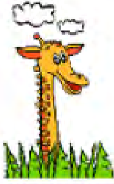

Welcome To

Kennesaw Pediatrics

Your Home for Pediatric Healthcare!

3745 Cherokee Street, Suite 401
Kennesaw, GA 30144
770 - 429-1005 - Phone
770-429-8005 Fax
www.kennesawpediatrics.com - Web
info@kennesawpediatrics.com - Email

PATIENT REGISTRATION FORM

Patient: Last Name ______________________ First Name ____________________ M.I. ____ DOB _______________

Gender M F Race ____________________________ Ethnicity ________________

Appointment Reminders:

Email Address __________________________________

Phone Number__________________________________

☐ Sign-up for EMAIL reminders
☐ Sign-up for TEXT reminders
☐ Sign-up for VOICE CALL reminders

Emergency Contact (other than parents):

Last Name _____________________________________ First Name ____

Phone ____ Relationship to the Patient ____________________________

Parent/Legal Guardian Information:

Mother Father Foster Other ________________________________

Last Name ____________________________ First Name _________________________ M.I. ____ DOB ______________

Social Security Number ________________ Primary Phone __________________ Secondary Phone ______________

Street Address _____________________________ City _________________________ State ________ Zip Code ___________

Employer ____ Employer's Phone Number_________________________________

Other Parent/Legal Guardian Information:

Mother Father Foster Other ______________________

Last Name _________________________ First Name _______________________ M.I. ____ DOB ________________

Social Security Number _______________ Primary Phone _____________________ Secondary Phone ________________

Street Address _____________________________ City_________________________ State ________ Zip Code ___________

Employer ____ Employer's Phone Number_________________________________

Insurance Information:

Insurance Company Name ________________________________ Policy Holder Name _______________________________

Subscriber/Policy Number _________________________________ Policy Group Number ____________________________

Policy Holder Information (only if the policy holder is not parent/legal guardian):

Last Name ____________________________ First Name ______________________________ M.I. ____ DOB ____________

Social Security Number ___________________ Home Phone _____________________ Cell Phone ___________________

Street Address _____________________________ City_________________________ State _______ Zip Code ____________

Employee ____ Employer Phone Number_________________________________

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Financial Policy

Thank you for choosing Kennesaw Pediatrics, P.C. as your health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. Please understand that payment of your bill is considered part of your care.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you are unable to provide proof of insurance, are on a plan in which we do not participate, or have no insurance coverage, payment is required at the time of your visit.

For those plans with which we do not have a relationship, you will be responsible for your entire bill at the time of service. We will provide you with a copy of your superbill at each visit so you will be able to file your claim with your insurance company. If we are a participating provider, we will routinely file a claim for services rendered although all co-pays and co-insurance amounts are due at the time of service. If you have a deductible plan, you will be required to pay $75 at the time of service towards your financial responsibility for any visit which is subject to the deductible, until the deductible is met for that year. Failure to pay your copay or deductible portion of $75 (whichever is applicable) at the time of service will result in a $25 administrative fee.

If you are scheduled for a WCC (Well Child Check-Up) and other health concerns are brought up that would typically require a separate sick visit, your insurance company may consider these two separate visits and bill your co-pay and other charges accordingly. Additionally, if it is determined that we need to treat a medical condition or must order additional tests or labs at the WCC (Well Child Check-Up), your bill will reflect all services rendered.

Should there be a dispute with your insurance company, we will attempt to resolve it for you. During this time, a statement will be mailed to you each month showing your account balance due for all insurances other than HMO's. If your insurance has not paid within 90 days the balance may be transferred to your personal balance, which must be paid upon receipt. Your insurance policy is a contract between you and your insurance company. Even though you have health insurance, you as the guarantor are responsible for payment of all services provided by Kennesaw Pediatrics, P.C.. Therefore, it is your responsibility to notify Kennesaw Pediatrics, P.C. immediately of any insurance change in order to ensure the correct insurance carrier is billed for services rendered. If there is a change in your insurance, please ensure that we are listed as the PCP, if a PCP is required to receive payment.

Newborns It is important that you add your newborn to your insurance policy within the first 30 days of life to prevent any lapse in coverage. Please contact your employer (Human Resource Department) or insurance carrier to start the process and ensure all the proper paperwork has been submitted.

Vaccines for Children Program (VFC) Children who are insured but do not have vaccine coverage, are enrolled in Medicaid, or are either American Indian or Native Alaskan qualify for the VFC Program. The vaccines are provided free of charge, but there is an administration fee, which is your responsibility. If your child qualifies and you would like to participate in the VFC Program, you must tell your nurse at the beginning of your child's appointment. We cannot implement this program retroactively.

Interest, Late Fees, and Collections Fee We reserve the right to charge interest in the amount of 1.5% monthly (18% annually), as provided by the state law, on all past due account balances. A late fee of $25.00 is applied to any item unpaid after insurance has adjusted the claim (or 60 days from the date of service, whichever is less). Any delinquent account referred to collections will have a $150.00 collections charge applied. In addition, you are responsible for all legal fees, attorney fees, collection costs, and any miscellaneous expenses related to the collection of delinquent accounts.

Divorce, Separation, and Custody Agreements Kennesaw Pediatrics, P.C. will not be partial to custodial, separation, or financial disputes relating to individuals with regard to minor children to whom services are provided. The individual who requests the medical services and signs the financial agreement is responsible for any balance due. All co-pays, co-insurance, and deductible, if applicable, will be collected at the time services are rendered from the individual requesting the medical services for the minor child(ren). We will not call the other parent for consent. The physician will discuss the minor's medical information with the accompanying parent at the time of the visit. Kennesaw Pediatrics, P.C. will provide a copy of any medical records requested, although we reserve the right to charge a fee. Both parents have access to the minor child's medical records, unless there is a court order that specifically mandates only one of the parents to have the right to authorize medical treatment and release of the minor's medical records. We reserve the right to discharge any patient from Kennesaw Pediatrics, P.C. if an issue comes between the divorced/separated parents which would disrupt our practice. We maintain that divorce, separation, and custody agreements should not enter into the medical care of a child; such matters should remain between the parents.

Signature: ____________________________ Patient Name: _________________________ Date: ____________

Patients who are not accompanied by a parent or guardian For unaccompanied minor patients, non-emergency treatment will be denied unless patient can pay all charges at the time of visit or parents arrange payment in advance. We accept Visa/ MasterCard (including debit cards), American Express, Discover, cash, or check at the time of service.

Missed Appointments Missed appointments are very disruptive to our office. They also deprive others from an appointment to see the doctor. A $35 fee will be charged for all no-shows or appointments cancelled in less than 24 hours in advance. If you repeatedly miss scheduled appointments, you may be asked to seek medical care elsewhere. *Please be courteous to those patients who need to be seen.*

Returned check fees A $30.00 processing fee will be charged for checks returned as insufficient funds, stop payment on an issued check, or checks drawn on a closed account. The charge is applied to your personal account balance and must be paid within 14 days of notification to avoid further action. Any family that has a history of more than 2 returned checks for insufficient funds will require cash or approved credit card payments for all visits thereafter.

Delinquent Accounts If a large bill is anticipated and financial arrangements needs to be made, a payment program may be arranged with our Practice Administrator prior to your visit. Failure to resolve any past due accounts, including returned checks, will result in referral to a collection agency. Any family whose account is forwarded to a collection agency will be dismissed from our practice. If you are on a plan that requires you to be assigned to a Primary Care Physician (PCP), then a copy of the dismissal letter will be sent to the insurance company so they will know to reassign you to another PCP.

Transferring of Medical Records Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to another physician's office. A medical summary, list of immunizations, and growth chart(s) can be provided at no charge. Otherwise, there will be a $25.88 administration fee for each child's record to be transferred.

Nurse Fee Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.) that do not require a face-to-face visit with the physician will incur a nurse fee in addition to the procedure performed. All appropriate co-pays will apply.

All patients are asked to please check-out before leaving the office. It is unlawful to intentionally walk out without satisfying your financial obligations after treatment has been rendered. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

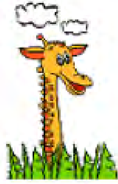
Cell Phones and Audio/Video Recording Policy When you step into our office, your child's healthcare is our number one priority. That is why we ask that you please refrain from using your cell phone once you enter the office and for the remainder of your visit. If you must take a call or have important calls to make, please step outside to do so. **No audio or video recording of any kind for any reason is allowed in the office.**

Parents agree to turn off or silence all cell phones/equipment upon entering the clinical area and in exam rooms. Use of cellular equipment interferes with the wireless technology utilized within the office. The doctor/medical provider reserves the right to terminate the interaction if parent or legal guardian/patient uses their cell phone.

Kennesaw Pediatrics, P.C. has a ZERO tolerance policy against aggressive behavior, unreasonable expectations, bullying, profanity, lying, and verbal abuse towards our staff from our patients and their family members. Any display of this behavior will be subject to being terminated as a patient from this office.

HMO or POS plans REQUIRE you to call your insurance carrier today (or prior to today) and have your PCP officially changed to Dr. Mark Long/Kennesaw Pediatrics. This will allow today's charges to be covered by your insurance plan.

Signature: ________________________________ **Patient(s) Name:** ________________________________



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Receipt of Notice of Privacy Practices:

Written Acknowledgement Form

I, ____________________________________, have been made aware that a copy of the HIPAA is located in the waiting areas of Kennesaw Pediatrics, P.C. and am aware that I can request a printed copy.

Signature: ____ Date: ______________

Relationship to Patient(s): ____

Patient(s) Name: _______________________________