Patient Name_____

Birthdate _____

Review of Systems (Please check all that apply)

Constitutional
- ☐ Fever/chills
- ☐ Excess weight loss/gain
- ☐ Loss of appetite

Eyes
- ☐ Blurry vision
- ☐ Eye redness
- ☐ Eye discharge

Ears/Nose/Throat
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing Loss
- ☐ Congestion
- ☐ Sore Throat

Cardiovascular
- ☐ Chest pain
- ☐ Fainting (syncope)
- ☐ Tiring easily with exertion

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Chest tightness

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐Constipation
- ☐ Blood in Stools

Genitourinary
- ☐ Discharge – penis or vagina
- ☐ Pain with urination
- ☐ Abnormal periods
- ☐ Bedwetting

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain

Skin
- ☐ Rash
- ☐ Diaper rash
- ☐ Skin lesions

Neurological
- ☐ Headache
- ☐ Numbness
- ☐Weakness

Psychiatric/Emotional
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress

Endocrine
- ☐ Increased thirst
- ☐ Increased drinking
- ☐ Temperature intolerance

Allergy
- ☐ Sneezing
- ☐ Itching eyes
- ☐ Hives

NEW PATIENT INFORMATION

Patient Last Name:	**Name of Guarantor (Responsible Party):**
Patient First Name:	**Address:**
Patient Middle Name:	**City:** **State:**
Address:	**Relationship to patient:**
City: **State:**	**Date of Birth:**
Zip:	**Social Security No.:**
Mom Cell:	**Phone: ( ) _____ - _____**
Dad Cell:	**Emergency Contact Information**
Home Phone:	**Name:**
Sex: M F	**Relationship:**
Date of Birth:	**Phone:**
Primary contact ☐ MOM ☐ DAD	**Mobile Phone :( ) _____ _____**
Parent email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	**Employer:**
Race:	**Address:**
Ethnicity:	**Phone:**
Marital Status:	
Other	**Pharmacy Information:**
Patient Referred by:	**Name:**
	Crossroads:
Insurance Information	
Insurance Plan Name:	**Address:**
Last Name (Of the policy holder):	**City:**

First Name (Of the policy holder):	**State:**
Middle Name:	**Zip**
Date of Birth (Of the policy holder):	**Sex (please circle): M or F**
Employer Name:	**Employer Address:**

To the best of my knowledge, the above information is complete and accurate.

Signed_____ **Date:**_____

ACKNOWLEDGEMENT AND AUTHORIZATION: PLEASE READ ALL STATEMETNS BELOW AND SIGN

- **I have been given the opportunity to read the HIPAA/Privacy Policy for Gwinnett Pediatrics and Adolescent Medicine.**

Signed_____ **Date:** _____

- **I hereby assign my insurance benefits to be paid directly to Gwinnett Pediatrics and Adolescent Medicine. I authorize Gwinnett Pediatrics and Adolescent Medicine to release medical information required to process my claims for services received. I authorize Gwinnett Pediatrics and Adolescent Medicine to pursue any unpaid or incorrectly adjudicated claims.**

Signed_____ **Date:** _____

- **I have read and understand the Financial Policy for Gwinnett Pediatrics and Adolescent Medicine. I understand that I am responsible for all amounts not covered by my health insurance.**

Signed_____ **Date:** _____

- **I authorize Gwinnett Pediatrics and Adolescent Medicine to obtain/have access to my medication and vaccine history.**

Signed_____ **Date:** _____

- **I authorize Gwinnett Pediatrics and Adolescent Medicine to contact me with automated text alerts. (text alerts will notify you if lab results are available, provide appointment reminders, and other important office messages.)**

Signed_____ **Date:**_____

- **I authorize Gwinnett Pediatrics and Adolescent Medicine to leave messages regarding my child's health on my voicemail.**

Signed_____ **Date:** _____

CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. **PLEASE NOTE we do not see patients under the age of 18 years old for checkups without an adult accompanying them and strongly encourage a parent or legal guardian to attend all well-child visits.** Please sign the first authorization below to allow us to care for your child. If you would like us to care for your child if the child comes in alone or brought in by another person, please sign the second authorization below as well.

Patient Name: _____ DOB: _____

1. **Authorization to treat a minor patient when accompanied by a parent or legal guardian**

I am the parent or legal guardian of the patient named above. I authorize and consent to the patient receiving medical, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Gwinnett Pediatrics and Adolescent Medicine.

Printed name of parent/guardian_____

Signature of parent/guardian:_____

Date:_____

2. **Advance authorization to treat a minor patient when not accompanied by a parent or legal guardian**

I am the parent or legal guardian of the patient named above. If the patient comes into the clinic alone or is brought in by any other person, I give advance authorization and consent to the patient receiving routine or emergency medical, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Gwinnett Pediatrics and Adolescent Medicine. If the patient is being seen for a well check visit or follow-up vaccine visit, and is due for vaccines, I understand that the vaccines that are appropriate for the visit will be given per vaccine schedule.

Printed name of parent/guardian:_____

Signature of parent/guardian:_____

Date:_____

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 final 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. Information regarding a visit will be available on the portal.

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 or deductible at the time of service. Your co-pay or deductible may be 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, coinsurance and/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.

Please note that your initial prior authorization for medications will be done by our staff at no cost to you. For any appeals there will be a $25 charge per occurrence.

As a courtesy to our patients, GPAM will bill your 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 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 may 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. We can keep your credit card on file securely for monthly automatic payments.

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. Appointments with the nutritionist require **48 hours' notice** for cancellations or changes, failure to do so will result in a $50 charge. As a courtesy we call 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. Also, you can make a non-urgent sick appointment through the patient portal for the next business day.

PAYMENT RESPONSIBILITY: By signing below, the adult who signs a minor child into our practice accepts final responsibility for payment. We will send statements to the guarantor listed on your registration sheet, but time of service payment and final payment is the responsibility of the accompanying adult. Parents are responsible between themselves to communicate with each other about the treatment and payment issues. You will be able to receive a summary of each visit via the patient portal which may be used for parent communication.

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 (this is an estimate from our billing dept)
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 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