TRI COUNTY PEDIATRICS

Registration Form

Patient Name: ____ **Date of Birth**: ____________________________

Sex: Male Female **Race:** White Black Asian Other **Hispanic:** Yes No Decline

Address ____ City:_______________ State:_____

Zip Code: __________ Primary Contact # ________________________________

Parent # 1 : _____________________________ Date of Birth: _________________ Relationship to child: __________________

Home Address: _________________________________ City/State/Zip: ____

Cell Phone #: _________________________________ Home Phone #: _________________________

Work Phone #: ________________________ Email: ____

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

- Medical Issues: Home Phone Cell Phone Work Phone
- Appointment Reminders: Home Phone Cell Phone Work Phone
- Billing Statements: Home Address Patient Portal

Parent # 2 : _____________________________ Date of Birth: _________________ Relationship to child: __________________

Home Address: _________________________________ City/State/Zip: ____

Cell Phone #: _________________________________ Home Phone #: _________________________

Work Phone #: ________________________ Email: ____

May Parent # 2 have electronic access to children's records? Yes No

Person Responsible for bill (guarantor): _____________________ Relationship to child: ____________________________

If the parents are divorced/separated who has custody? ________________ Are there any legal restrictions on the non-custodial parent consenting to treatment or receiving medical information? YES NO **If so, you must provide us a copy of legal paperwork.**

In case of Emergency:

Name of local friend or relative (not living at same address): ____

Relationship to Patient: ____________________________ Phone Number: ______________________________________

Signature: _____________________________________ Date: _________________________________

Please list below additional persons who may bring the child to appointments, or who are authorized for us to communicate with regarding visits, medical information, ect. Example: Step-Parents, Grandparents, Nanny, Ect.

Contact Name (First/Last): ______________________________________ Relationship:_____________ Phone Number: _________________

Contact Name (First/Last): ______________________________________ Relationship:_____________ Phone Number: _________________

Contact Name (First/Last): ______________________________________ Relationship:_____________ Phone Number: _________________

Contact Name (First/Last): ______________________________________ Relationship:_____________ Phone Number: _________________

- Permission to treat a minor (under 18): In the event of an emergency and I cannot be contacted, I giver permission to Tri County Pediatrics to treat my child in their office as required by the events of that emergency situation.
- E-mail permission: I authorize my e-mail to be used to send encrypted medical records, patient reminders, and patient statements.

Insurance Information

Primary Insurance Company Name: ____

Subscriber Name and Date of Birth: ____

Secondary Insurance Company Name: ____

Secondary Subscribes Name and Date of Birth: ____

I, the undersigned, understand that payment for all services is due at the time of service. Responsibility and payment shall be that of the guardian bringing the child for treatment. I understand that I am financially responsible for all charges whether or not paid by my insurance company and for any co-pay, deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any cost incurred in the collection of patients account in case of default, including reasonable attorney fees and court cost. I understand that it is my responsibility to notify the practice of any changes in address or other contact information and any changes in insurance coverage and that payment for services shall be my responsibility if I fail to notify the practice of my correct insurance information. I hereby grant permission to the practice to release any pertinent information to my child's insurance company or their agent. I hereby assign to the Practice any insurance or other third-party benefits available for heath care services provided. I understand that the practice has the right to refuse or accept assignment of such benefits.

Signature: ____ Date: ____

Tri County Pediatrics

Notice of Privacy Practice_(HIPPA)

As part of my health care, Tri County Pediatrics originates and maintains paper and/or electronic records describing patients health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning patient care and treatment
- A means of communication among the many health professionals who contribute to patient care
- A source of information for applying my diagnosis and surgical/treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Consent to Disclosure of Patients Protected Health Information

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for heath care operations such as quality reviews.

I understand and have been provided with the practice Note of Privacy practice before signing this document.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction on how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand by failing to sign or revoking this consent, the practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and accept the terms of this consent.

Guarantor Recognition of Fiscal Responsibility

I understand that I am responsible at the time services are rendered. I also understand that even though the office, out of courtesy, may verify my benefits, this is not a guarantee of payment. All benefits and eligibility are subject to change without notice. The benefits we verify are only a general summarization and are not intended to be used as an authorization of services provided. In the event my insurance does not cover all charges, I agree to pay the balance due in a timely manner. I am also responsible to notify the office of insurance changes.

Vaccine Policy

I understand Tri County Pediatrics strongly believe in effective communication concerning vaccine benefits and risks. They strive to stay on track with the vaccine schedule and encourage me to follow the time schedule that is given as it is recommended by the AAP and CDC. All vaccines are recorded in patients chart and reported to the Georgia Registry of Immunization to ensure that each patient's vaccination history remains current. No alternative vaccine schedule will be approved/allowed. Parents interested in alternate vaccine schedule may follow up at the Health Department**. I understand If I refuse to vaccinate, I will have 90 days to reconsider my decision or my child will be released from the practice.**

Signature ____ Date: _______________________________________