GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE
www.gwinnettpeds.com

Congratulations on your new baby and thank you for choosing Gwinnett Pediatrics and Adolescent Medicine for your child's healthcare. We understand that you have a lot going on with the new addition to your family and we wanted to help you check one thing off of your list.

In order to have your hospital and doctor's claims processed properly, you will need to notify your insurance of the baby's arrival as soon as possible. They allow a specific amount of time during which you will be able to add the baby to your policy, otherwise you may have to wait for the open enrollment. It is crucial for the baby's coverage to start from the baby's date of birth; make sure that the insurance policy is back dated to that day. Most insurance companies will require baby's social security number and the birth certificate. Please make sure that you have those documents available to prevent any issues with adding the baby to your insurance coverage.

Please understand that it is our requirement to have your baby added to your plan by the time of their two (2) month checkup. If your child is not covered by their two-month checkup and we cannot verify that their coverage is active you would have to pay out of pocket for that visit on the day of the appointment and you would be responsible for any previous balances accrued on the account.

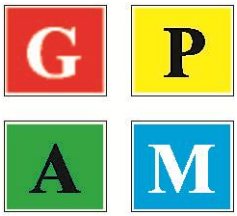
Please note that we do not accept Medicaid or Peach State. If your child at any point between his or her birth and the age of four months is covered under this insurance we will not be able to continue seeing them in our office.

We hope that this is a smooth transition for you and your baby and we are looking forward to seeing you in our office.

Best Regards,

The GPAM Team

Patient Name_____DOB_____



Risk Assessment 2 – 5 days

Concerns about how child sees	No	Yes	Concerns
Sleeps on back	Yes	No	Comment
Sleeps in crib	Yes	No	Comment
Does baby eat well	Yes	No	Comment
Has 6 – 8 wet diapers per day	Yes	No	Comment
Regular car seat use	Yes	No	Comment
Car seat rear facing	Yes	No	Comment
Home and car are smoke-free environment	Yes	No	Comment
Water temp <120 degrees	Yes	No	Comment
Know how to take baby's temp rectally	Yes	No	Comment
Both parents up to date on TDap (whooping cough vaccine)	Yes	No	Comment
Vitamin D Supplement if breast feeding	Yes	No	Comment
Was your baby breech during the last month of pregnancy	No	Yes	Unknown

2-5 days Development

Turns and calms to parent/caregiver voice	Yes	No	Comment
Follows parent/caregiver face	Yes	No	Comment
Can suck, swallow, & breathe easily	Yes	No	Comment

NEWBORN HISTORY FORM

Date _____

Name _____ D.O.B. _____

Welcome to Gwinnett Pediatrics and Adolescent Medicine. We are pleased you have chosen us to care for your baby. Who may we thank for referring you? _____

BIRTH HISTORY

Was your baby full term? _____ Pre-term? _____ Adopted? _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery: Vaginal _____ C-Section _____

If C-Section please explain why: _____

Please describe any problems after birth: _____

Were there any problems during pregnancy? _____

Was your baby exposed to tobacco, alcohol, or drugs during pregnancy? _____

Did your baby pass the hearing screen in the hospital? Yes _____ No _____

Did your baby have a metabolic screen done(PKU)? Yes _____ No _____

Was your baby breech anytime in the last month of pregnancy? Yes _____ No _____

FAMILY HISTORY

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early heart attack (under 50 yrs old)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐
Ear tubes	☐	☐	☐	☐

Name:_____

Condition	Mother	Father	Sibling	Grandparent
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐
Drug/alcohol abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip dysplasia	☐	☐	☐	☐
Other	☐	☐	☐	☐

SOCIAL HISTORY

Who lives in your child's home? _____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Does anyone who cares for the baby smoke? Yes _____ No _____

If there are guns in the home, are they locked/secured? Yes _____ No _____

Will your child be in daycare? Yes _____ No _____

Have both parents had the Adacel vaccine (whooping cough)? Yes _____ No _____

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

PATIENT INFORMATION

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female

Address:_____ **City, State, Zip:**_____

Home Phone:_____ **Mom Work Phone:**_____ **Mom's Cell:**_____

Dad's Work Phone:_____ **Dad's Cell:**_____

Email Address:_____
(We send out appointment notices via email) *We can text appointment reminders.*

*Pharmacy Name*_____ *Pharmacy Address*_____

GUARANTOR INFORMATION *(Responsible Party / Will be SELF if patient is 18 yrs or older)*

Name:_____
First **Middle Initial** **Last**

Date of Birth:_____ **Sex:** □ Male □ Female **Social Security#:**_____

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Other** **Relation:**_____

Address:_____ **City, State, Zip:**_____

EMERGENCY CONTACTS

Emergency Contact Name:_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

Nearest Relative (not living with you):_____ **Relation:**_____

Phone #1:_____ **Phone #2:**_____

INSURANCE INFORMATION *(copy of insurance card required to file insurance)*

Primary Insurance Carrier Name:_____

Address:_____ **City, State, Zip:**_____

Insurance Phone #:_____ **Effective Date:**_____

Policy Holder Name:_____ **Group #**:_____**Group Name:**_____

Relationship to Patient:_____ **Birthdate**:_____**Social Security #:**_____

Name & Address of Employer_____

Your signature below indicates your consent for treatment of /as patient and responsibility for the payment of the bill. Thank you.

_____ **Date:**_____
Guardian or Patient Signature

GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE
FINANCIAL AND BILLING POLICIES

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.

Please note: the party that brings the child to the office will be responsible for the visit's copay AND will also be the responsible party on record. We will not be involved in parental court cases.
Co-Pays, coinsurance and/or deductible 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.

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 your 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 the 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-pay is also required at each follow up visit. If you have missed making a copayment in the past, we may ask for credit card information to be held on a secure site to be used for payment prior to making your next appointment. If we have deductible information, your deductible will be due at the time of service. If you have failed to make copay, coinsuranceand/or deductible payment at the time of visit you may be charged an additional $25.00 billing fee.Medical care not covered by your plan is due in full at the time of the visit.

As a courtesy to our patients, GPAM 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 balances after primary insurance has paid and payment in full is due with the receipt of the 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. . Balances 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 can be scheduled.

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

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. Unpaid balances that are transferred to the collection company may result in family dismissal from the practice. There will be a re-instatement fee of $35.00 once the balance has been paid in full.

We accept cash, check, MasterCard, Visa or Discover. There will be a $25.00 for all returned checks**. Proof of current, valid insurance MUST be provided at the time of each service. Failing to prove you have valid insurance will require the visit to be paid that day.**

PAYMENT PLANS: If you are having difficulty paying your balance in 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 further action.

CANCELLATION AND MISSED APPOINTMENTS: If it is necessary to cancel your appointment, we require that you cancel AT LEAST 24 hours prior to the appointment. Failure to cancel the appointment will result in a $50.00 fee for Well and ADHD visits. Sick visits will incur a $25.00 fee. As a courtesy wecall or e-mail reminders, however, you are still responsible for the cancellation even if you did not receive a call and/or text. We reserve the right to discharge you from our practice for missing appointments frequently.

LATE APPOINTMENTS: Because of our physician schedule, we may ask you 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.

WALK IN APPOINTMENTS: Please do not bring your sick child to the office without an appointment. This can be dangerous for the child as it may delay appropriate treatment. Our nurses will triage the child for urgent problems. The doctor will review the triage notes and determine if this child can wait until an appointment can be made. We will charge the parent for the triage and review a $40.00 fee. This will be payable when you arrive at the office without an appointment. If there is an appointment available we will schedule an appointment with any provider. We will not disrupt our regularly scheduled patients in order to accommodate a walk in appointment unless it is a true emergency. Call the office and speak to our advice nurses if you feel your child needs to come to the office that same day.

AFTER HOUR CALLS: Our physicians 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 hour calls to the nurse advice line, non-urgent calls made after hours may be charged $15.00 per call.

PAYMENT RESPONSIBILITY: By signing below, the adult who signs a minor child into our practice accepts responsibility for payment. We will communicate about treatment and payment with the parent that is present. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FOR EACH VISIT PLEASE BRING:

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

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of Gwinnett Pediatrics and Adolescent Medicine 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.

_____ _____

Signature of Parent or Responsible party (or patient >18 yrs.) Date

_____ _____

Patient Name Date of birth

_____ _____

Patient Name Date of birth

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

Gwinnett Pediatrics understands that insurance information can be confusing and overwhelming. It is very important to understand one's insurance coverage. Every plan is different and it is critical to know what services your plan will cover and what services will fall under your responsibility. We strongly recommend for you to read and understand your "Summary of Benefits and Coverage Guide" that your health plans must provide you with. It will outline everything that it will cover and it will give you the precise information on the things that you would be expected to be responsible for yourself. We would like to inform you of the most common terms used and it is imperative to understand what they mean:

Deductible:

The amount you owe for health care services before your health insurance plan begins to pay. For example, if your deductible is $1,000, your plan will not pay anything until you have paid $1,000 for services. Some plans pay for certain health care services before you have met your deductible. Please remember that some plans also include a family deductible that has to be met before they start paying.

Coinsurance:

Your share of the costs of a health care service, calculated as a percentage (for example, 20%) of the total visit cost is your responsibility. For example, if the health insurance pays a $100 for a procedure, your 20% coinsurance payment would be $20. The health insurance plan should pay the rest.

Copayment:

A fixed amount (for example, $15) you pay each time you see a physician. Your insurance requires you to pay this copay anytime you see the provider before they will cover the services. Please remember that all recheck visits are sick visits and to require a copay. Also, many plans require deductible for labs in addition to your copay.

Network:

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

PCP (Primary Care Provider):

Some plans require you to select a Primary Care Physician. If your plan requires one, please make sure to select one of our providers. If we are not listed as your PCP your insurance company will not pay for the claim and may consider us as out of network.

Exclusions:

Some plans will have specific procedures and /or treatments that will not be covered no matter how medically necessary those may be.

Coordination of Benefits:

Insurance companies want to know if you have more than one health coverage. To determine primary versus secondary coverage they use the birthday rule. Excluding the year, whosever birthday comes first would be designated as the primary payer. Please do reply to your insurance company when this information is requested even if you do not have any other medical coverage.

100 % coverage for a health well check up

Many insurance companies cover a health checkup / physical at a 100%, which means it will cover the visit and vaccines only. Many times, they apply deductible to any labs and testing that the provider is required to do at that visit.

If you have further questions please call your insurance provider or our billing office 770-995-0823.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for

Child's Name_____ Date of Birth_____

I am related to the child by _____ (Indicate Relationship).

Please list who **IS ALLOWED** access to your child's financial and medical history:

_____

1. Offered (but refused to read/sign) _____ (check here**) –or--,**
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home)_____ (check here),

A copy of GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If yes, what telephone number should we leave the results on?_____

Date: _____ Signature: _____

Pharmacy Name:_____ Address:_____

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:

Race:

Unknown African American Asian Caucasian Filipino Hispanic
Indian Japanese Chinese Native American Native Hawaiian
Pacific Islander Other Unknown/Decline

Ethnicity:

Hispanic Non-Hispanic Unknown/Decline

Primary Language:

English Spanish Other Unknown/Decline

How did you hear about our office?

Website Friend Ad Facebook Festival Other