

NORTH POINT PEDIATRICS

Who would you like as your child's Primary Care Provider?

- Dr. Cabrera Dr. Muller Dr. Campbell
- Dr. Wilson Dr. Stephansson

Child's Legal Name: _____

Date of Birth: _____

Patient Sex: **M** **F** Child's Home Address: _____

Who does child live with?

- Mom Dad Both Other*

*If other - Do you have legal custody of this child?

- Yes No

Child's Home Phone: _____

Cell Phone: _____

Email: _____

Do you have new insurance? Yes No

(if you have new insurance, give your insurance card to the receptionist)

Current Insurance: _____

Please list all siblings:

Policy/ID#: _____

Group#: _____

Subscriber Name: _____

Subscriber date of birth: _____ Subscriber's SS#: _____

*******(WE MUST HAVE YOUR SS# TO FILE CLAIMS)*******

Guarantor Information:

(Person responsible for bill)

Name: _____

Date of Birth: _____

SS#: _____

**** Check if address is the same

Address: _____

City: _____

State: _____ Zip: _____

If changed: _____

Home Phone: (____) _____

If changed _____

Cell Phone: (____) _____

Employer: _____

Work Phone: (____) _____

Other Parent Information:

Name: _____

Date of Birth: _____

SS#: _____

**** Check if address is the same

Address: _____

City: _____ State: _____

Zip: _____

Home Phone: (____) _____

Cell Phone: (____) _____

Employer: _____

Work Phone: (____) _____

EMERGENCY CONTACT - SOMEONE NOT IN THE HOME

Name: _____ Phone#: _____

Don't forget to complete pages 2 and 3

Thank You

Signature of Parent or Legal Guardian

Date

**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, North Point Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to North Point Pediatrics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review/receive the Notice of Privacy Practices prior to signing this consent. North Point Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to North Point Pediatrics, Privacy Officer at 11975 Morris Rd., Suite 210, Alpharetta, GA 30005.

With my consent, North Point Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, North Point Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, North Point Pediatrics may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that North Point Pediatrics restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to North Point Pediatrics' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already < made disclosures in reliance upon my prior consent. If I do not sign this consent, North Point Pediatrics may decline to provide treatment to me.

Signature of Parent or Legal Guardian

Print Name of Patient or Legal Guardian

INSURANCE STATEMENT/FINANCIAL RESPONSIBILITY

I understand that North Point Pediatrics will bill insurance companies for which they are providers, and verify the insurance information on those insurance plans which they are contracted, prior to services as allowed. My child(rens') insurance ID cards must be presented each and every visit. I am responsible for all balances my insurance carrier does not pay within 90 days. In the event my account becomes delinquent and is referred to any third party for collection effort, I agree to pay all reasonable attorneys' fees, court cost and collection expenses applicable on referred balance. In the event a physician is requested for a court appearance, I am responsible for physician fees not paid by my attorney or representing parties. If a check is returned on my account, I am aware that my account will be charged an additional \$35.00 fee. And if I cancel (shorter than 48 hours notice) or do not show three (3) consecutive times for well care appointments, I understand that my account will be charged \$75.00.

Signature of Parent or Legal Guardian

Date

BILLING AND INSURANCE

We appreciate your selecting North Point Pediatrics to serve your child(rens') needs. We will do all we can to provide your child/children with the very best care possible. Our purpose is to provide our patients with expert, comprehensive and continuous medical care from birth through adolescence in the setting of a group practice.

Our fees are based on our cost of delivering quality care. All charges are to be paid at the time services are rendered. We accept cash, Mastercard, Visa and Discover.

If you are insured by one of the health plans in which we participate, we will gladly follow the contractual arrangements in the plan agreement. You must show your plan card at the time of each visit and be prepared to pay your co-pay, deductible or any non-covered service at the time of your visit. Please become familiar with your health benefits as many plans have restriction on certain services such as well child care and immunizations. Also, please remember that your insurance contract is between you and your insurance carrier. If you have questions regarding your coverage, payment determination: or other details relating to your contract you should contact the insurance carrier directly.

***Please note we DO NOT accept Medicaid or any State Funded programs. If your financial situation changes and you have applied for any of these plans we must be notified immediately. Based on state and federal guidelines, our physicians will no longer be able to care for your child. We will be happy to recommend a pediatrician that will fit your needs.

Our billing service will assist you if you have any billing or insurance questions. You can reach the business office at 678-336-1409 during the hours of 9:00am 5:00pm.

AUTHORIZATION TO RELEASE INFORMATION/PAY INSURANCE BENEFITS

I hereby authorize the physicians of North Point Pediatrics to release (PHI) required information to process claims. I hereby authorize payment to be made directly to North Point Pediatrics for all covered benefits under my insurance policy and I also understand that I am responsible for any unpaid portion not covered by my insurance.

Signature of Parent or Legal Guardian

Date

I am responsible for paying in full for the services rendered by North Point Pediatrics at the time of service, if they are not providers of my health insurance or if I do not have any and/or verifiable insurance coverage to the time of the visit.

Signature of Parent or Legal Guardian

Date

In the event that I am unable to be reached, I give my permission to North Point Pediatrics to treat my child/children.

Signature of Parent or Legal Guardian

Date

I authorize North Point Pediatrics to complete any/all camp forms and/or school forms as requested by me for my child/children.

Signature of Parent or Legal Guardian

Date

NAME: _____

BIRTHDATE: _____

PATIENT HISTORY

Is child adopted? _____ At what age? _____ Race: _____ Is child aware? _____

Where was the child born? _____ Obstetrician: _____

Full term pregnancy? _____ If no, how early? _____ Type of delivery? _____

Problems at birth or in first few weeks? (ie. Ventilator, Oxygen therapy, etc.)? _____

Does the mother or father have any history of S.T.D. or other infections (herpes, HIV, Group B Strep etc.)? _____

Any developmental issues or delays? _____

List any medications your child is currently taking: _____

PATIENT'S PAST MEDICAL/SOCIAL HISTORY AND ALLERGIES

Allergic to any medication? _____

Allergic to any food or insects? _____

Any smokers at home? _____ Any pets? _____

CHICKEN POX Disease _____ Vaccine _____ PNEUMONIA _____

CONVULSIONS/SEIZURES _____ URINARY INFECTIONS _____

MENINGITIS _____ ASTHMA _____

HEART DISEASE _____ HEART MURMUR _____

Has child received blood transfusion or blood products? _____

Previous Pediatrician? _____

Has your child seen a Specialist? (Name and Reason for visit) _____

OPERATIONS (Enter Dates)

SCHOOL PROBLEMS/PERFORMANCE:

Scholastic: _____

Conduct: _____

FAMILY HISTORY

Any history in mother, father or close relative(grandparent, sibling,aunt,uncle)of:

(please check appropriate items and indicate which family member it applies to)

- | | |
|-------------------------------|--|
| _____ Birth Defects | _____ Kidney Disease |
| _____ Bleeding Tendencies | _____ Liver Disease |
| _____ Cancer | _____ Mental or Emotional Problems |
| _____ Diabetes | _____ Other Heart Disease |
| _____ Early Heart Attacks | _____ Seasonal Allergies |
| _____ Genetic Disorders | _____ Seizures or Epilepsy |
| _____ High Blood Pressure | _____ Substance Abuse |
| _____ High Cholesterol | _____ Sudden Unexpected Death or fatality from illness |
| _____ HIV/AIDS | _____ Thyroid Disease |
| _____ Interrupted Pregnancies | _____ Tuberculosis |

Other: _____

Has there been a separation, divorce or death? _____ When? _____

Who is legal guardian? _____ With whom does child live? _____

OFFICE USE ONLY:

Today's Date: _____

Nurse: _____ Physician: _____