HEALTHY STAGES PEDIATRICS
1115 MT ZION ROAD
SUITE E
MORROW, GA. 30260
PHONE# 770-960-9999
FAX# 770-960-0931

MEDICAL RECORD RELEASE

Patient's Name _____

Date of Birth_____/_____/_____

Please release my medical records from:

Name of Provider/ Facility_____

Provider's / Facility Phone #_____

Provider's/ Facility Fax#_____

Provider's/ Facility Address _____

_____

_____

Records are to be released to :

Healthy Stages Pediatrics
1115 Mount Zion Road
Suite E
Morrow, Ga. 30260

_____ _____ _____

Signature **Relationship to Patient** **Date**

HEALTHY STAGES PEDIATRICS

PATIENT INFORMATION

1.NAME:_____
FIRST MIDDLE LAST
DATE OF BIRTH: ____/____/_____ SEX: ◯MALE ◯FEMALE
2.NAME:_____
FIRST MIDDLE LAST
DATE OF BIRTH: ____/____/_____ SEX: ◯MALE ◯FEMALE
ADDRESS: _____
CITY, STATE, ZIP:_____
(MOM) CELL PHONE: (_____) _____-_____ (DAD) CELL PHONE: (_____) _____-_____
(MOM) WORK PHONE:(_____) _____-_____(DAD) WORK PHONE: (_____) _____-_____
HOME PHONE: (_____) _____-_____ OTHER: (_____) _____-_____

GUARANTOR INFORMATION (RESPONSIBLE PARTY/ WILL BE SELF IF PATIENT IS 18 YEARS OR OLDER

NAME:_____
FIRST MIDDLE LAST
DATE OF BIRTH: ____/____/_____ SEX: ◯MALE ◯FEMALE SS#: _____
MARITAL STATUS: ◯SINGLE ◯MARRIED ◯DIVORCED RELATIONSHIP TO PATIENT: _____
PLEASE COMPLETE IF ADDRESS IS DIFFERENT FROM PATIENT:
ADDRESS: _____
CITY, STATE, ZIP: _____

INSURANCE INFORMATION (COPY OF INSURANCE CARD REQUIRED TO FILE INSURANCE)

PRIMARY INSURANCE CARRIER: _____
POLICY HOLDER NAME: _____RELATION TO PATIENT:_____
DOB: ____/____/_____ SS#:_____ EMPLOYER: _____
MEMBER ID#:_____GROUP NAME/NUMBER:_____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME:_____ RELATION:_____
PHONE#1: _____PHONE#2:_____

SIBLINGS

PLEASE LIST ANY ADDITIONAL SIBLINGS AND THEIR DOB (PLEASE INCLUDE FIRST AND LAST NAME):

_____ _____
_____ _____

PARENT/GUARDIAN SIGNATURE_____

EMAIL:_____

THE PRIVACY ACT REQUIRES YOU TO BE INFORMED OF YOUR RIGHTS TO PATIENT PRIVACY. IN ORDER TO DEMONSTRATE THAT YOUR WERE ADVISED OF YOUR RIGHT TO PRIVACY OF YOUR MEDICAL RECORDS, WE ASK THAT YOU COMPLETE THE FOLLOWING:

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEGEMENT FORM

I, _____ (Legal Guardian's Name) am the responsible party for
1._____ (Child's Name) ____/_____/_____ (DOB)
2._____ (Child's Name) ____/_____/_____ (DOB)
My relation to the child is (circle one): PARENT/ FAMILY MEMBER/ LEGAL GUARDIAN/ OTHER
IF FAMILY MEMBER OR OTHER PLEASE SPECIFY: _____
Please list who IS ALLOWED access to your child's financial and medical history:
NAME: RELATIONSHIP TO CHILD:

_____

_____

LAB RESULTS:

THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 REQUIRES THAT WE GATHER ADDITIONAL INFORMATION FROM YOU ABOUT YOUR BACKGROUND. THANK YOU FOR ANSWERING THE FOLLOWING 3 QUESTIONS:

MAY WE LEAVE YOUR CHILD'S LAB RESULTS ON YOUR VOICEMAIL? YES _____ NO _____
IF YES, WHAT TELEPHONE NUMBER SHOULD WE LEAVE THE RESULTS ON? _____
RACE:
_____UNKNOWN _____AFRICAN AMERICAN _____ASIAN _____CAUCASIAN _____FILIPINO
_____HISPANIC _____NATIVE AMERICAN _____INDIAN _____JAPANESE _____CHINESE
_____HAWAIIAN _____PACIFIC ISLANDER _____OTHER: _____
ETHNICITY: _____ HISPANIC _____NON- HISPANIC
PRIMARY LANGUAGE: _____ENGLISH _____SPANISH _____OTHER: _____

I HAVE RECEIVED A COPY OF HEALTHY STAGES PEDIATRICS NOTICE OF PRIVACY PRACTICES AND I HAVE REVIEWED A COPY OF THE FINANCIAL POLICY ATTACHED. I GIVE MY CONSENT TO HAVE MY CHILD/ CHILDREN TREATED AT HEALTHY STAGES PEDIATRICS AND UNDERSTAND MY OBLIGATION FINANCIALLY AND MY RIGHTS TO PRIVACY.

PARENT/GUARDIAN
SIGNATURE:_____DATE:_____

We accept cash, check, MasterCard, Visa, or Discover. There will be a $25.00 fee for all returned checks. PROOF of current, valid insurance MUST be provided at the time of each service.

PAYMENT PLANS: If you are having difficulty paying your balance is full, please call our financial department for arrangements. We must have a signed payment plan and you must be paying regularly to keep your account from going to the collection agency.

CANCELLATION AND MISSED APPOINTMENTS: If it is necessary to cancel your appointment, we require that you cancel AT LEAST 24 HOURS PRIOR TO APPOINTMENT. Failure to cancel the appointment will result in a $50.00 fee for WELL EXAMS. As a courtesy we will call you as a reminder however, you are still responsible for the cancellation even if you did not receive the reminder call. We reserve the right to discharge you from our practice for missing appointments frequently.

LATE APPOINTMENTS: Because of our providers schedules, we may ask your to reschedule if you arrive to the office more than 15 minutes past your appointment time. Late arrivals cause appointments arriving on time to be late. Continuous late arrivals may result in a discharge from the practice.

AFTER HOUR CALLS: Our providers are available on call 24 hours/day – 365 days/year for calls of a truly urgent nature. Since our practice is charged per call for after hours to the nurse advice line, non- urgent calls, made after hours may be charged $15.00 per call.

VACCINES: Our office requires patients to receive all mandatory vaccines. Refusal of any mandatory vaccine will result in immediate dismissal from the practice. Parents who refuse to have their children vaccinated will not be accepted into the practice. Initial:_____

FOR EACH VISIT PLEASE BRING:

1. Current insurance card
2. Driver's license (don't be offended it is for your protection!)
3. Co-Pay for the day's visit
4. Deductible that may be due for the visit
5. Cash, Check or credit card for paying balance from previous billing

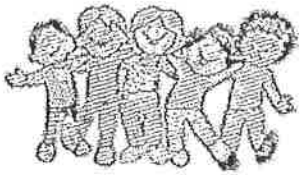
By signing below the responsible party acknowledges that he or she has read and understood the financial policy of Healthy Stages Pediatrics and is bound by the terms and conditions set forth therein. You also understand that failing to sign this agreement may result in discharge from the practice.

1.PATIENT
NAME:_____D.O.B._____

2.PATIENT
NAME:_____D.O.B._____

PARENT/GUARDIAN NAME (PRINTED)_____

PARENT/GRUARDIAN SIGNATURE:_____DATE:_____



HEALTHY STAGES PEDIATRICS

Our providers follow the American Academy of Pediatrics guidelines in their approach to care. We are committed to providing you with the best medical care available. The following financial policy is provided to avoid any misunderstanding and provide you with an outline of our expectations.

Insurance, Billing and Patient Responsibility

Please note that there are over 1000 plans and it is ***YOUR*** responsibility to become familiar with your plan. If you do not understand you specific plan coverage, please call your insurance plan or your HR department at work. The number for your plan is listed on your insurance card.

You are expected to know if vaccines, well-checks, labs or other procedures are covered or might fall into your deductible. It is your responsibility to know if your well-check is made within the timeframe allowed by your insurance company. PLEASE REMEMBER: we are contractually obligated by your insurance company to collect your co-pay at the time of service. Your co-pays also required at each follow up visit. If you have missed making a copayment in the past, we may ask you for credit card information to be held on a secure site to be used for payment prior to making your next appointment. If you have a deductible it will be due at the time of service or we may require a deposit for the deductible. Medical care not covered by your plan is due in full at the time of the visit.

As a courtesy to our patients, HSP will bill your primary insurance company. Please remember that your insurance is a contract between you and the insurance company, not the doctor. You are responsible for the balances after primary insurance has paid and payment in full is due with the receipt of the first statement. We participate in most plans, but if we do not accept your insurance you will be responsible for the day's charges at the end of the visit. Balance and/or unpaid claims over 60 days will be required to be paid in full or financial arrangements will have to be made before any future appointments will be scheduled.

***** We do not file secondary, automobile, general liability or homeowner's insurance *****

PLEASE NOTE: The party that brings the child to the office will be responsible for the visit's copay. The parent or the guardian bringing the child to the office will also party on our record. We will not be involved in parental court cases. Co-Pays and deductibles are due at the time of service or the visit may be rescheduled. Whoever brings the child to the office for a visit will be authorized to receive financial and medical information.

You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. INVALID INSURANCE INFORMATION causing the claim to be returned will be subject to a $25.00 refiling fee. Unless other arrangements are made with our financial department we refer unpaid bills to a collection company after 60 days. If your account is sent to collections we will assess a 30% collections fee charge on each line item. Unpaid balances that are transferred to the collection company may result in dismissal from the practice.

HEALTHY STAGES PEDIATRICS

CHILD NAME: _____ D.OB. _____

CHILD NAME: _____ D.O.B. _____

Healthy Stages Pediatrics is a practice that welcomes children of all nationalities, however, the practice is an English language based practice. It is our policy to require any parent who is unable to communicate in English to bring a translator who has signed a HIPPA release and is over the age of 18years to each visit. If you are unable to do this, a translator is provided by some insurance companies at no charge. The translator must be available at the time of the visit and able to identify themselves as an insurance provided translator and able to speak with the provider while in the room with your child. If the provider feels the parent is unable to fully understand instructions or relay information regarding the child's visit, you may be asked to come back with a translator as described above or to go to the nearest emergency room for further treatment. This policy is in place to protect the well being of your child and to insure proper care is given based on accurate information.

I understand the policy of Healthy Stages Pediatrics in regards to language/translation situations. I understand this office does not offer translation on site.

_____

Signature/Date

Effective 08/17/2016. Required by all patients to sign.