# NEW PATIENT REGISTRATION FORM

**PATIENT LAST NAME**:_______________________________ **FIRST NAME**:__________________________ **MI**: ______

**DATE OF BIRTH:** ______/______/______ **Sex:** MALE____ FEMALE____ **Primary Language**:___________________

**Ethnicity:** Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White /Unknown

**MAILING ADDRESS**:___________________________________________________________________________________

(Street or PO Box) (City) (State & Zip)

**PH #**:____________________________ Who lives at this household? ___________________________________________

*(Please note, this information is being requested to improve intake of your child's Social History.)*

**PHARMACY**____________________**ADDRESS**_____________________________________ **PH #**____________________

## INSURANCE INFORMATION

**Primary Policy**: Policy Holder's Name:________________________________________ Birth Date:__________________

Policy Holder's SSN:_______________________ Policy Holder's Sex: M / F Relation to Patient:__________________

Insurance Carrier:________________________ Policy ID#:_______________________ Group #:______________________

**Secondary Policy**: Policy Holder's Name:_____________________________________ Birth Date:_________________

Policy Holder's SSN:_______________________ Policy Holder's Sex: M / F Relation to Patient:__________________

Insurance Carrier:_______________________ Policy ID#:_______________________ Group #:______________________

## CONTACT INFORMATION

**Mother / Guardian Name** :____________________________________________ Date of Birth: _____ / _____ / _____

Lives with patient? YES____ NO____ If no, please list Contact's primary phone #:___________________________

Relation to Patient:________________________________ Biological Relation to Patient?: YES_____ NO_____

*(Please note, this information is being requested to improve intake of your child's Family Medical History.)*

Address: _____________________________________________________________________________________________

Work Phone:_________________________________ Cell Phone:_________________________________

Preferred Email: _________________________________________________ HOME or WORK email *(please circle)*

How would this contact ideally prefer to be contacted? *(check one)*: Home____ Cell____ Work____ Email____

**Father / Guardian Name** :_____________________________________________ Date of Birth: _____ / _____ / _____

Lives with patient? YES____ NO____ If no, please list Contact's primary phone #:___________________________

Relation to Patient:________________________________ Biological Relation to Patient?: YES_____ NO_____

*(Please note, this information is being requested to improve intake of your child's Family Medical History.)*

Address: _____________________________________________________________________________________________

Work Phone:_________________________________ Cell Phone:_________________________________

Preferred Email: _________________________________________________ HOME or WORK email *(please circle)*

How would this contact ideally prefer to be contacted? *(check one)*: Home____ Cell____ Work____ Email____

**Emergency Contacts**, other than parents:

1: ___________________________________ Relationship_____________________ Phone:______________________

2: ___________________________________ Relationship_____________________ Phone:______________________

**Additional Contact Questions:**

Who should receive billing statements? ____________________________________________

May all contacts have access to the patient's medical records electronically? Yes ____ No ____

If no, list who **may** have access: ________________________________________________________________________

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

Who has physical custody? ___________________Who has legal 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.

_____________________________________________________________________________________________________

## INTERVAL HISTORY INFORMATION

Completed by: __________________________________________ Date Completed: _____________________

**Allergy / Reaction Information**

**Medication Allergies:** No: ______ Yes: ____ (explain below)

1: ________________________________________________________________________________________

(Medication) (Reaction)

2: ________________________________________________________________________________________

(Medication) (Reaction)

**Non-Medication Allergies:** None: ____ Yes (please list):___________________________________________________

**Vaccine Reactions:** None: _____ Yes (please list): ______________________________________________________

**Current/Chronic Medications**

1. ________________________________________________________________________________________________

(Medication) (Dose) (Date Started)

2. ________________________________________________________________________________________________

(Medication) (Dose) (Date Started)

3. ________________________________________________________________________________________________

(Medication) (Dose) (Date Started)

4. ________________________________________________________________________________________________

(Medication) (Dose) (Date Started)

**Problem List**

1.______________________________________________ Details:_________________________________________

(Diagnosis) (Date)

2.______________________________________________ Details:_________________________________________

(Diagnosis) (Date)

3.______________________________________________ Details:_________________________________________

(Diagnosis) (Date)

4.______________________________________________ Details:_________________________________________

(Diagnosis) (Date)

**PERTINENT PAST MEDICAL HISTORY**
(check if Yes and provide details including date)

______ Serious Injuries Please list: ____________________________________________________________

______ Surgeries Please list: ____________________________________________________________

______ Hospitalizations Please list: ____________________________________________________________

Pertinent Family Medical History:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Pertinent Social History:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

* * * * * * * * * * * * * * * *

## RECEIPT OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, __________________________________, acknowledge that I have received and read the Cumming Pediatric Group Notice of Privacy Practices and Individual Rights.

## CONSENT TO TREAT

Permission is hereby given for patient ______________________________, date of birth _________________, to receive any medical/surgical procedures, x-rays, drug or laboratory tests, medication or exam as may be deemed necessary by the physicians. In case of a minor, the consent below is given on his/her behalf.

**Please Initial:**

_______ I hereby authorize Cumming Pediatric Group to obtain medical records from any other physician or medical facility necessary in the course of my child’s treatment.

______ I hereby authorize messages to be left on a voicemail system or answering machine concerning my child.

___________________________________ ___________________________________

Patient Name Parent/Legal Guardian Name (Please print)

___________________________________ ________________________

Parent/Legal Guardian Signature Date

## BIRTH TO 5 YEARS

Date:________________PATIENT:___________________________________D.O.B_______________

### Patient's Past Medical History

| | | | |
|---|---|---|---|
| Prior Testing/ Developmental Test | None | Yes | Test:___________________ |
| Allergies | No | Yes | Date_______________ |
| History of Chicken Pox | No | Yes | |
| Cancer | No | Yes | |
| Blood/Lymph Disorder | No | Yes | |
| Ear Disorder | No | Yes | |
| Eye Disorder | No | Yes | |
| Diabetes | No | Yes | |
| Endocrine/Metabolic Disorder | No | Yes | |
| Nose, Mouth. Throat Disorder | No | Yes | |
| Cardiovascular Disorder | No | Yes | |
| GI Disorder | No | Yes | |
| GU / Kidney Disease | No | Yes | |
| Musculoskeletal Disorder | No | Yes | |
| Neurologic Disorder | No | Yes | |
| Psychiatric / Learning Disorder | No | Yes | |
| Respiratory Disease / Asthma | No | Yes | |
| Skin Disease | No | Yes | |
| History of injury / trauma | No | Yes | |

Other Chronic Problems: ___________________________________________________________________________

________________________________________________________________________________________________

### Family Medical History

| Family Medical History | | | List family member and details |
|---|---|---|---|
| Bleeding Disorder | No | Yes | |
| Cancer | No | Yes | |
| Diabetes | No | Yes | |
| Congenital Heart Disease | No | Yes | |
| Heart Disease before 50 | No | Yes | |
| Eye Disorder | No | Yes | |
| Ear Disorder | No | Yes | |
| Respiratory Disorder | No | Yes | |
| GI Disorder | No | Yes | |
| GU Disorder | No | Yes | |
| Musculoskeletal Disorder | No | Yes | |
| Neurologic Disorder | No | Yes | |
| Psychiatric Disorder | No | Yes | |
| SIDS | No | Yes | |
| Skin Disease | No | Yes | |
| Other | | | |

## Birth History

| | | | |
|---|---|---|---|
| Birth Weight | | | ________________________________________ |
| Discharge Weight | | | ________________________________________ |
| Length | | | ________________________________________ |
| Head Circumference | | | ________________________________________ |
| Gestational Age | Full Term | | Weeks:_________________________________ |
| Birth Location/ Hospital | | | ________________________________________ |
| Type of Delivery/ Complications | None | | ________________________________________ |
| Birth Complications | None | | ________________________________________ |
| Apgar Scores | | | ________________________________________ |
| Oxygen at Birth | | | Yes No |
| NICU Stay | | | Yes No How Long?_________________ |
| Synagis Prophylaxis given at hospital | | | Yes No |
| Hep B given at birth | | | Yes No |
| Mother's pregnancy health | | | Normal? _________________________________ |

## Newborn Screening Test

| | | | |
|---|---|---|---|
| Newborn Hearing Test | NL | ABN | Not Performed |
| Newborn State Screen | NL | ABN | Not Performed |
| Other Newborn Screening Test | NL | ABN | Not Performed |

## Surgical/Hospitalization History

| | | | Details |
|---|---|---|---|
| Non surgical hospitalizations | None | Yes | |
| Surgical history | None | Yes | |
| Ear surgery | None | Yes | |
| Eye surgery | None | Yes | |
| Nose/mouth/throat surgery | None | Yes | |
| Cardiovascular surgery | None | Yes | |
| GI surgery | None | Yes | |
| GU Surgery | None | Yes | |
| Eye surgery | None | Yes | |
| Orthopedic surgery | None | Yes | |
| Other surgery | None | Yes | |

## Child Social History

**Patient information**: (circle all that apply)

| | | | |
|---|---|---|---|
| Parents together | Father Involved | Father Not Involved | Mother/Father Deceased |
| Lives with Mother | Mother Involved | Mother Not Involved | |
| Lives with Father | Guardian Parents | Same sex Parents | |

**Child care:** Name of daycare: ____________________________________________________

**Home occupants** (list all) ____________________________________________________

**Parent's smokers:** (circle one) NO YES Outside only

**Pets:** What kind, how many, inside or outside?____________________________________________________

**Extracurricular activities:** (sports, music, etc.)____________________________________________________

# CUMMING PEDIATRIC GROUP FINANCIAL POLICY

***Please initial each section indicating that you have read and understand our financial policy agreement.*

Patient Name__________________________________________ Date of Birth________________________________

## INSURANCE COVERAGE

You MUST provide your insurance card or proof of insurance at the time of each visit. If you do not have your insurance, are unable to provide proof of insurance, or are on a plan which we do not participate with, FULL payment is required at the time of your visit.
It is VERY important that you become familiar with your insurance plan and understand your benefits. Some plans have restrictions on certain services and procedures that may not be covered in office. It is your responsibility to be aware of these restrictions. If you have any questions regarding your coverage, then you need to contact your insurance company directly.
ALL co-payments, deductibles, and co-insurance fees are your responsibility. If certain procedures and services are not covered by your insurance, you are personally responsible for these services. You will also be responsible for all balances that your insurance carrier does not pay within 90 days. If you are self pay, you must pay in **FULL** at the time of service. We do offer a discount for these charges.

_______ (Initial)

## PAYMENT METHODS

All co-payments are due at time of service. These fees can not be waived or billed. For your convenience, we accept cash, checks, HSA/FSA cards, and all major credit cards.
***Please note, if you have a returned check, you may be charged a return check fee. Any unpaid balances may also be sent to our collections agency.

________ (Initial)

## REFERRALS

If you are being referred to a specialist and your plan requires a referral, YOU are responsible for requesting the referral. The physicians may verbally refer you, but no hard copy will be sent without your request. Once services are rendered, and a referral has been done, you are responsible for any fees not paid by your insurance company.

________ (Initial)

## MISSED APPOINTMENTS/CANCELLING APPOINTMENTS

Missed appointments seriously disrupt the practice and inconvenience our patients. Therefore, please call within 24 hours notice to cancel your appointment, before the visit is missed. If you fail to show for an appointment, our policy requires that we charge a $25.00 fee by our billing department. If you accumulate multiple missed appointments without cancellation, you may be dismissed from the practice.

________ (Initial)

## DELINQUENT ACCOUNTS

A payment plan can be arranged with our billing department for past due amounts. Failure to pay or arrange payment of a past due balance will result in a referral to our collection agency. **A 25% fee is added to your total balance owed, if your account is sent to collections.** In order to re-establish good standing with our practice, your past due balance will need to be paid in full.

________ (Initial)

## MEDICAL RECORDS REQUEST

If you are requesting medical records to be sent to a specialist, there is no charge and we will forward them as a courtesy. If you are transferring to another practice to continue care, we will send records to you via our web portal, or to the new physician, free of charge. If you want to pick up a full set of medical records, there will be an $18.00 fee for one child, or a $28.00 fee for the family.

________ (Initial)

Parent/Guardian Name_________________________________________

Parent/Guardian Signature_______________________________________ Date__________________________

*****The original copy of this financial policy will be kept on file for future references. If you would like a copy for your records, please ask the front desk to provide you with a copy.

1800 Northside Forsyth Drive, Suite 460
Cumming, GA 30041
Tel: (770)888-8888 Fax: (770)888-4502

## Parent/Legal Guardian Consent to Bring/Communicate Form

Patient Name_____________________________________________ Date of Birth_________/_________/___________

The following person(s) have my permission to accompany my child to appointments and/or to communicate with the nurse/office staff at Cumming Pediatric Group. I am aware that the office visits may include vaccinations, medications, referrals, and/or labs.

This form authorizes the following persons to receive information regarding my child's insurance or other medical care.

Name___________________________________________________ Relation___________________________________

Name___________________________________________________ Relation___________________________________

Name___________________________________________________ Relation___________________________________

Name___________________________________________________ Relation___________________________________

Name___________________________________________________ Relation___________________________________

Parent/Legal Guardian Name (print name)____________________________________

Parent/Legal Guardian Signature__________________________________________ Date______________________

**Consent to Request Medical Records**

1800 Northside Forsyth Dr. Suite 460 Cumming, GA 30041

Phone 770-888-8888 Fax 770-888-4502

Please transfer the medical records of: D.O.B:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Requesting records from:

Practice/Physician Name: _______________________________________________________

Address: _______________________________________________________

Phone #: _________________________________

Fax #: _________________________________

Reason for transferring records:

_______________________________________________________________________________

The signature below serves as authorization to transfer records. I understand that these records may include psychiatric, chemical, substance abuse, HIV, and AIDS information. I understand that I may withdraw this authorization in writing at any time, except to the extent that action has been taken on this authorization.

****If the patient is under the age of 18 years old, my signature serves as authorization.

Authorized Signature __________________________________________________

Print Name _______________________________________ Date ____________________

# ROUTINE WELL CHECK POLICY

Your appointment today is scheduled for a routine well check. As of 2018, many changes have been made to insurance billing policies that require us to code your visit differently than in years past. We want to make you aware of some of these changes.

**Per HEDIS guidelines**, you may notice certain procedure codes such as G0447 (behavioral counseling) This particular code must be documented beginning at age 24 months regardless of BMI results or appearance of over/under weight per the Bright Futures Periodicity schedule. Codes such as this one are not always covered 100% and you may be charged a fee based on your insurance plan.

Depending on the specifics of your particular policy, your insurance carrier may pay all, part or NONE of the cost of this examination. It is the responsibility of the insured to be aware of coverage limitations that are associated with their plan and benefits prior to this exam. Any charges not covered by the insurance carrier may be the responsibility of the insured.

In addition to your routine well check, it may be necessary for our Providers to document a problem oriented visit (ie: follow up on previous office visit, ear infection, etc) In this case, the physician will go over the information with you and update the chart. The routine physical exam and the problem oriented visit will be billed separately under the same date of service. You may be billed a copay associated with that visit. In the event that you have a deductible that has not been met, you may be responsible for all or a portion of this additional service.

Also, if upon examination, the provider discovers a problem or condition, such as an ear infection or eczema, that does not fall under a routine well check, this too will be considered a “problem oriented visit” and will be billed accordingly.

Your signature below indicates you have read and acknowledge the terms as listed above.

______________________ ______________________

Patients Name DOB

______________________ ______________________

Parent Signature Date

# HIPAA
# PATIENT CONFIDENTIALITY NOTICE

- Our practice is dedicated to maintaining the privacy of your child's health information. We are required by law to provide you with the notice of our policies that effect the information.

- We will use the date and information we collect to treat your child and will supply this information to those that are helping us diagnose and treat the patient

- We will disclose this information to our health insurer and others who are responsible for payment of servies that are rendered.

- We will disclose the patient's Protected Health Information (PHI) in the conduct of the business of this practice and as required by law to public health organizations, police and law agencies.

- We will disclose your PHI to family members involved in your child's care, unless instructed not to do so.

- You have the right to request that we handle your child's PHI in a particular manner, such as instructing us to call your home rather than your work, or requesting that we only speak to certain persons about your child's health. To request confidential communication, ask for more information at the front desk. You do not have to give us a reason for this request.

- Patients have the right to inspect and obtain a copy of the PHI including medical records and billing records. A written request must be submitted and a small cost may be involved.

- You may ask us to amend the PHI if you believe they are incorrect. This request must be done in writing. If we deny the request, you may appeal and another health care professional will conduct the review. This applies only to the records we have created and not the records of other physicians.

- You have the right to have a printed copy of our Patient Confidentiality Notice. This can be obtained at any time from the front desk.

- If you believe your privacy right have been violated, you may file a complaint with our Office Manager, Panyavee Khan MD, or with the Department of Health and Human Services.

THIS IS YOUR COPY TO KEEP.