EXCELLENT PEDIATRICS NOTICE:

- Everyone will have to fill out new Registration forms
- All insurance information is required @ time of service
- All Co-Pays are due before services are rendered
- For every missed appointment without calling 24 hours ahead of time, there will be a $20.00 charge to the patient's account. (The caretaker will be responsible for that charge)
- If you are 15 minutes late to your appointment without notifying us ahead of time , you are considered a walk in and a $20 now show fee may be imposed
- 3231 Form $5.00 (vaccine)
- 3300 Form $5.00 (Ear, Eye, Dental)
- 3189 Form $5.00 (Varicella & MMR)
- Any Physical forms & Other Documents to be filled out by the Physician will have a $15.00 charge without office visit.
- You must give our office 1 week advanced notification for medication refills.
- Any Medical records must have a signed record release and you will be charged by chart size $10 & up
- If you are billed, and you don't pay promptly , a 40% may be added to your account for collection agency charges
- Due to HIPPA rules and regulation no medical information will be faxed without a Guardian signature

Signature: ________________________________ Date: ___________________________

UPDATED 09/2011

EXCELLENT PEDIATRICS

PATIENT NAME: ________________________________ DATE OF BIRTH ______/______/_______

ACKNOWLEDGEMENT FORM

PLEASE LIST ALL PERSONS THAT YOU ALLOW TO BRING YOUR CHILD TO OUR OFFICE FOR EVALUATION AND TREATMENTS.

1.___________________________________ 2.___________________________________

3.___________________________________ 4.___________________________________

5.___________________________________ 6.___________________________________

7.___________________________________ 8.___________________________________

I, (PRINT NAME) ____ GIVE EXCELLENT PEDIATRICS PERMISSION TO TREAT MY CHILD IN MY ABSENCE ACCORDING TO THE ABOVE LIST.

____ ________________________________

SIGNATURE DATE

New Patient Intake Form

Please Complete All Area

	Fill In or Circle Answers Here
Today's Date	
Patient's Name (last, first)	
Date of Birth	
Gender	
Place of Birth	
Birth Weight	
Type of birth (circle one)	Vaginal or Cesarean(C-Section) or Unknown
Term	Full Term or Premature (___ weeks at time of birth)
The baby stayed how many Days in the hospital before the discharge home ?	
List Pregnancy Complications ?	
Has the child been hospitalized since birth? (Give dates and duration of illness)	
Has the child had any surgeries? (Give dates and duration of illness)	
Does the child have any illnesses or chronic conditions ?	
What MEDICATION and DOSAGE does the child take currently ?	
List all MEDICATION allergies	
List all FOOD allergies	
When was the last full physical exam for this child ?	
What is your relation to this child ?	
Please list everyone that currently lives in the home with this child [names not necessary]	
Please list the **ages and gender** of this child's brothers and sister, and parents.	
Does this child's **biological** mother or father or siblings have any medical illnesses ? If Yes, please list	
Are there any smokers in the home ?	Yes No
Are there any pets in the home ?	Yes No
How many people currently live In the home with this child ?	
How Did You Hear about this office ?	

EXCELLENT PEDIATRICS

DEMOGRAPHIC INFORMATION		
Patient's Name:		Birthday:
Address:		
City, State, ZipCode:		
Home Phone #:	Race:	Language:
Social Security#:		Sex: Male / Female
MOTHER'S INFORMATION		
Name:		Birthday:
Address: (Same)		
City, State, ZipCode:		
Home Phone #:	WorkPhone:	CellPhone:
Social Security#:		
Employer:		
Employer Phone #:		
Email Address:	@	
FATHER'S INFORMATION		
Name:		Birthday:
Address: (Same)		
City, State, ZipCode:		
Home Phone #:	WorkPhone:	CellPhone:
Social Security#:		
Employer:		
Employer Phone #:		
Email Address:	@	
CURRENT LEGAL GUARDIAN / EMERGENCY CONTACT		
Name:		Birthday:
Address:		
City, State, ZipCode:		
Home Phone #:	WorkPhone:	CellPhone:
Social Security#:		
Email Address:	@	
Employer:		
Employer Phone #:		

Please mark here if you would like for our office to contact you via [check all that apply]:

- Email
- Text message
- Home Phone
- Mobile Phone

SIGNATURE OF PERSON COMPLETING THIS FORM	DATE
X	

EXCELLENT PEDIATRICS

333 ALCOVY STREET, SUITE # 1
MONROE, GEORGIA 30655
678-807-2230 PHONE / 770.267.5710 FAX

Guarantors Statement

I request payment of authorized benefits be made to the above-named facility on my behalf, for any services provided to me or my child. I authorize any holder of medical and other information about me or my child to release to an insurance company, any other third-party payer, state medical assistance agency, or any other governmental or private pay are responsible for paying benefits, any information needed to determine these benefits or benefits for related services. I authorized a copy of this authorization to be used in place of the original.

I agree to pay for All Charges not covered by a third-party payer (insurance company).

Patient Name: ____________________________ ______________________________

Date of Birth: ____

Print Parent Name: ____

Signature: ____

Date: ______/______/______

EXCELLENT PEDIATRICS

333 Alcovy Street Suite 1

Monroe, Georgia 30655

Phone:678-807-2230 Fax:770-267-5710

PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that Excellent Pediatrics, LLC has a privacy policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996, (HIPAA).

As a patient of Excellent Pediatrics, I understand and acknowledge the following:

1. Excellent Pediatrics has a privacy policy in effect in their offices.

2. Excellent Pediatrics has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.

3. Excellent Pediatrics has made me aware, that as a patient I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implanted by Excellent Pediatrics, LLC and have read and understand the acknowledgement form. If you desire a copy of the privacy policy, please request one at this time.

__________**No, I do not want a copy**, but acknowledge the Privacy Policy Exists.

__________**Yes, I do want a copy** of the privacy policy.

Patient Name ____

Parent Name ____

Parental Signature _______________________________________

Today's Date ____

Date: ____________________ Provider/Physician: ______________________________
MM/DD/YYYY

Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: ____ **Date of Birth:** ________________
Last Name First Name MI MM/DD/YYYY

Parent/Guardian: ____
Last Name First Name MI

INELIGIBLE FOR STATE-SUPPLIED VACCINE ***(Check if applicable)***

- ☐ The child has insurance that pays for immunizations. (*Fully-insured / Private Pay*)

ELIGIBLE FOR STATE-SUPPLIED VACCINE
This child qualifies for vaccination with state-supplied vaccine because (*check only one box*):

- ☐ The child is enrolled in Medicaid
- ☐ The child is American Indian or Alaskan Native
- ☐ The child does not have health insurance (*Not Insured*)
- ☐ The child has health insurance that does not pay for vaccines (*Underinsured*)
- ☐ The child is enrolled in PeachCare for Kids

Note To Providers:
A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. ***While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.***

SCREENING UPDATES

	VFC ELIGIBILITY* (Check only one category)					NOT ELIGIBLE
DATE SCREENED	PEACHCARE FOR KIDS	MEDICAID ENROLLED	UNINSURED	AMERICAN INDIAN OR ALASKAN NATIVE	UNDER-INSURED	INSURANCE COVERS VACCINATIONS**

*This form should be retained in the child's medical record for at least three (3) years and updated at each visit during which an immunization is provided. Further documentation of VFC eligibility is not required.

** Children with insurance that has coverage for immunizations are not eligible to receive VFC vaccines.