WEST ATLANTA PEDIATRICS – New Patient Information Sheet

PATIENT INFORMATION

Patient Name: _____ Sex: _____ Date of Birth:_____
Physical Address:_____ City:_____ State:_____
Zip Code:_____ Primary Phone: _____Secondary Phone:_____
County:_____ E-Mail Address: _____
Child's Cell Phone (if over 16):_____
Pharmacy Name:_____ Pharmacy Phone#_____
Pharmacy Location (Street, City) _____ School: _____

MOTHER'S INFORMATION

Mother's Name: _____ Date of Birth: _____
Maiden Name:_____(Needed to access child's Immunizations in GRITS)
Mailing Address: _____ City:_____ State:_____
Zip Code:_____ Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone:_____
Social Security Number _____ Occupation:_____

FATHER'S INFORMATION

Father's Name: _____ Date of Birth: _____
Mailing Address: _____ City:_____ State:_____
Zip Code:_____ Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone:_____
Social Security Number _____ Occupation:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____
Subscriber's Name: _____ Date of Birth:_____ ID#_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____
Subscriber's Name: _____ Date of Birth:_____ ID#_____

Which office will your child be seen at primarily? Dallas_____ Lithia Springs_____
List names & birthdates of all siblings: _____
List any medication allergies: _____
Any significant health problems?_____
Who was your child's previous physician?_____

Emergency Contact Name (other than parent) :_____

Relationship:_____ Phone Number:_____

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or West Atlanta Pediatrics accept assignment.

Authorization To Release Medical Information: I hereby authorize West Atlanta Pediatrics to release any information necessary for my course of treatment.

I acknowledge that I have been given a copy of West Atlanta Pediatrics office policies.

Parent Signature _____ **Date:** _____

West *Atlanta Pediatrics*

westatlantapediatircs.org

915 Thornton Rd., Lithia Springs, GA 30122 770.739.9292 26 Citizens Square Rd. Ste 100, Dallas GA 30157 770.505.3162

HIPAA Privacy Practices Acknowledgement

I, _____, hear-by acknowledge that I have either read or received the option of either a paper or digital copy of the Notice of Privacy Practices of WEST ATLANTA PEDIATRICS. (For a digital copy please scan code below)

Proxy Authorization

_____ _____

_____ _____

_____ _____

Please designate in the spaces above others who have permission to bring your child(ren) into the office and/or call the office, provide medical information about your child, receive medical advice/instructions for your child, and to make medical decisions pertaining to your child(ren) at the time of the visit.

PATIENT: _____ DATE OF BIRTH: _____

GUARDIAN: _____(Printed)

GUARDIAN: _____(Signature) DATE: _____OR

PATIENT (18+): _____(signature) DATE: _____

Earl Young, M.D. Lindsey Ransom, M.D. Lauren Judah, M.D. Morgan Joseph, M.D.

Chad Stough, PA-C Margaret (Katie) Gilligan, APRN Jennifer Everett, APRN

COMMUNICATION PREFERENCE SHEET

(Please indicate how you prefer to be sent reminders of appointments, announcements and birthday wishes)

TEXT ☐ **Email** ☐ **Both Text and Email** ☐

Based on your preference, please let us know which phone number or email address we should send communications to.

Cell Number(s) _____ _____

Email Address _____

Patient(s) <u>All</u> children seen in our practice _____

_____

Immunization Policy Agreement

It is the policy of West Atlanta Pediatrics that all children who come to our practice for care receive all immunizations that are required to be given according to the schedule put forth by the American Academy of Pediatrics, (Flu and COVID vaccine are not required.)

We are unable to provide care to families who do not follow the required Schedule. We will be happy to answer any questions you may have, however, there are no exceptions to this policy without valid medical contraindication.

West Atlanta Pediatrics believes that immunizations are of vital importance in the health of children individually and the population as a whole.

By signing below, I acknowledge the immunization policy of WEST ATLANTA PEDIATRICS and agree to have my child immunized according to the AAP immunization schedule.

Patient's (including siblings) Name: _____

Date of Birth(s): _____

Parent(s) Name: _____

Signature: _____ Date: _____



West Atlanta Pediatrics

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Release and/or disclose records and information regarding:
Patient Name: _____ Date of Birth: _____

I hereby request medical records be released from:

_____
Physician / Practice

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Fax

I hereby request medical records be sent to:

_____
Physician / Practice

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Fax

- ☐ Pertinent Medical Records
- ☐ Immunization Records
- ☐ Information about drug or alcohol abuse
- ☐ Other_____
- ☐ Lab Reports
- ☐ HIV Status
- ☐ Psychiatric Records (ex: ADD Records)

**Pertinent Medical Records will include: Immunization Record, Most Recent Well Checkup, Growth Chart, Consultation reports, lab reports, & x-ray reports for the last 12 months, and Patient Summary which includes Medication list, visit dates, and diagnoses.*

Requested Date(s) From:_____ To:_____
Reason for leaving: _____

I hereby authorize the releasing facility to release information as indicated. The releasing facility is hereby released from all legal liability that might arise from the release of the information requested. I understand that my records are protected and cannot be disclosed without my written permission, with the exception of information released pertaining to treatment, payment, or healthcare operations as specified by HIPAA or as required by law. This request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first.

Parent Signature:_____ Parent printed _____ Relationship _____
OR... Patient signature if over 18 years of age _____
Date:_____ Phone Number: _____

FOR OFFICE USE ONLY

☐ PARENT PICKED UP RECORDS ☐ FAXED RECORDS ☐ MAILED RECORDS

DATE: _____ **EMPLOYEE:** _____

915 Thornton Road
Lithia Springs, GA 30122
Phone: (770) 739-9292

Earl Young, M.D. F.A.A.P.
Lindsey Ransom, M.D., F.A.A.P.
Lauren Judah, M.D., F.A.A.P.
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Katie Gilligan, R.N., C.P.N.P.
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West Atlanta Pediatrics

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Earl Young, MD - Lindsey Ransom, MD - Lauren Judah, MD

Chad Stough, PA - Katie Gilligan, NP - Jennifer Everett, NP - Ashley Brasher, NP

West Atlanta Pediatrics is committed to providing your family with the best possible medical care. In order to provide care in the most efficient manner possible, it is important that parents understand our policies regarding payment for services, insurance filing, collection processes, appointment cancellations, referrals, prescription refills, forms and immunizations.

FINANCIAL POLICIES

1. It is your responsibility to pay your co-pay at the time of service, any balances left from a co-insurance or deductible plan is expected to be paid promptly in order to avoid late fees and further collection action. WE DO NOT BILL FOR CO-PAYS. We offer several convenient payment methods via the patient portal, online, over the phone, or with our Easy Pay Program. Payment may be made by cash, check, Visa, Mastercard, American Express or Discover.
2. If co-payment is not made by the end of business on the date of service, a $10.00 service charge will be applied to your child's account.
3. You are responsible for any charges not covered by your insurance plan.
4. If your child has insurance that we do not participate with, or if your child does not have insurance, payment in full is expected at the time of service. If payment arrangements need to be made, those arrangements should be made prior to the office visit.
5. Physicals, well-child check-ups, ADHD rechecks and other elective visits may be rescheduled or cancelled if there is a past due balance on the family account that is not current or on a payment plan.
6. The parent or adult who brings the child for care is responsible for payment due at the time of service. Please do not place our practice in the middle of divorce or marital disputes. It is your responsibility to work out payment arrangements for your child's medical care with the other parent. We will be happy to provide you with a receipt for your payment so that any money due you from the other parent can be recouped.
7. We do not file secondary insurance for co-payments unless your secondary plan is a Medicaid plan.
8. A $45.00 fee will be charged for any check returned for insufficient funds.
9. It is your responsibility to provide our office with your most current insurance information and a copy of your most current insurance card. Many insurance companies have 60 or 90 day filing limits. If current/correct insurance information is not provided

intime for us to file a claim, the balance for that visit becomes your responsibility.
10. If your insurance plan is one that requires a primary care physician (PCP), one of our doctors must be on your card. If our practice is not listed as your child's PCP, you will be responsible for all services rendered until the correction is made.
11. If your insurance company requests information from you in order to process our claims, please provide that information as soon as possible. If you do not provide information within 30 days of the request, the balance will become your responsibility.
12. Any past due account that is turned to our collection department must be taken care of to prevent any interruption in your care.
13. Please call us promptly if you have a question about your bill. Most problems can be solved quickly and easily. We are happy to work with you to take care of your financial obligations, but it requires that you communicate with us if there is a question or a problem.

APPOINTMENT CANCELLATION

1. We ask that you provide us with a 24 hour notice of appointment cancellation whenever possible. This allows us to give that appointment to another child who needs to be seen.
2. We have a strict no-show policy for missed appointments. If your child misses 3 visits in a 12 month period without notifying us BEFORE that appointment time, your children will be dismissed from the practice. If one of the no-shows is a checkup, only one additional missed appointment will be allowed. Upon notification of dismissal, we will provide emergency care for thirty days in order to give you time to find another
healthcare provider for your children. No-shows affect everyone, especially other patients. PLEASE simply call us ahead of time if you realize that you are not going to be able to come for a scheduled visit.
3. As a courtesy, we make every effort to confirm appointments the day before, but it is your responsibility to remember appointments that you have scheduled.
4. If you are 10 minutes or later for your appointment, you may be asked to reschedule.

IMMUNIZATIONS

1. It is the policy of West Atlanta Pediatrics that all children who come to us for care receive all immunizations recommended by the American Academy of Pediatrics. The immunization schedule changes from time to time as new vaccines become available. We are unable to provide care to families who do not follow these guidelines. West Atlanta Pediatrics believes that immunizations are of vital importance in the health of children individually and the population as a whole. There are no exceptions to this policy. If there are questions, please do not hesitate to let us know. You may refer to the A.A.P. website (www.aap.org) regarding immunization practices and recommendations.

TRANSFER OF RECORDS

1. If you transfer records to another practice, we are happy to provide one copy of your

child's medical record free of charge. Any additional records requests will require a $25.00 fee paid in advance to cover copying and mailing costs.

REFERRALS

1. Advance notice is needed for all non-emergent referrals, usually 3-5 business days. The amount of time needed varies by insurance company. It is your responsibility to know your benefits and how they work. If your plan requires a referral when your child sees a specialist, you will need to notify our office as soon as you have made the appointment.

We will need to know your child's name, birth date, the specialist's name and specialty, the reason for the visit, which office location, and the phone and fax numbers for the specialist.

2. In general, if it is not an emergency situation, your child will need to be seen for a problem before any referrals are given for specialist visits.

PRESCRIPTION REFILLS AND FORMS

1. Please allow 24 hours for medication refills. When requesting a refill, please provide your child's name, birth date, medication name and dosage, pharmacy name and phone number and whether you will be picking up the prescription or need it to be phoned out to your pharmacy.
2. ADD/ADHD medication refills must be requested at least 24 hours in advance as well and can be sent electronically to your pharmacy.
3. Please allow 72 hours for immunization, camp, school and sports forms. When possible, please bring forms with you to your child's well check-up visit so that they can be completed at that time.
4. We follow the guidelines established by the American Academy of Pediatrics and require that patients be seen according to their preventative care schedule. We also require that patients with asthma or ADHD be seen quarterly. Medication refills will not be given if the patient has not had their quarterly recheck and yearly well checkup.

I acknowledge that I have read and understand WEST ATLANTA PEDIATRICS Office Policies.

_____	_____	_____
Parent/Guardian Signature	Today's Date	Child's Name