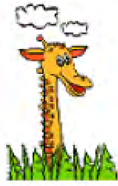

Welcome To

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

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:

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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:

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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:** ____________