North Fulton Pediatrics

Today's date:_____

Patient's Name:_____

Date of Birth:_____

MEDICAL HISTORY

FAMILY HISTORY (Ages Birth to 5 years)

Mother:_____ Birth Date:_____

Health:_____

Father:_____ Birth Date:_____

Health:_____

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

Child's Name	Relationship to child	Birth Date

Are there siblings not listed? If so, please list their names and ages and where they live.

_____

_____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?_____

_____

_____

Family Health Problems (Check appropriate items):

□	Allergies	□	High blood pressure	□	Sickle cell disease
□	Anemia	□	High cholesterol	□	Sleep disorder
□	Asthma	□	Immune problem, HIV, AIDS	□	Sudden death
□	Cancer	□	Kidney disease	□	Tuberculosis
□	Diabetes	□	Liver disease	□	Other_____
□	Heart attack/stroke < age 50	□	Seizures	□	_____

CHILD'S HEALTH HISTORY

Birth: Weight_____ Type of delivery_____

Problems during pregnancy:_____

Newborn problems:_____

Hospitalizations/Surgery:_____

_____

Are immunizations up to date?_____ Allergies to medication:_____

Current medications:_____

Check appropriate items child has had in part:

□	Allergies	□	Constipation	□	Heart murmur/problem
□	Anemia	□	Fainting spells	□	Pneumonia
□	Asthma	□	Frequent abdominal pains	□	Seizures
□	Blood transfusion	□	Frequent ear infections	□	Sleep disorder
□	Bronchiolitis/bronchitis	□	Frequent headaches	□	Urinary Infection
□	Chicken pox	□	Frequent sore throats	□	Other_____

Has your child had any problems in his/her development?/Behavior concern?_____

_____

Former Pediatrician and other Specialists who have seen your child (name/location):_____

_____

_____

North Fulton Pediatrics
Patient Registration

Child 1: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

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

Child 2: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

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

Child 3: *Last Name:* _____ *First Name:* _____ *MI:* _____

D.O.B.: _____/_____/_____ *Sex*: _____ *Primary Language:* _____

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

Mailing Address:

_____

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

Home Phone: (_____) _____ - _____

Who lives at this household? _____
(Please note, this information is being request to improve intake of your child's Social History.)

Contact 1: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

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

Lives with patient? Yes / No *Date of Birth:* ____ / ____ / ____

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

How would you ideally prefer to be contacted regarding (circle one):

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

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email

Recall Notices: Home Address / Home Phone / Work Phone / Cell Phone / Home Email

Billing Statements: Home Address / Home e-mail / Work Email

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

Patient Portal Notifications: Cell Phone / Home Email / Work Email

Contact 2: *Name*: _____

Relation to Patient: _____ *Biological Relation to Patient:* _____

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

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

Work Phone: (____) _____ - _____ *Cell Phone*: (____) _____ - _____

Home Email: ____ _____ *Work Email:* _____

Employer: _____ *Occupation:* _____

If this contact will need to be notified in addition to Contact 1 for Medical Issues, Appointment Reminders, Recall Notices, Billing Statements, General Practice Notices and Patient Portal Notifications list their preferences here:

_____

_____

Additional Contact Questions:

Who should receive billing statements? _____

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

Insurance:

Primary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's Sex:* Male / Female

Insurance Carrier: _____ *ID#* _____

Secondary Policy: *Policy Holder's Name*: _____

Policy Holder's Birth Date: _____ *Policy Holder's SSN:* _____

Insurance Carrier: _____ *ID#* _____

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

1: _____ Relationship _____ *Phone*: (___) _____ - _____

2: _____ Relationship _____ *Phone*: (___) _____ - _____

3: _____ Relationship _____ *Phone*: (___) _____ - _____

North Fulton Pediatrics

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name:_____Date of Birth:_____

I, _____, have had the opportunity to review a copy of North Fulton Pediatrics Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Relationship to patient

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

I hereby grant permission to North Fulton Pediatrics to contact me and/or leave a message at either my home or workplace. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up, or to conduct any other relevant business that is deemed necessary.

Personal or detailed information will not be left on an answering machine or voice mail.

_____

Signature of Patient/Parent/Guardian

FOR INTERNAL USE ONLY

Patient/Parent/Guardian refused to sign _____ _____
Date Initials

North Fulton Pediatrics

Richard A. Levitt, MD
Gerald H. Clark, MD
Laura M. Zucker, MD
Jodi M. Greenwald, MD
Richard M. Szabo, MD
Pat Musto, CPNP

Advanced Benefit Notice (ABN Form)
Notice of Patient/Parent Responsibility for Service

Please be aware that some of the services provided may be "non-covered services" and not considered reimbursable under your insurance plan or get applied to your plans deductable. You are personally responsible for these services. Not all in office procedures are covered under your co-pay.

Additionally, your insurance carrier processes claims according to your plan specifics. If your carrier determines that a particular procedural service or an extended visit (more time) for chronic (asthma, ADHD, school problems, anxiety) and/or new problems during the **Well Check** is subject to **your deductible/co insurance** and or copay, then some additional payments may be required from you for that particular service.

Some examples may be but are not limited to:

1. Wart removals (please note this fee can be up to $150)
2. Breathing treatments
3. Ear washes/cerumen removal
4. Extended office visits when extra time is spent during a well checkup for "chronic" and/or "new" health concerns.
5. Most in office procedures
6. New Vaccines that have just become available
7. Screening during well exams and for consultations

With all of the recent changes in medical insurance coverage's and more higher deductable plans being offered, it does require a insured to be more aware of their individual benefits. We always try to be thorough at every visit and are required to file all services provided to the insurance company. According to the Affordable Care Act we have to meet certain guidelines and bill for screenings and services as well as time for performing these services. We ask for your understanding in the event that you receive a bill for a copay, coinsurance or deductible.

If this happens, I agree to be personally and fully responsible for payment as indicated in the office financial policy.

Parent Signature: _____
Child's/Children's Name_____
Date: _____

North Fulton Pediatrics, PC, Roswell Medical Center
1285 Hembree Road • Suite 100 • Roswell, GA 30076 • Phone (770) 442-1050 FAX (770) 475-1621
www.northfultonpediatrics.com

NORTH FULTON PEDIATRICS, P. C.
FINANCIAL POLICY

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

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payments and deductibles are due at the time of service. These fees cannot be waived. For your convenience, we accept cash, check, Visa/MasterCard (including debit cards), American Express and Discover.

NON-CONTRACTUAL INSURANCE
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 bill, at each visit, so you will be able to file your claim with your insurance company.

CONTRACTUAL INSURANCE
If we are a participating provider, all co-pays and co-insurance amounts are due at the time of service. In the event that your insurance coverage changes to a plan for which we are not a participating provider, we will provide you with a bill so you will be able to file the claim with your insurance company. The full amount will then be due at the time of service.

Please be aware that some of the services provided may be non-covered services and not considered reimbursable under your insurance plan. You are personally responsible for these services.

We will routinely file your insurance claim for each visit. Should there be a dispute with your insurance company we will attempt to resolve it with you. During this time a statement will be mailed to you each month your account shows a balance due. For all insurance other than HMO's, if your insurance has not paid within 90 days; the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company; therefore, your balance is your responsibility.

VACCINES FOR CHILDREN (VFC) PROGRAM
Children who are not insured, or are insured but do not have vaccine coverage, are enrolled in Medicaid, or are American Indian or Native Alaskan qualify for the Vaccines For Children program. The vaccines are provided free of charge, but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC program, it is required that the nurse be told at the beginning of your child's visit. We cannot implement this program retroactively.

INTEREST
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.

ADMINISTRATIVE FEE

Participation forms for camp, school, and sports, etc. will be charged a $10.00 processing fee payable in advance. Any 2nd request for state forms will be charged a $10.00 fee payable in advance.

PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

All patients under the age of 18 years old must be accompanied by a parent or guardian. Only patients for emergency treatment will be seen without a parent or guardian.

RETURN CHECK FEES

A $25.00 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check and checks drawn on a closed account. This charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action. Any family account that has a history of more than two returned checks for insufficient funds will require cash or approved credit card payments for all visits thereafter.

DELINQUENT ACCOUNTS

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator prior to your visit. Failure to resolve any past due accounts including any returned checks will result in referral to a collection agency. In the event your account is sent to a collection agency, a 30% collection fee will be added to your outstanding account balance.

North Fulton Pediatrics may need to disclose to a collection agency personal health information related to receiving payment for services rendered in the event your account is delinquent.

Any family whose account is forwarded to a collection agency will be dismissed from our practice. At this point, if you have a PCP assigned to you then you must contact your insurance company and request to be assigned to another office.

TRANSFERING 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 another physician's office. An immunization record, growth chart, and problem list can be provided at no charge. Otherwise, there will be an administration fee charged in accordance with the State regulations for the copying of medical records.

NURSE FEE

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in addition to the procedure performed. All appropriate co-payments 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.

I have read and understand this Financial Policy.

_____	_____	_____
Signature of Parent or Guardian	Date	Patient Name

North
Fulton
Pediatrics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please complete this form and have it signed by the parent or guardian, it may be faxed to the physician's office that you are requesting the records from. If you do not have the information with you today for us to forward this on, please take it home with you and send it to your child's last Physician's office so that they may forward your child's medical records to us.

Previous Provider/Specialist/Facility:_____

Office Phone Number:_____

Office Fax Number:_____

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby request a summary of medical records for myself/child/children named below to include immunization records be faxed or mailed to address below:

_____Date of Birth_____

_____Date of Birth_____

BE RELEASED TO:

North Fulton Pediatrics
1285 Hembree Road, Suite 100
Roswell ,GA 30076
www.northfultonpediatrics.com
(f) 770-475-1621

Parent/Patient/Guardian signature: _____

Date: _____ **Expiration Date**: _____

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Jodi M. Greenwald, MD
Richard M. Szabo, MD
Pat Musto, CPNP

New Patient referral Form:

New Patient's Name: _____

Date: _____

Who can we thank for referring you to our office today?

- ☐ Yellow Pages
- ☐ Insurance Plan list of providers
- ☐ Saw your sign on the building
- ☐ Mall Kiosk Add
- ☐ Hospital Referral Service
- ☐ Your website, like it
- ☐ Emergency Room
- ☐ Physician: Full Name:_____ Practice Name:_____
- ☐ Patient here:
  - Name of parent: _____
  - Name of Child: _____

- ☐ Seen today by which provider?
- ☐ Dr. Richard Levitt
- ☐ Dr Gerald Clark
- ☐ Dr Laura Zucker
- ☐ Dr Jodi Greenwald
- ☐ Dr Rich Szabo
- ☐ Pat Musto, CPNP

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