. Grayson Pediatrics, LLC will not intervene to determine a parent's responsibility for payment.

Initial Here: _____

Payment for Services - Payment in full is due at the time of service. We accept cash and all major credit cards as forms of payment. If you are enrolled in an insurance plan in which we participate, we will file your claim for you. Payment is expected in full at the time of service for:

- Copayments. If you do not have your copay at the time of the visit, we will bill you for a $15 administrative fee
- If you have a deductible plan, 80% of the visit is due at the time of the visit
- If we are not contracted with your insurance company
- If you do not have insurance coverage
- If we are unable to verify your insurance eligibility or we do not have your new insurance information on file.

Payment is due within 14 days of receipt of your statement. If your account becomes past due we reserve the right to send you to collections and you will be responsible for all collection and fees that the practice incurs as a result. We reserve the right to refuse to see any patient that has been placed into collection.

Insurance Coverage – To properly file your insurance claim(s), we must obtain a current copy of your child's insurance card each time you visit our office. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, **if you provide us with incorrect insurance information, you will be responsible for the bill. If incorrect insurance information is given that requires a claim to be re-filled, there will be a $35 re-filing fee.**

- It is your responsibility to contact your insurance company and find out whether or not our Doctors are participating physicians within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that our Doctors may participate in only one of these areas, not in all.
- It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on your own insurance policy. You will be responsible for the charges of any services and procedures that are not covered by your insurance policy.
- The following circumstances may result in you being billed directly (not intended to be an exhaustive list). Remember that your insurance company, not your provider or physician's office, makes decisions about what will be paid for and what will not.
    - We are no participating physicians in your plan; insurance coverage is not in effect because of the date of visit

- Non-covered lab work is ordered/performed
- Non-covered service is performed or denied for the reason, "not medically necessary"

Services Rendered – If your child is being seen for a well check-up or preventive visit and another condition is treated during the same appointment, we will bill for each of the services performed.

Initial Here: _____

Description of Administrative Fees – Listed below are services for which we charge an administrative fee. Most of these services are time consuming and cumbersome on staff's time. These services are not billed to your insurance company unless otherwise indicated and they are your responsibility. Please contact our office for questions about our current administrative fees.

SERVICE and FEES	DESCRIPTION
No show/Missed Appointment Fees	**No show/missed appointments will be charged a $50 "No Show Fee" for each appointment missed. These fees are not covered by your insurance. To avoid such fees please attend all scheduled appointments on time (which is provided to you) or call our appointment line at least 24 hours in advance to cancel the appointment. All No show/missed appointment fees MUST be paid prior to scheduling your next appointment.**
NSF Checks	If your check is not honored by our bank we will assess an NSF processing fee, which you will be billed **along** with a $20 administrative fee to reprocess your payment.
Insurance re-filing	If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee. This fee is not covered by your insurance.
Co-payment & Co-Insurance	Co-payments & Co-Insurance are collected up front and are due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay, we will bill you for a $20 administrative fee.
After Hours Services	A $20 after hours fee will be billed to your account when a provider is contacted (phone, email, social media, etc.) and reached during non-office hours. This fee is not covered by your insurance.
Health Forms	We will provide your child with **one** health form for school (form 3300), certificate of immunization (Form 3231) or camp per year free of charge if given at the prevention visit. These forms requested outside of your child's prevention visit will be assessed an administrative fee of $10 each. Other form fees: • Sports/physical form: $45.00 if cash pay or not covered by insurance • Special Olympics form: $45.00 (unless completed at the well check) • All other forms: $20.00
Walk-In Visits	If you walk in without an appointment, you may be directed to the Urgent Care Facility or the Emergency Room. **We work by appointment only. There will be a $50 convenience fee in addition to your copay for walk ins. Both your copay and $50 convenience fee will be due at the time of service.**
Ear Piercing	$75.00 cash for ear piercing service and choice of in-house earrings
Medical/immunization Records Requests	If you need a complete set of your child's medical records, there is a $25 administrative fee. Copies of your child's immunization records are provided free of charge (if requested at the time of the prevention visit).
Third Party Medical Records Requests	If a non-medical entity needs a complete copy of your child's chart, we charge a fee based on Georgia medical record copying laws. If we refer you to a specialist for further treatment we will send a copy of your child's chart free of charge.

By signing below, I acknowledge that I have read, understand and agree to abide by Grayson Pediatrics, LLC's Financial Policy and pay for any and all medical services your child(ren) receive(s) from Grayson Pediatrics, LLC. I understand that if my insurance company refuses to pay, for whatever reason, these fees will become my responsibility.

_____ _____ _____

Signature of Parent/Guardian Assuming Financial Responsibility | Relationship to Child/Children | Date

AUTHORIZATION OF RELEASE OF PROTECTED HEALTH INFORMATION

I _____hereby authorize the following healthcare providers:
(Print: Name of parent or legal guardian)

Name of Practice/Facility	Office address	Office Phone Number

To release the following information contained in the patient record of:

	Patient's Name	Date of Birth
1		
2		
3		
4		
5		
6		

Grayson Pediatrics, LLC
297 Cooper Road
Loganville, GA 30052
Phone: 678-381-2630
Fax: 678-381-2627

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law. I understand that the Health Care Provider who I am asking to disclose the information to, Grayson Pediatrics, LLC, may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third parity.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that. I may revoke this authorization at any time by giving written notice to the disclosing Health Care Provider of my desire to do so.

I also understand that I cannot revoke this authorization after the disclosing Health Care Provider has already relied on it to use or disclose the protected health information. Written revocation must be sent to the disclosing Health Care Provider's office.

_____ _____
Signature of Consenting Individual, Parent or Guardian Date

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA), **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND YOUR CHILDREN (AS PATIENTS OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI). PLEASE REVIEW THIS NOTICE CAREFULLY.**

A. Our Commitment to Your Privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and your children and the services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you or your children. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI.

We realize that these laws are complicated, but we must provide you with the following important information:

1. How we may use and disclose your IIHI
2. Your privacy rights in your IIHI
3. Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your children's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this notice, please contact Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. E mail: Admin@graysonpediatrics.com.

C. We may use and disclose your IIHI in the following ways:

1. Treatment. We may use your child's IIHI to treat your child. For example, we may ask your child to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might also use your child's IIHI in order to write a prescription for them. All of the permanent employees at Town & Country Pediatrics may use or disclose your child's IIHI to treat your child or assist other health care providers in their treatment. Additionally, we may disclose your child's IIHI to others who may assist in your child's care, such as your spouse or parents. We may also use and disclose your child's IIHI to inform you of potential treatment options or alternatives. An example would be to refer you to a home healthcare agency.
2. Payment. Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your child's treatment. We also may use and disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your child's IIHI to bill you directly for services and items. We may disclose your child's IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health Care Operations. Our practice may use and disclose your child's IIHI to operate our business. As an example, our practice may use your child's IIHI for the state and regulatory agencies to evaluate the quality of care you received from us.
4. Health Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. Examples are free formula or pharmaceutical supply houses to procure expensive drugs such as Synagis.
5. Release of Information to Family/Friends. Our practice may release your child's IIHI to a friend or family member who is involved in your child's care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter or nanny take their child to our practice for treatment of a cold. In this case, we may disclose your child's IIHI to the babysitter or nanny.
6. Disclosures Required by Law. Our practice will use and disclose your child's IIHI when we are required to do so by federal, state, or local law.

D. Use and Disclosure of Your Child's IIHI in Certain Special Circumstances:
Public Health Risks. Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

1. Maintaining vital records, such as births and deaths
2. Reporting child abuse or neglect
3. Preventing or controlling disease, injury, or disability
4. Notifying a person regarding potential exposure to a communicable disease
5. Notifying a person regarding a potential risk for spreading or contracting a disease or condition
6. Reporting reactions to drugs or problems with products or devices
7. Notifying individuals if a product or device they may be using has been recalled

Health Oversight Activities. Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Examples are: investigations, inspections, audits, surveys, licensure and disciplinary actions, civil administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding and in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
1. Regarding a crime victim in certain situations, if we are unable to obtain your agreement
2. Concerning a death we believe has resulted from criminal conduct
3. Regarding criminal conduct at our offices

4. In response to a warrant, summons, court order, subpoena or similar legal process
5. To identify/locate a suspect, material witness, fugitive or missing person
6. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if your child is an organ donor.

Serious Threats to Health or Safety. Our practice may use and disclose your child's IIHI when necessary to reduce or prevent a serious threat to their health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

E. Your Rights Regarding Your Child's IIHI:

1. Confidential Communications: You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Privacy Officer, 297 Cooper Road, Loganville, GA 30052, email: Admin@graysonpediatics.com, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your child's IIHI for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your child's IIHI to only certain individuals involved in your care or the payment of you care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when child's IIHI, you must make a request in writing to Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. Your request must describe in a clear and concise fashion:

1. The information you wish restricted
2. Whether you are requesting to limit our practice's use, disclosure or both; and
3. To whom you want the limits to apply

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your requests in writing to Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com to inspect and/or obtain a copy of your child's IIHI. Our practice will charge a fee for the costs of copying, mailing and labor/supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. You must provide us with a reason that supports your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete, (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your child's IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your child's information to file your insurance claim. To obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. All requests for an "accounting of disclosures" must state a time period, which may be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice will charge you for an additional list within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. A copy of this notice is also located on our website at www.graysonpediatrics.com.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services or the Georgia Attorney General. To file a complaint with our practice, Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. A copy of this notice is also located on our website at www.graysonpediatrics.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. You may revoke any authorization you proved to us regarding the use and disclosure of your child's IIHI at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your child's healthcare. Again, if you have any questions regarding this notice or our health information privacy policies, please contact, Privacy Officer, 297 Cooper Road, Loganville, GA 30052. Phone: (678) 381-2630. Email: Admin@graysonpediatrics.com. A copy of this notice is also located on our website at www.graysonpediatrics.com.

By signing the Financial Policy & Notice of Privacy Practices Signature form, you acknowledge that you are your child's parent, guardian, or other representative duly authorized to act on your child's behalf, and that you have read and understand Grayson Pediatrics, LLC's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available upon request at our office or on our website, GraysonPediatrics.com.

_____ _____ _____

Signature of Parent/Guardian Assuming Financial Responsibility | Relationship to Child/Children | Date

Employee Initials: _____