PATIENT REGISTRATION

Primary Care Physician: ☐ Dr. Stone ☐ Dr. Behm ☐ Dr. Alexander ☐ Dr. Callan ☐ Dr. Williams ☐ Dr. Rosinia

Patient Information *(legal first, middle and last name required)*

Last Name ______ First ______ Middle ______
Nickname ______ DOB ______ Sex: ☐ M ☐ F SS # ______ Preferred Phone # ______
Address ______ City/State/Zip ______

Parent/Legal Guardian Information *(legal first, middle and last name required)*

Mother ______
☐ Natural ☐ Adoptive ☐ Step-parent ☐ Legal Guardian
SS # ______ DOB ______
Address ______
City/State/Zip ______
Email ______
Home Phone ______
Work Phone ______
Cell Phone ______

Father ______
☐ Natural ☐ Adoptive ☐ Step-parent ☐ Legal Guardian
SS # ______ DOB ______
Address ______
City/State/Zip ______
Email ______
Home Phone ______
Work Phone ______
Cell Phone ______

Parents are: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sibling Information

Name ______ DOB ______ Name ______ DOB ______
Name ______ DOB ______ Name ______ DOB ______
Name ______ DOB ______ Name ______ DOB ______

Emergency Contact & Relationship ______ Phone # ______

Preauthorization to Treat Minors

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. This may include, but is not limited to, a grandparent, babysitter, or family friend. Please be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making. Please also note that the person bringing in the child is responsible for payment.

☐ I authorize Coastal Pediatrics and it's personnel to provide medical care to this child in my absence. ______ Initials

☐ I **do not** authorize Coastal Pediatrics to provide medical care in my absence. ______ Initials

Insurance Information *(you must also provide us with a copy of your current insurance card)*

Primary Insurance

Insurance Company ______
Name of Insured ______
Member ID # ______
Employer *(if applicable)* ______
Relationship to Patient ______
Group # ______ Effective Date ______

Secondary Insurance

Insurance Company ______
Name of Insured ______
Member ID # ______
Employer *(if applicable)* ______
Relationship to Patient ______
Group # ______ Effective Date ______

Authorization of Treatment and Assignment of Benefits

I have completed this form to the best of my ability and verify that the information is correct. I understand I am responsible for full payment of any and all services. I authorize the release of any medical or other information necessary to process any insurance claims. I request and authorize payment of any benefits from any insurance or medical plan, including those listed above or attached to Coastal Pediatrics.

Parent/Legal Guardian Signature ______ Date ______

Your Child's Medical History

Child's Name ______________________ **DOB** __________ **Date** __________

Child's Past Medical History

Has your child ever been treated or diagnosed with: *(explain)*

- ☐ ADD/ADHD ______________________
- ☐ Allergies (seasonal) ______________________
- ☐ Allergies (food) ______________________
- ☐ Anemia ______________________
- ☐ Asthma or reactive airway disease ______________________
- ☐ Broken bone ______________________
- ☐ Cancer ______________________
- ☐ Chicken pox ______________________
- ☐ Constipation ______________________
- ☐ Depression/anxiety ______________________
- ☐ Diabetes ______________________
- ☐ Ear infections (recurrent) ______________________
- ☐ Eczema ______________________
- ☐ Heart murmur ______________________
- ☐ Kidney disease ______________________
- ☐ Migraines ______________________
- ☐ Pneumonia ______________________
- ☐ Sickle cell disease ______________________
- ☐ Seizures ______________________
- ☐ Urinary tract infections ______________________
- ☐ Wheezing or bronchiolitis ______________________
- ☐ Other chronic medical conditions ______________________

____

Has your child ever been hospitalized? ☐ No ☐ Yes

If yes, explain. ______________________

____

____

Past surgeries or procedures? ☐ No ☐ Yes

If yes, explain. ______________________

____

____

Please list any specialist your child has seen, dates and reason: ______________________

____

____

Allergies

List allergies to medicine:

____

____

____

Medications

List current medications:

____

____

____

Any concerns about your child's development/nutrition?

____

____

____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad

☐ step ________ ☐ siblings (#___) ☐ Grandparent(s)

☐ Other ______________________

Mom's age ________ Dad's age ________

Parents are: ☐ married ☐ unmarried ☐ divorced ☐ other

Do any household members smoke? ☐ No ☐ Yes

Family History

Do any family members have any of the following conditions?

	Family Member		
Condition	Mother	Father	Sibling(s)
ADD/ADHD	☐	☐	☐
Alcoholism	☐	☐	☐
Allergies	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Blood disorder	☐	☐	☐
Cancer	☐	☐	☐
Depression/anxiety	☐	☐	☐
Diabetes	☐	☐	☐
Heart attack/disease	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Kidney disease	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Other issues	☐	☐	☐

Please explain all positives:

____

____

____

Financial Policy

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. Co-payments will be collected at the time of check-in. Coastal Pediatrics accepts cash, personal check (in-state only), VISA, and MasterCard. There is a $30.00 charge for returned checks. Patients with an outstanding balance for more than 60 days must make arrangements for payment prior to scheduling an appointment. We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation you seek your child's immunizations and/ or medical care through a public health clinic or the Chatham County Health Department.

The parent/guardian that brings the child in for treatment is responsible for payment. This includes divorced parents, grandparents, babysitters, etc. There are no exceptions.

INSURANCE:
We bill participating insurance companies as a courtesy to you. Therefore, we will request a copy of your insurance card at **each** visit. Please understand that insurance is a contract between you and your carrier. Therefore, you are ultimately responsible for your bill. **You are responsible for knowing the coverage, limitations and exclusions specific to your insurance policy, *particularly concerning vaccinations and lab tests*.** If charges have been filed and we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You will be expected to contact your insurance carrier for explanation of why payment is delayed. If you need assistance paying your account, please speak to the receptionist.

MEDICAID/PEACHCARE:
Medicaid and PeachCare insurance plans (Wellcare, Amerigroup, CareSource and Peach State CMOs) are not accepted as primary nor secondary insurance.

MINOR PATIENTS:
A parent or guardian must accompany all minors before treatment can be provided.

REFUNDS:
Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for your child. We ask that you kindly give 24 hour notice for cancellation of your appointment. Three missed appointments in a family will result in discharge from this practice. First appointments missed by new patients will not be rescheduled.

I have read and understand the Coastal Pediatrics Financial Policy. I agree to assign insurance benefits to Coastal Pediatrics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for any legal and/or collection fees.

Signature of insured or authorized guardian:

____ Date: ____________________

Patient Consent for Use and Disclosure of Protected Health Information & Receipt of Practice Privacy Policy

I hereby give my consent for Coastal Pediatrics to use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO). Examples of such instances include, but are not restricted to: your medical insurance carrier, physicians to whom your child is referred, school health officials, etc. Coastal Pediatrics' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Coastal Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at any time by forwarding a written request to Coastal Pediatrics' privacy officer at 2 Wheeler Street, Savannah, GA 31405.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing Coastal Pediatrics to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, clinical care (including test results) and insurance issues. I understand that I have the right to request that Coastal Pediatrics restricts how it uses or discloses my PHI to carry out TPO. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form, I agree that they are allowed to receive PHI in the same manner as described above (with the exception of information relating to STD, HIV/AIDS, pregnancy testing and records relating to drug, alcohol or mental health treatment, which all require an additional release).

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, Coastal Pediatrics may decline to provide treatment to me/my child.

For patients under 18 years of age:

________________________________	________________	________________
Patient Name	Date of Birth	Date

________________________________ Signature of Parent/Legal Guardian

________________________________ Printed Name of Parent/Legal Guardian

ADDITIONAL HIPAA APPROVED CONTACTS

________________________________	________________________________
Name/Relationship to Patient	Name/Relationship to Patient
________________________________	________________________________
Name/Relationship to Patient	Name/Relationship to Patient

******If the patient is over 18 years of age, they must sign for themselves.******

For patients 18 years of age and older:

________________________________	________________	________________
Patient Name	Date of Birth	Date

________________________________ Signature of Patient

Now that you have turned 18, you get to choose who may have access to your medical information. Remember to add your "ADDITIONAL HIPAA APPROVED CONTACTS" above. By providing your email address and phone number, we will update the primary contact information on your account.

________________________________	________________________________
Patient Email	Patient Phone Number