455 S. Main St. #103, Hinesville, GA. 31313 PH 912-876-6868 FX 912876-6566 www.phillipspeds.com

PATIENT INFORMATION FORM

Please complete all pages in full. Today's date: _____
Who referred you to our practice? _____

Child's Information

Child's Legal Name: _____ D.O.B.: _____
Goes by/Nickname: _____ M / F: _____
Address: _____
_____
Home phone #: _____

Parent/Guardian Information

Parent/Guardian Name: _____ D.O.B.: _____
Address: _____ SS#: ___ / ___ / ____
_____
Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____
Insurance Company Name: _____ Primary or Secondary
Policy number: _____ Effective Date: _____

Parent/Guardian Information

Parent/Guardian Name: _____ D.O.B.: _____
Address: _____ SS#: ___ / ___ / ____
_____
Phone Numbers: Home: _____ Cell: _____ Work: _____
Employer: _____ Occupation: _____
Email: _____
Insurance Company Name: _____ Primary or Secondary
Policy number: _____ Effective Date: _____

Siblings' Information

Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____
Sibling's Name: _____ D.O.B.: _____

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PATIENT HISTORY FORM

Patient's Name: _____

Birth History

Was this child? Full Term Preterm Adopted
If preterm, how many weeks? _____ If adopted, at what age? _____
Birth Weight: _____ Length: _____
Type of delivery: _____ Obstetrician: _____
Did he/she have any problems in the newborn period? _____

Past Medical History

Please circle any illnesses your child has had and list approximate dates and/or frequency:

Anemia	Heart Murmur	Seizures
Asthma	Pneumonia	Strep throat
Chicken Pox	RSV Bronchiolitis	Urinary infections
Ear infections	Reflux (GERD)	Other: _____

List any surgeries/hospitalizations: _____
List any known allergies: _____
List all medications taken on a regular basis: _____

Family History

Has a family member ever been diagnosed with any of the following?
Please circle and list the relationship. Only include you and the **child's** other parent, siblings, grandparents, aunts, uncles, and cousins.

Anemia	Allergies	Asthma	Bleeding disorder
Cancer	Crohn's disease	Diabetes	Eczema
Emotional problems	Epilepsy	Heart Attack	High blood pressure
High cholesterol	Kidney Disease	Lazy Eye	Psoriasis
Stroke	Thyroid disease	Tuberculosis	Ulcerative Colitis
Unexplained/Sudden Death	Urinary Reflux		

Other _____
If you circled any of the above, please identify the relative: _____
. _____
Is there anything more you would like us to know about your child? _____
. _____
Person completing this form: _____

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CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for **Phillips Pediatrics** to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes of *treatment, payment, and health care operations.* You may refuse to sign this consent form.

You should read the ***Notice of Privacy Practices*** for **PHI** attached to this form before signing the consent. The terms of the Notice may change from time to time, and you may request a revised copy by asking the **Privacy Office** at **Phillips Pediatrics**.

You have the right to request that **Phillips Pediatrics** restrict how **PHI** is used or disclosed to carry out *treatment, payment, or health care operations*. **Phillips Pediatrics** is not required to agree to requested restrictions; however, if **Phillips Pediatrics** agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the **Protected Health Information** used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

●You may communicate with the following individual(s) regarding my child's condition or course of treatment: _____.

● You may communicate confidential information to me, including invoices for services, to the following address and/or phone/fax numbers:

_____.

_____ _____
Print Name of Individual or Personal Representative Relationship to Patient

_____ _____
Signature of Individual or Personal Representative Date

●As a personal representative, I have the authority to act for the individual because I am the individual's _____/Name: _____.

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PATIENT COMMUNICATION CONSENT FORM

Patient First Name: _____Last Name: _____

D.O.B: _____ Primary Care Physician: _____

I agree to allow **Phillips Pediatrics** to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize **Phillips Pediatrics** to leave messages for me when I am unavailable.

Method		**Number/Address**	**Messages (Yes or No)**
___	Home Phone	(____) _____ - _____	☐ Yes ☐ No
___	Cell Phone	(____) _____ - _____	☐ Yes ☐ No
___	Alternate Phone	(____) _____ - _____	☐ Yes ☐ No
___	Text Messages	(____) _____ - _____	☐ Yes ☐ No
___	Email	_____@_____	☐ Yes ☐ No
___	Patient Portal *(must provide email address for portal access)*	_____@_____	

I authorize Phillips Pediatrics, and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	**Relationship to Patient**	**Contact Info**

By my signature below I acknowledge that I have read and understand the information provided on this consent form. I understand the risk associated with the different methods of communications, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities as well as any other instruction **that Phillips Pediatrics** may impose.

_____

Patient/Parent Name **Date**

Phillips Pediatrics Financial Policy

Thank you for choosing Phillips Pediatrics, LLC as your health care provider for your children. We are committed to providing you and your child/children with the highest caliber of care. As part of your relationship with Phillips Pediatrics, a clear understanding of our financial policies is important so you will know what actions Phillips Pediatrics will be undertaking on your behalf as well as what your financial responsibilities are to Phillips Pediatrics. Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs.

You are required to:

- Present the proper insurance card for your child/children at the time of service. You must bring a valid insurance card to every visit.
- Present a picture ID (driver's license preferred) for verification of identity; if requested.
- Pay your co-pay at the time of service. As participating providers with your medical insurance plan our office is required to collect your co-payment on the date of service.
- Submit payment and assume responsibility for any and all charges your health insurance company does not pay for. This includes your co-pay, co-insurance, policy deductibles, and any and all non-covered services and the outstanding balance after your insurance company has submitted payment to Phillips Pediatrics.
- Pay your account balance in full within 30 days of receiving Phillips Pediatrics statement of outstanding charges. If your payments are not received in a timely manner and your account is not kept current, your account will be sent to Phillips Pediatrics Third Party collection agency. Please note you will be responsible for all collection fees. Provided below is a more detailed description of your financial responsibilities.
- You are responsible for knowing the benefits and provisions of your particular insurance plan. If you have any questions regarding your benefits, please contact your carrier prior to your visit in the office.

Fees and Insurance Coverage

We request that you be able to provide valid insurance coverage at every office visit. If we are unable to verify active coverage, any and all fees for your services will be due on the date of service. Insurance claims are filed as a courtesy with the participating plans when there is a valid insurance card provided. You must report any insurance changes to the office as soon as possible.
Any information that is inaccurate or received after the date of service may not be billable to the insurance carrier (in some cases) and may become the responsibility of the account guarantor.

When adding a newborn to your insurance plan, please check with your Human Resources department about requirements of your particular plan. Most plans require that newborns be added to the policy within 30 days of birth.

Many insurance policies require prior authorization for tests, including lab and radiology, procedures, specialists' referral visits or hospital admissions. While we try to assist our families with these guidelines, it is

the responsibility of the policy holder to know and understand these requirements in order to avoid any costly penalties and denials by your insurance company.

Responsibility for Payment

Even though you have health insurance, you as the guarantor are responsible for payment of all services provided by Phillips Pediatrics. Phillips Pediatrics will bill your insurance company for all services rendered, with the information you have provided us. If your insurance information has changed, please notify us immediately so we may bill the correct insurance carrier.

Co-Payment

Your health insurance policy may state that you must pay a co-payment for all physician visits. This payment is due the day the services are rendered to your child/children. If, for an unforeseeable reason, you do not have the co-payment amount with you at the time of service, please be aware that Phillips Pediatrics may charge you an administrative surcharge of $10.00 for processing your co-payment after your visit. Phillips Pediatrics has a contractual agreement with the health insurance carriers to collect all co-pays on the date the services are rendered. Phillips Pediatrics accepts cash, personal check, Visa, MasterCard and American Express.

Divorced Parents

Phillips Pediatrics will not get involved in custodial, separation or financial disputes involving or relating to divorced parents for a minor child(ren) to whom we provide services. The parent who signs the financial policy and registration form of the minor child(ren) will be the responsible party for payments of services rendered. Please note that the court Divorce Decree is an agreement between the two divorcing parties and not between Phillips Pediatrics and the parents.

Medical Records

Requests for medical records require a signed Medical Release Form stating the authorization of release from Phillips Pediatrics to either the parent or current physician's office. After one (1) copy of medical records, there will be a charge in accordance with the guidelines set forth by the State of Georgia for copying medical records. All medical records will be subject to a processing fee and will only be released after the fee is collected. Please be advised that we are unable to fax medical records.

If you are transferring from another pediatrician, we request that you have those medical records transferred to our office before services are rendered here.
Please keep in mind that due to the large volume of forms we complete daily that we have a 5-7 business day turn around time. We provide our parents with a copy of the super bill at the time of service, additional billing copies required for tax purposes will be subject to a charge.

Remaining Balance After Your Insurance Company has paid

Phillips Pediatrics will submit a claim to your health insurance company (s)for services provided. Once your insurance company(2) has processed your claim, Phillips Pediatrics will post any payment it receives to your account. If there is a remaining balance, the balance will now be your responsibility. This balance may include your deductible, co-insurance and any and all non-covered charges. As stated before, we request that you pay your balance in full within 30 days of receiving your statement. We encourage our patients to enroll in our Autopay program for a more convenient and efficient way to pay your remaining balance.

Missed Appointment/ No Show Visits

Missed appointments and late cancellations/rescheduling represent a cost to us, to you and other patients who could have been seen in the time set aside for you. **We require at least a 24-hour notice** for any cancellations or rescheduling of a previously scheduled appointment. Failure to cancel or reschedule your appointment 24 hours in advance will result in a $25.00 administrative fee per appointment. These fees are not covered by your insurance company and are the sole responsibility of the guarantor on the account.

Dismissal

If you are dismissed from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You will have to place your child in the care of another physician. We will refer you to someone if you need.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won't follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical records to your new doctor after you let us know who it is and a release form is signed.

Returned Checks

Phillips Pediatrics charges a service charge of $30.00 for all returned checks.

Splitting Vaccines/Shot Only Clinics

If you are a parent that has elected to 'split up' vaccines or vary the vaccination schedule, you will be required at each visit to pay any co-payment according to your plan benefits. Please verify with your insurance company the impact these particular situations/visits may have on your benefits.

I have read the above financial policy for Phillips Pediatrics, LLC and I agree to the terms listed above.

Print Name: _____

Signature: _____ Date: _____

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INSURANCE LIABILITY NOTICE

Physician Statement

In many cases, your insurance company will limit payment of a service due to limitations of your policy. If your insurance company does not pay for a service due to policy limitation, you are financially responsible for the payment of that service.

Beneficiary Agreement

I understand that in some cases, certain services will be denied payment from my insurance company due to limitations of my personal policy. In the case that my insurance company denies payment for this service, I understand that I am fully responsible for the payment of this service.

Signed: _____

Date: _____

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RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____City: _____ State: _____ Zip _____

Phone : (_____)_____ Fax: (_____) _____

Please release medical records to:

Phillips Pediatrics
455 S. Main St. #103
Hinesville, GA 31313
Fax: (912) 876-6566
Email: info@phillipspeds.com

Signatures:

Parent/Legal Representative: _____ Date: _____

Relationship to Patient: _____

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Request for Release of Medical Records From Phillips Pediatrics

Information Requested:

☐ Standard Records (growth chart, immunization records, last physical)

☐ **Additional Records*** please list_____
(a fee will be charged for additional records)

The purpose of requesting medical records:

☐Changing Doctors ☐Personal use ☐Moving ☐ Transfer to Internist ☐Legal/Attorney

☐ Other (specify):

_____ I hereby

Authorize Phillips Pediatrics to release the records of:

Patients Name: _____ DOB: _____

Patients Name: _____ DOB: _____

Patients Name: _____ DOB: _____

I hereby Authorize Phillips Pediatrics to release the medical records in the following methods:

☐ Mail to:

_____

_____

Practice/Person Name and Address

☐ Fax To:

_____

Practice/Person Name and Fax Number

☐ Pick Up

_____

Phone Number to be called when ready for pick up

* Release of records requires one week to process

_____ _____

Signature of Parent or Guardian Date

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Informed Consent for Pediatric Telemedicine Services

1. **What Is Telemedicine?** Telemedicine involves the use of electronic communication tools to enable health care providers to evaluate, diagnose, consult on, and treat certain health conditions where the patient and the health professional are not in the same physical location. Telemedicine allows your child's health care providers to see and communicate with you and your child in real-time. During a telemedicine consultation, your child's health care providers may include physicians, physician assistants, nurse practitioners, nurses, and other medical and non-medical assistants and technicians (all such individuals are referred to herein as the " **Providers**").

2. **Information Collected**. During a telemedicine consultation, medical information will be collected using telecommunication tools. This information, along with your child's prior medical records, if and when available, will be used for evaluation, diagnosis, treatment, follow-up, and/or education. Video, audio, and/or photo recordings may be taken of you and your child during the consultation.

3. **Confidentiality**. Reasonable efforts have been made to eliminate confidentiality risks associated with telemedicine consultations, and all existing confidentiality protections under federal and Georgia state law will apply to information disclosed during each telemedicine consultation. Electronic systems used during a telemedicine consultation will incorporate network and software security protocols to protect confidential patient information and will include measures designed to safeguard data to help prevent intentional or unintentional disclosure or corruption of data.

4. **Secure and Private Locations.** In an effort to further protect your child's privacy, your healthcare provider will speak with you and your child from a location where only the Providers can hear or watch the consultation with you. It is important, however, that you and your child also be in a private location where only you, your child, and those approved by you, can hear and see the telemedicine consultation. Please understand that it is up to you to be sure that your child's privacy is protected at your location.

5. **Access to Medical Information and Records**. You will have the same access to your telemedicine visit medical records as you have to records generated during a regular clinic visit. Each telemedicine visit may be recorded; however, not all of your telecommunications with your child's health care Providers are recorded and stored.

6. **Follow-ups and Emergencies**. The telemedicine services your child receives from Providers are not intended to replace your relationship with other specialist providers involved in your child's care. Please follow-up with your child's other specialty physicians and other caregivers as recommended during your telemedicine visit, and you should always seek emergency help when directed by your Providers or when otherwise needed.

7. **Risks**. With any telemedicine consultation, there are potential risks. These risks include, but may not be limited to:

    * in rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate health care decision making by your child's Providers;

    * delays in medical evaluation or treatment could occur due to failures of the electronic equipment used during the telemedicine consult;

    * in rare instances, security protocols designed and implemented to protect against the improper transmission or distribution of private and confidential information could fail, causing a disclosure of personal health information;

    * a lack of access to all of your child's medical records by Providers during a telemedicine consultation could result in adverse drug interactions, allergic reactions, or challenges that might have been avoided if the consultation had taken place in-person;

Print Name_____ Signature_____ Date _____