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 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 backdated 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. In addition, 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 him/her in our office.

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

Best Regards,

The GPAM Team

Patient Name_____DOB_____

Risk Assessment 2 – 5 days

Concerns about how child sees	No	Yes	Concerns
Follows parent/caregiver face	Yes	No	Comment
Can suck, swallow, & breathe easily	Yes	No	Comment
Responds to parent/caregiver voice	Yes	No	Comment

Hip dyplasia risk:

Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment

Anticipatory Guidance:

Sleeps on back	Yes	No	Comment
Sleeps in crib or bassinett	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
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 regularly	Yes	No	Comment

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.

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. 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. 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. In March,2017, we have the ability to schedule online appointments.

PAYMENT RESPONSIBILITY: By signing below, the adult who signs a minor child into our practice accepts <u>final</u> 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.
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.

GWINNETT PEDIATRICS & ADOLESCENT MEDICINE

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Beverly Peer
595 Hurricane Shoals Rd., NW
Suite 300
Lawrenceville, GA 30046
770-995-0823

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment. You have the right to limit disclosure of genetic information.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

9. Breach of electronic information. Our practice will notify you if there has been a breach of our electronic records.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military**. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Beverly Peer 770-995-0823** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our

disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request unless payment is in full and we have a written request**; however, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Beverly Peer 770-995-0823**.

Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Beverly Peer 770-995-0823** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Beverly Peer 770-995-0823**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor when sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Beverly Peer 770-995-0823**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Beverly Peer 770-995-0823**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Beverly Peer 770-995-0823**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Beverly Peer 770-995-0823.**

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:_____