PATIENT INFORMATION

Patient Name:_____ □ Male □ Female
Last First Middle
Patient's Social Security #:_____ Age:_____ Date of Birth (DOB):_____

Address:_____

City/State/Zip:_____ Cell Phone:_____

Race: □ American Indian □ Asian □ Native Hawaiian □ Black/African American □ White □ Hispanic □ Other □ Refuse to report

What made you choose Monroe Pediatrics, Inc.? _____

PARENT(S) OR GUARDIAN(S) GUARANTOR INFORMATION

PARENT/GUARDIAN NAME:_____ SSN:_____ DOB:_____
RELATIONSHIP TO PATIENT: □ MOTHER □ FATHER □ GRANDPARENT □ FOSTER PARENT □ OTHER_____

□ MALE □ FEMALE CELL PHONE:_____

Address:_____City/State/Zip:_____

EMPLOYER:_____ OCCUPATION:_____

WORK ADDRESS:_____ PHONE:_____

PARENT/GUARDIAN NAME:_____ SSN:_____ DOB:_____
RELATIONSHIP TO PATIENT: □ MOTHER □ FATHER □ GRANDPARENT □ FOSTER PARENT □ OTHER_____

□ MALE □ FEMALE CELL PHONE:_____

Address:_____City/State/Zip:_____

EMPLOYER:_____ OCCUPATION:_____

WORK ADDRESS:_____ PHONE:_____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND WE MAY CONTACT **AT A DIFFERENT ADDRESS:**

NAME: _____ PHONE: _____

ADDRESS: _____ RELATIONSHIP TO PT: _____

AUTHORIZATION TO LEAVE MESSAGES REGARDING PATIENT INFORMATION

I hereby authorize Monroe Pediatrics, Inc. to leave voice and/or text messages regarding testing results and scheduled appointments to the cell phone number(s) listed above (Standard SMS rates may apply).

PATIENT EMAIL ADDRESS: _____ _____
INITIAL HERE

OTHER

MOTHER'S MAIDEN NAME: _____

PREFERRED PHARMACY: _____ PHONE #: _____
HOW DID YOU HEAR ABOUT US?: □ INTERNET SEARCH □ PHONE BOOK □ INSURANCE COMPANY □ ADVERTISEMENT □ FRIEND/FAMILY
□ OTHER _____

PLEASE GIVE THE RECEPTIONIST **ALL** INSURANCE CARDS AT EVERY VISIT

MONROE PEDIATRICS, INC.
PARENTAL DESIGNATION FORM AUTHORIZING TREATMENT OF A MINOR

I _____, am the:
Print Parent/Guardian Name

□ Natural or Adoptive Parent

□ Guardian of

□ Person, who under court order is authorized to give consent for the minor:

Name: _____ DOB: _____
Print Name of Minor Minor's DOB

I authorize Monroe Pediatrics, Inc., to discuss and provide medical treatment of the above named minor with the following authorized adult(s) who are <u>over the age of 18</u> (ie: Grandparents, Siblings, Aunts/Uncles, Step-Parents, etc):

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

Name: _____ Relation to Minor: _____ Phone: _____

_____
Signature of Parent/Guardian

_____
Date Signed

FINANCIAL POLICY | ASSIGNEMENT OF BENEFITS | PAYMENT AGREEMENT MONROE PEDIATRICS, INC.

I understand, accept, and acknowledge the following terms:

- Payment for all services is my responsibility and is due and payable at the time services are rendered. Any checks returned unpaid by your financial institution will be subject to a fee of $35.00.
- Unless either I or my health coverage carrier has made prior arrangements in advance, full payment is due at the time of service. Any contract for Insurance coverage is made between my employer, the insurance company and myself. Monroe Pediatrics, Inc. has no influence over available benefits or the approval of claims.
- If my health insurance carrier has accepted Monroe Pediatrics, Inc. as a participating provider at the time of service, Monroe Pediatrics, Inc. will submit a claim to my insurance carrier.
- Claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.
- If my health insurance carrier HAS NOT accepted Monroe Pediatrics, Inc. as a participating provider at the time of service, I am responsible for full payment at time of service. I understand charges for my child's care and treatment(s) are due at the time of service. (**No Exceptions!**)
- I will provide **all valid insurance information**, including primary and secondary insurance coverage. Failure to do so will result in termination of my relationship with Monroe Pediatrics, Inc. and I will be immediately dismissed from the practice and deliver prompt payment for all involved dates of service.
- Any credit on my account will be a credit only, and not refunded by Monroe Pediatrics, Inc. unless I request one in writing.
- If I wish to use my insurance benefits to cover the cost of any ordered tests, procedures or visits to third party providers it is my responsibility to contact my insurance carrier to verify available benefits as well as participating facilities, providers and specialists. Payment for such services is my responsibility under the terms provided by said individuals.
- Referrals are not a guarantee of insurance benefits or payment. Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to my insurance carrier.
- **Non-Covered Services**: All health plans are not the same and do not cover the same services. In the event my health plan determines a service to be "not covered" I will be responsible for the complete charges. I understand payment is due at the end of the office visit or upon receipt of a statement from Monroe Pediatrics, Inc. (if determined after billing is complete).
- **Well-Child Checks**: Periodic preventative health checks may or may not be covered under my health insurance policy, therefore, I will review my individual plan(s) for coverage information. Should one not be covered and I desire for my child to have one, I will pay for the visit at the time of the visit.
- **Personal Injury Cases**: I understand Monroe Pediatrics, Inc. does not bill for auto accidents or other liability or lawsuit related cases. I am responsible for payment at the time of service. I will submit my own claims. Monroe Pediatrics, Inc. does not accept liens.
- **Minor Patients**: For all services rendered to minor patients, I understand the adult accompanying the patient and the parent or guardian with custody is responsible for co-pays, deductibles, co-insurance, and outstanding account balances at the time of service.
- **Missed Appointments**: In fairness to other patients and the physician, I will provide at least a 24 hour notice to cancel well-child checks. Otherwise, I will pay a fee as follows for missed appointments: $20.00 for well child visits. Three missed appointments within a year will cause dismissal from Monroe Pediatrics, Inc.
- I agree to pay for all charges for services rendered and/or materials furnished for this and any future visit.
- I hereby authorize **Monroe Pediatrics, Inc**. to release any medical information concerning my illness and treatment deemed necessary to process this claim and any future claims to all insurers having responsibility for charges incurred. Additionally, I hereby assign all insurance benefits due me be paid to **Monroe Pediatrics, Inc**. For any amounts not paid by me, I direct all insurers pay directly to **Monroe Pediatrics, Inc**. all such benefits. I understand that I am responsible for any amounts not covered by insurance. A copy of this signature is as valid as the original.
- An account will be considered outstanding if not paid within thirty (30) days of the invoice/bill and may bear interest of 18% per annum (1.5% monthly). It is also understood and agreed to by the undersigned patient (or parent(s)/guardian of minor child) that any account, which becomes more than ninety (90) days delinquent may be turned over to our Attorney for initiating litigation to collect the outstanding invoice. In such event, the undersigned patient (or parent(s)/guardian of the minor child) understands and agrees he/she will be responsible for the original invoice amount, **plus** the collections company fee of thirty percent (30%) of the original invoice amount, interest as may be applied, an Attorney's fee of forty percent (40%) of the outstanding balance of all invoices turned over, and all court costs incurred as a result of litigation.

COLLECTION POLICY & AGREEMENT

When payment is not made as agreed, account balances inclusive of all charges and reasonable collection costs agreed to herein including but not limited to reasonable attorney's fees may be sent to outside collection firms for legal collection action. The patient and/or guarantor or responsible party shall be responsible for and agree to pay all reasonable collection costs including, but not limited to, reasonable collection agency fees, attorney's fees, and court costs. Such fee represents administration, accounting, bookkeeping, account maintenance, legal and management fees associated with delinquent accounts. In consideration of the acceptance of the patient named on this form by Provider and for services rendered or to be rendered to such patient, the undersigned promises to pay for and guarantees payment of all amounts due and any and all charges including collection costs described herein. If payments due hereunder is not made as agreed, Monroe Pediatrics, Inc., may without notice or demand, declare the entire unpaid balance of the account including collection costs agree to herein to be immediately due and payable. If court action is necessary to enforce payment hereunder, the venue for any such court action shall be in Walton County, Georgia unless Monroe Pediatrics, Inc. elects otherwise. The undersigned waives any objection to venue or jurisdiction. A copy of this Agreement shall be as valid as the original.

I have read and understand the financial policy of the practice and I agree to be bound by its terms for payment of all professional fees. By signing this statement, you and your designated parties have agreed that the insurance information you have provide to MONROE PEDIATRICS, Inc. is the only health insurance coverage for the patient. I understand and agree that such terms may be amended by the practice. The patient/parent is ultimately responsible for all professional fees.

Signature of Parent/Guardian: _____ Date: _____

Print Name of Parent or Guardian: _____

Please Print FULL Name of the Patient: _____ Date of Birth: _____

Practice Site

MONROE PEDIATRICS

Patient Name: _____

DOB: _____

Date: _____

Allergies: (Include Drug, Reaction, and Age of Onset):

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____

Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: □ Vaginal □ C-Section

Duration of Labor: _____ If C-Section why? _____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____

Infant Feeding: □ Breast □ Bottle □ Both Formula Name? _____ Newborn Hearing Screening: □Pass □Fail

Other Comments: _____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD _____	YES	NO	Allergic Rhinitis _____	YES	NO
Anemia _____	YES	NO	Asthma _____	YES	NO
Congenital Heart Disease _____	YES	NO	Constipation _____	YES	NO
Developmental Delay _____	YES	NO	Diabetes _____	YES	NO
Eczema _____	YES	NO	Food Allergies _____	YES	NO
GE Reflux _____	YES	NO	Mental Illness _____	YES	NO
Murmur _____	YES	NO	Prematurity _____	YES	NO
Recurrent Otitis (ear infections) ___	YES	NO	Recurrent Strep Throat _____	YES	NO
Seizures _____	YES	NO	Substance Abuse _____	YES	NO
UTI _____	YES	NO	Vision Problems _____	YES	NO
Vesicoureteral Reflux _____	YES	NO	Wheezing _____	YES	NO

Other Medical History: _____

_____

Surgical History (Check Appropriate Box)

			Date	Surgeon
Adenoidectomy (adenoids removal) _____	YES	NO		
Appendectomy (appendix removal) _____	YES	NO		
Ear Tubes _____	YES	NO		
Fundoplication _____	YES	NO		
Gastronomy Tube Placement _____	YES	NO		
Heart Surgery _____	YES	NO		
Hernia Repair _____	YES	NO		
Orthopedic Surgery _____	YES	NO		
Tonsillectomy _____	YES	NO		
Urologic Surgery _____	YES	NO		
VP Shunt _____	YES	NO		

Other Surgical History: _____

_____

Practice Site

Patient Name: _____

DOB: _____

Date: _____

Family History: (Check All Boxes That Apply)

Relationship To CHILD		Name	A: Alive	D: Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		A	D																		
	Father		A	D																		
Siblings	Sister		A	D																		
	Brother		A	D																		
Aunts/ Uncles	*M Aunt		A	D																		
	*M Uncle		A	D																		
	*P Aunt		A	D																		
	*P Uncle		A	D																		
Grand-parents	*MGM		A	D																		
	*MGF		A	D																		
	*PGM		A	D																		
	*PGF		A	D																		

Comments (including other family medical problems): _____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to Child	Name																				
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		

Home Environment:

Number of People at Home: _____

Lives with biological parents: ☐ Yes ☐ No

Foster Care: ☐ Yes ☐ No

Primary Care Givers: ☐ Parents ☐ Daycare ☐ Relatives ☐ Other: _____

Daycare (hours/day): _____

Time at relatives (hours/day): _____

Pets: ☐ Yes ☐ No

Smokers in Home: ☐ Yes ☐ No If Yes, who? _____

Parent's Status:

Parent's marital status: ☐ Married ☐ Divorced ☐ Single ☐ Other: _____

Mother's Occupation: _____ Father's Occupation: _____

Primary Insurance Company	**Secondary Insurance Company**
Insurance Company Name: _____ Billing Address: _____ _____ Policy/Member Number: _____ Group Number: _____ Policy Holder's Name: _____ _____ Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Place of Employment & Telephone Number: _____ _____	Insurance Company Name: _____ Billing Address: _____ _____ Policy/Member Number: _____ Group Number: _____ Policy Holder's Name: _____ _____ Policy Holder's Social Security Number: _____ Policy Holder's Date of Birth: _____/_____/_____ Policy Holder's Place of Employment & Telephone Number: _____ _____

Medicaid – Georgia Better Health - PeachCare
If Insurance is Medicaid or PeachCare please write ID# here _____ and complete the information requested below. Person responsible for bill payment:_____ Address:_____ City:_____ State: _____ Zip Code: _____ Home Telephone:_____ Work Telephone:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance and any other health plans to Monroe Pediatrics, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance, specifically telephone consultations, prescriptions and after hour visits. I hereby authorize assignee to release all information necessary to secure the payment.

Signed: _____ Date: _____/_____/_____

Andrea V. Hill, MD
311 Alcovy Street
Monroe, GA 30655
Phone: (770) 207-7916
Fax: (855) 449-2597

Lab Consent

As a patient at Monroe Pediatrics, I agree that my child will have labs done that are required by insurance.

If labs are refused for my child, I understand that my child will no longer be under the care of Monroe Pediatrics and should seek medical care elsewhere.

_____ _____

Patient's Name **Patient's Date of Birth**

_____ _____

Parent/Guardian Signature **Date**

Andrea V. Hill, MD
311 Alcovy Street
Monroe, GA 30655
Phone: (770) 207-7916
Fax: (855) 449-2597

Attention Monroe Pediatric Patients

Work Orders:

If you are given any kind of work-order for LABS, X-RAY, MRI, ULTRASOUND, PHYSICAL, SPEECH, OR OCCUPATIONAL THERAPY, you must call your insurance company to verify that they will cover the test and location of the services requested. We are finding that many private insurance plans have exclusive agreements and will only pay for services at certain facilities. If you do not follow the directions of the insurance company and you obtain services at a different location then YOU WILL GET A BILL AND WE WILL BE UNABLE TO ASSIST YOU IN CORRECTING THE BILL.

We do not wnat this to happen to you. Therefore, it is YOUR RESPONSIBILITY TO BE CERTAIN that you use whatever network laboratory or facility you insurance insists that you use.

YOU ARE RESPONSIBLE FOR UNDERSTANDING YOUR INSURANCE BENEFITS. LACK OF KNOWLEDGE OF YOUR BENEFITS COULD COST YOU MONEY!

I understand that any charges not covered by my insurance will be my financial responsibility. I have read and understand the policies listed above.

_____ _____

Patient's Name **Patient's Date of Birth**

_____ _____

Parent/Guardian Signature **Date**

Vaccine Recommendation and Parent Decision Form

Patient Name: _____	**DOB:** _____
Parent/Guardian Name: _____	**Date:**_____

Vaccines are recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) to help protect children from serious, potentially life-threatening diseases. This form documents the parent/guardian's decision regarding those recommendation(s). Please ask your provider if you have any questions about vaccine benefits, risks, or the immunization schedule.

Parent/Guardian Decision

□ I **ACCEPT** the recommended vaccine(s) for my child

□ I **DECLINE** some or all recommended vaccine(s) for my child

□ I wish to **DELAY** some or all recommended vaccine(s) for my child

If Declining or Delaying Vaccines

If you choose to decline or delay any recommended vaccine(s), it is important to understand that your child may remain susceptible to vaccine-preventable diseases. Your provider is available to discuss your concerns and review the known benefits and risks of vaccination.

- I understand my child may be at increased risk for vaccine-preventable diseases
- I understand my unvaccinated child may transmit disease to others
- I understand the risks and benefits have been explained to me

Parent/Guardian Signature

I have received and reviewed the Vaccine Information Statements. My questions have been answered. I understand the risks and benefits.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

Andrea V. Hill, MD
311 Alcovy Street
Monroe, GA 30655
Phone: (770) 207-7916
Fax: (855) 449-2597

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Monroe Pediatrics, Inc.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Parent/Guardian **Date**

Andrea V. Hill, MD
311 Alcovy Street
Monroe, Georgia 30655
Phone: 770-207-7916
Fax: 855-449-2597
www.monroepediatrics.net

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY / STATE / ZIP: _____ PHONE: _____

I, the undersigned, hereby:

☐ Authorize **Monroe Pediatrics, Inc.** to release my Protected Health Information to the following person(s)/organization(s):

Name _____
Address _____
City / State / Zip _____
Phone: _____ Fax: _____

☐ Authorize _____ Fax: _____
(Primary Care Physician or Healthcare Provider)
to release my Protected Health Information to: **MONROE PEDIATRICS, INC., 311 Alcovy St. Monroe, GA 30655**

Reason for Request (please check one):

☐ Transfer to another provider ☐ Legal Issues ☐ Appointment with specialist
☐ Personal Use ☐ Insurance Purposes ☐ Other _____

INFORMATION TO BE RELEASED

☐ Entire Record ☐ Immunization Record Only ☐ Laboratory Results Dated _____
☐ Other Specified Records _____
☐ Records generated by this office (ie: recent physical, shot/med record, growth chart, problem list, and routine labs) **including** HIV Test Results, Mental Health, Drugs, and Alcohol, and Psychiatric and Psychotherapy Treatment.
☐ Records generated by this office (ie: recent physical, shot/med record, growth chart, problem list, and routine labs) **excluding** HIV Test Results, Mental Health, Drugs, and Alcohol, and Psychiatric and Psychotherapy Treatment.

Please Note: We do not copy information generated by other physicians / offices.

COPY FEE

1. I understand there is a charge for copying and handling my request. Per Georgia State guidelines, Monroe Pediatrics, Inc. has 21 business days to release your medical records.
2. Request for paper copies by patient/parent will be charged $0.10 per page with a minimum charge of $15.00 plus postage/shipping if mailed. Requests from other parties (ie: Attorney, Disability, Insurance Company, Personal Representative, etc.) will be charged as outlined: Parties requesting copies will incur a $20.00 charge for records retrieval plus $0.10 per page copied. If records are mailed, the actual shipping/postage charge will be incurred.

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail or pick-up. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for one (1) year.

_____ _____
Signature of Patient or Parent/Guardian (if patient is under 18) Date

_____ _____
Print Name of Patient or Parent/Guardian (if patient is under 18) Relationship to Patient