Twinkle Pediatrics LLC

Dr. Aparna Peethambaram
1815 Satellite Blvd. Suite 501 Duluth, GA 30097
Ph: 678-496-2600 Fx: 888-226-8819
www.twinklepediatrics.com

PATIENT INFORMATION

Last Name:_____ Name: _____ M.I:_____

Date Of Birth: _____ Age: _____ Sex F / M Social Security # _____-_____-_____

Address: _____ City:_____ Zip Code: _____

Home Phone Number _____-_____-_____ School Name/Daycare:_____

INSURANCE INFORMATION

□ **MEDICAID** □ **PEACHCARE FOR KIDS**

Member ID Number: _____ □ AMERIGROUP □ CARESOURCE

Plan ID Number: _____ □ WELLCARE □ PEACHSTATE

PRIVATE INSURANCE

Insurance Name: _____ Policy # _____ Group # _____

Name Of Insured: _____D.O.B: _____ Social Security # _____-_____-_____

Employer Name & Address:_____

PARENT/GUARDIAN INFORMATION

Last Name: _____ First Name: _____ D.O.B:_____

Sex F / M Social Security # _____-_____-_____ Cell Phone # _____-_____-_____

Work Phone # _____-_____-_____ Email Address:_____

Emergency Contact:_____ Phone Number:_____-_____-_____

Preferred Pharmacy: _____
(Name, Address & Phone Number)

Appointment Reminders? □ VOICE CALL □ TEXT MESSAGE How Did You Hear About Us?

AUTHORIZATIONS

************PLEASE PRESENT INSURANCE CARD & PICTURE ID TO THE RECEPTIONIST************

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by **Twinkle Pediatrics, LLC**. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of **Twinkle Pediatrics, LLC** as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to **Twinkle Pediatrics, LLC**, for services rendered.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

X_____ _____
Parent Signature Or Legally Authorized Representative Date

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FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Twinkle Pediatrics, LLC as your child's health care provider. We are committed to successfully managing your child's health. Please understand that payment of the bill is considered part of your treatment. This Financial Responsibility Statement must be read and signed by the child's guardian prior to any treatment. All patients should also complete our Patient Information and Insurance forms before seeing the doctor. Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns. While we do participate with many insurance plans, accounts covered by other plans must be paid in full at the time of service unless prior arrangements have been made. We accept Cash, Checks with prior approval and MasterCard, Visa, Amex, or Discover.

Insurance:

We will be happy to file insurance claims for you provided we are a participating provider in your plan. It is your responsibility to provide us with a correct address, telephone number and insurance information at each visit. Insurance coverage and knowledge of plan benefits are the responsibility of the patient. Please refer to your Explanation of Benefits (EOB) provided to you by your insurance plan for questions regarding deductibles or amounts considered patient responsibility. Insurance plans that offer a copayment require that we collect the copay for each and every office visit regardless of the services being performed. All copayments are due at check-in, prior to treatment. We will apply an administrative fee should we have to bill for your copayment.

Referrals required by your insurance company are your responsibility. If you see the specialist BEFORE receiving approval, you may be required to pay out of pocket. If you must take your child to an urgent care facility after hours or on weekends, please contact our office on the next business day so we may do a referral for you.

Other Fees:

Missed Appointments: Unless cancelled at least one hour prior to the appointment time, there is an administrative fee for all missed appointments. Future appointments will not be scheduled until this fee is paid.

Please help us serve you better by keeping scheduled appointments.

NSF fee:

Our office will charge an administrative fee if your bank returns your check for non-sufficient fund (NSF).

PE Forms/Medical Records:

Charges are to cover the costs to our office.

Please list all children (with 1st and last names) and their date of birth:

_____

_____

_____

_____

I have read and understand the Financial Responsibility Statement. I agree to these conditions.

X_____ _____

Parent Signature Or Legally Authorized Representative Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law.

I hereby voluntarily authorize _____
(Previous Clinic Name, Phone & Fax Number)

To release: _____ _____,
(Childs Name) (Date Of Birth)
information specified below to or from:

Twinkle Pediatrics, LLC
1815 Satellite Blvd Suite 501 Duluth, GA 30097
Phone: (678) 496-2600 Fax: (888) 226- 8819

The specific purpose(s) for this disclosure is/are:

____ My personal use

____ Sharing with other healthcare providers

____ Other (please describe) _____

SPECIFIC INFORMATION TO BE RELEASED: (Please check all that you are requesting be released)

____ Complete Medical Records for this Office

____ History & Physical

____ Other (Please List) _____

• I understand that I May revoke this authorization at any time by notifying the office in writing at ATTN: Practice Manager, Medical Records Request of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before revocation.
• I understand this authorization expires 180 days from the date signed, unless otherwise revoked.
• I understand that once the above information is disclosed, it May be re-disclosed by the recipient and the information May not be protected by federal privacy laws or regulations.
• I understand that I May be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named patients medical record which I am requesting.
• I understand that I May be charged for copies of my child's medical record, which I request for myself for use by others.
• I also understand fees for copies are due and payable before copies are released.
• I understand that a photocopy or facsimile of this authorization is as valid as the original.

_____ _____
Parent Signature or Legally Authorized Representative Date

_____ _____
Printed Name Relationship to Patient

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____ the parent or legally authorized representative of _____ have been given the opportunity to read, review and request a copy of **Twinkle Pediatrics, LLC Notice of Privacy Practices** as Required by the Privacy Regulations Created As a Result of the ***Health Insurance Portability & Accountability Act (HIPAA)*** in which this notice describes how health information about my child may be used, disclosed, and how I can get access to my child's individually identifiable health information.

X_____ _____

Parent Signature Or Legally Authorized Representative Date

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Consent To Vaccinate

I, _____ the parent or legally authorized representative of _____ give my consent and authorization for my child to receive all the vaccinations that are required by ***The American Academy Of Pediatrics (AAP) & The United States Center For Disease Control (CDC).*** If I at any point in time have questions or concerns regarding any vaccine I will inform the M.A or Dr.Aparna during consultation so that my issue be resolved.

X_____ _____

Parent Signature Or Legally Authorized Representative Date

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Prescription Medication Consent

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** - Provides the health care provider with information about your child's current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your child's health care provider at Twinkle Pediatrics, LLC as well as other health care providers involved in your child's care and may include sensitive information including, but not limited to, medications related to mental health conditions, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

By signing this consent form you are agreeing that your provider's at Twinkle Pediatrics, LLC may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your child's ability to get medical care, payment for his/her medical care, or their medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Twinkle Pediatrics, LLC to check my child's prescription history. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Patient Name Date Of Birth

_____ _____
Parent Signature or Legally Authorized Representative Date

_____ _____
Printed Name Relationship to Patient

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Consent for Telemedicine Services

• I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

• I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

• I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

• I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

• I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.

• I understand that by signing this form that I am consenting to receive health care services via telemedicine.

X_____ _____

Parent Signature Or Legally Authorized Representative Date