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

How did you hear about us?

Please list all that apply

1. **FRIEND/WORD OF MOUTH**_____
2. **INTERNET SEARCH**_____
3. **OBGYN/HEALTHCARE PROVIDER**_____
4. **COMMUNITY EVENT/FESTIVAL**_____
5. **SOCIAL MEDIA** _____
6. **MAGAZINE AD** _____
7. **CHILD CARE CENTER OR SCHOOL**_____
8. **DID YOU TAKE AN OFFICE TOUR?**_____

Your Child's Name: _____ Date: _____

We welcome you to leave any comments you may have:

_____

_____

_____

_____

_____

_____

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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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Authorization of Treatment and Assignment of Benefits:

I authorize Kennesaw Pediatrics, P.C., to treat my child. I further authorize payment directly to Pediatricians of Kennesaw Pediatrics, P.C. for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all of my insurance submissions. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Patient(s) Name: _____

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Parent/Patient Authorization Signatures

Patient Name(s):

Last Name _____ First _____ M.I. ___ DOB _____ M F

Please initial all applicable spaces. If a category does not apply you, please write "N/A" in the space.

Initials

Financial Responsibility

_____ I have received a copy of Kennesaw Pediatrics, P.C. Financial Policies statement. I understand that insurance coverage is not a guarantee of payment, and I agree that I am ultimately responsible for any health insurance co-payments, deductibles and any remaining balances not covered or payable by my insurance company. I understand that Kennesaw Pediatrics, P.C. is not responsible for knowing what services my plan covers and does not cover.

Insurance Responsibility

_____ I irrevocably assign and transfer to Kennesaw Pediatrics, P.C. all insurance benefits covered the Kennesaw Pediatrics, P.C. services for payment of services rendered. I understand that it is my responsibility for providing a current copy of my insurance card and notifying Kennesaw Pediatrics, P.C. of any changes/additions to a patient's insurance coverage.

Authorization for Release of Information

_____ I hereby authorize Kennesaw Pediatrics, P.C. to release any necessary information for the following reasons: to other physicians for continuing professional care, to any insurance company or their representatives, or otherwise as allowed by law. I release Kennesaw Pediatrics, P.C. from any liability for the release of information and I understand this release includes any and all blood and related tests, including HIV, HIB, and other diseases. This authorization is irrevocable and is not limited in time.

Authorization for Care/Treatment

_____ I am aware that my child(ren) may require medical treatment when I am not able to be present. In my absence, I give the individual(s) listed below my permission to authorize any and all medical treatment(s) for my child(ren) named above. Furthermore in my absence, I give permission to Kennesaw Pediatrics, P.C. and its entire staff to examine and provide emergency treatment to my child(ren) listed above. In addition, the physician/clinic has my permission to refer my child(ren)'s emergent care and treatment to the appropriate service for the treatment of the illness or injury. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child(ren)'s care whether or not services are covered by insurance. This authorization is not limited in time.

Individual(s) Name	**Relationship to Patient:**
Full Name: _____	_____
Full Name: _____	_____
Full Name: _____	_____
Full Name: _____	_____

Signature: _____ **Patient Name:** _____ **Date:** _____

Release of Data for e-Prescribing

I hereby authorize Kennesaw Pediatrics, P.C. to exchange prescription data with any/all prescription networks to facilitate the care of my child(ren) named above. This will include but not limited to medication history check, prescription eligibility coverage, generic vs. branded drug costs, and drug interaction verification. This authorization is not limited in time.

_____

Medicaid Allotment

I understand that Kennesaw Pediatrics, P.C. Medicaid allotment is currently full and I agree not to carry Medicaid coverage on my child(ren) as primary or secondary insurance to other coverage. If at any time I enroll and carry Medicaid on my child(ren), I understand that I will need to transfer to another practice that is currently accepting Medicaid.

_____

PHI Release

Who do you authorize to receive your child(ren)'s Personal Health Information (step-parents, babysitters, grandparents, etc…)? If a person, other than the parent/legal guardian, is not listed below, they will be unable to gain access to your child(ren)'s PHI, either written or verbal from Kennesaw Pediatrics, P.C. (Does not include access to complete medical records).

_____

Individual(s) Name	**Relationship to Patient:**
Full Name: _____	_____
Full Name: _____	_____
Full Name: _____	_____
Full Name: _____	_____

Description of information that may be disclosed:

_____

_____

_____

You may revoke or terminate this authorization by submitting a written revocation. You should contact the Privacy Officer to terminate this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Communication

We may contact you via phone, text, or email at the number(s) and address(es) provided for appointment reminders, health reminders, account related matters and other issues as needed. We may leave a voicemail or a message with whomever answers.

Yes No

If you answered No, please advise us on how we may best contact you for appointment changes, account related matters, and/or any health matters:

_____

_

_____

_

_____

_____

Health Information Exchange

I understand that Kennesaw Pediatrics participates in CareQuality, a health information exhange. This allows KP to quickly and accurately access information from another health care provider through secure, electronic means and could include information such as you child's medications, allergies, test results and doctor's notes. It would not include psychotherapy notes or other information that requires specific authorization to release under federal law. This helps our doctors to make quick and accurate treatment decisions, especially in the case of an emergency or urgent situation.

_____

Signature: _____ Patient Name: _____ Date: _____

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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: _____

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Advanced Beneficiary Notice (ABN)

YOU WILL NEED TO MAKE A CHOICE ABOUT RECEIVING THESE HEALTHCARE ITEMS OR SERVICES

Your healthcare insurance MAY NOT pay for the item(s) or service(s) offered at Kennesaw Pediatrics, P.C. that are described below. The plan that you have chosen as your health insurer only pays for covered items and services and may not cover all of your healthcare costs. It is the guarantor/parent/legal guardian's responsibility to understand their coverage/benefits as Kennesaw Pediatrics, P.C. cannot guarantee coverage of services.

The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive this service.

The purpose of this notice is to help you make an informed choice about whether you want to receive these items/services if you do have to pay yourself, out of pocket. By signing below, you agree to take financial responsibility for the cost of the item(s)/ service(s).

You are welcome to file a claim with your insurance company directly and attempt to receive payment. However, we make no assurance that you will be successful.

Lab/Procedure	Out of Pocket Cost	Estimated Result Time	For Service via Insurance
Bilirubin/Hepatic Panel	$45	20 minutes	• Must take your child to Lab Corp/Quest location, sign in/wait, have specimen drawn • Results depend on the lab • 3-6 hour for most lab results • Some may take over 24 hours.
Complete Blood Count (CBC)	$35	20 minutes	
Comprehensive Metabolic Screen	$45		
Ear Washing	$70		
EKG	$100		
FLU (Influenza) Rapid Test	$40	10 minutes	
Hearing Screen OAE/Manual	$95/$25		
Vision Screen SPOT/Manual	$40/$15		
Lead Level	$25	10 minutes	
Lipid/Cholesterol Profile	$45	20 minutes	
MonoSpot Test	$25	10 minutes	
Newborn Metabolic Screening/PKU	$75		
RSV Rapid Test	$30	10 minutes	
Throat Culture	$35		
Urine Culture	$25		
Wart Removal	$75-250		

*Prices are subject to change without notification

This only applies to non-covered charges; not to amounts applied to your deductible

Keep in mind that certain procedures are considered SURGICAL PROCEDURES by your insurance. This may include, but is not limited to: Foreign Body Removal (splinters, beads, food, ear wax, etc.), Wart Removal, and Ear Washing.

Signature: _____ **Patient Name:** _____ **Date:** _____

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Patient(s) Family History

Information about your child(ren):

Full Name _____ DOB: _____ Gender: M F

Mother:

Full Name _____ DOB: _____ Height: _____Weight: _____

Medical Problem(s): _____ Education Level: _____

_____

Father:

Full Name _____ DOB: _____ Height: _____Weight: _____

Medical Problem(s): _____ Education Level: _____

_____

Is there a family history (including child's parents, siblings, grandparents, aunts, uncles) of any of the following?
Please circle YES or NO to all questions:

Allergies	YES	NO	Early Heart Attacks	YES	NO	Kidney Disease	YES	NO
Asthma/Wheezing	YES	NO	Emotional Problems	YES	NO	Mental Problems	YES	NO
Birth Defects	YES	NO	Epilepsy	YES	NO	Thyroid Disease	YES	NO
Bleeding Tendencies	YES	NO	High Blood Pressure	YES	NO	Tuberculosis	YES	NO
Convulsions	YES	NO	High Cholesterol	YES	NO	Lazy Eye	YES	NO
Diabetes	YES	NO	Hip Disorders in Infancy	YES	NO	Other Heart Disease	YES	NO
						Other Illnesses	YES	NO

If you answered YES to any of the above, please explain:

_____

_____

Social History:

Do you and your family have a religious preference? YES NO If yes, please specify _____
Marital Status of parents: Married Single
Has there been a separation, divorce, or death? Specify: _____
What has been the attitude of your child to this situation? _____
Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, acupuncture or herbal medicine? YES NO If yes, please specify:_____
Is there a gun in your home? YES NO
Are there pets in your home? YES NO
Does anyone in your home smoke? YES NO
Are there any financial problems in the family? YES NO
Are there family disagreements on how to raise the child(ren)? YES NO

List all family members child(ren) live with: _____

Name of person completing the form: _____ Relation to patient: _____

Signature: _____ **Patient Name:** _____ **Date:** _____

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Patient's Medical History

Child's Full Name: _____ Previous Pediatrician: _____

Pregnancy History with Child

Have you had breast surgery? YES ☐ NO ☐
Did you take hormones during pregnancy? YES ☐ NO ☐
Did you take any drugs during pregnancy? YES ☐ NO ☐
Did you smoke during pregnancy? YES ☐ NO ☐
Did you drink any alcoholic beverages during pregnancy? YES ☐ NO ☐
Has the child's mother had any miscarriages, still births, or abortions? YES NO ☐

Birth History of Child

Please circle one: Full Term Pregnancy ☐ Premature birth: ☐ at ____ weeks
Adopted: at what age? _____ Has he/ been told their adopted? YES ☐ NO ☐
Type of delivery? _____ Obstetrician: _____
Birth Weight: _____ Length: _____ Head Circumference: _____ APGARS: _____
Please circle one: Breast fed ☐ Bottle fed ☐
Any problems at birth? YES ☐ NO ☐ If yes, please specify: _____

Child's Development

Please list age of child when the following milestones were reached:
Sat alone: _____ mos Walked: _____ mos Sentences: _____ mos Words: _____ mos First teeth: _____ mos
Bladder trained: _____ mos Bowel trained: _____ mos
Does the child have any handicap? YES ☐ NO ☐ If yes, please specify: _____
Is there a bed wetting problem? YES ☐ NO ☐ Is there a family history of bed wetting? YES ☐ NO ☐

School Performance

School Performance: Academic: _____
Behavior: _____
Has the child ever been in special education class(es)? YES ☐ NO ☐
Has the child had a learning problem? YES ☐ NO ☐ If yes, please specify what type: _____

Past Illnesses

Please mark date or frequency of illness or specify causing allergy:

Asthma		Pneumonia	
Chicken Pox		Roseola	
Colds		Rubella (German Measles)	
Convulsions		Tonsillitis	
Ear Infections		Scarlet Fever	
Mumps		Urinary Tract Infection	

Allergic to Medication: _____
Allergic to Foods: _____
Allergic to Insect Bites: _____
Has he/she received desensitization shots? YES ☐ NO ☐
Other: _____

Operations and Hospitalizations *Please specify date or reason:*

Appendectomy: _____ Tonsils and Adenoids: _____ Ear Tubes: _____
Other: _____

Medications

Is your child taking any medications on a regular basis? YES ☐ NO ☐
If yes, please specify: _____
Is there anything else about your child you feel we need to know to provide the best medical care for him/her?
Please specify: _____

Name of person completing the form: _____ Relation to patient: _____

Signature: _____ **Patient Name:** _____ **Date:** _____