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L. Deana Smoak, MD
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Dear Parent,

Welcome to ABC Pediatrics, Fayetteville.

We look forward to providing pediatric medical care to your child.

The forms enclosed in this mailing need to be completed in full and returned to us **prior** to your appointment or, if you bring them to the first appointment, please plan to arrive ten minutes early. Most of our office policies are published on the ABC Pediatrics website www.myabcpediatrics.com. Please take time to review our website and be sure to register for the patient portal. We have enclosed the entire No-Show policy and a summary of the Financial Policy (the entire policy is on the website) for you to read and sign.

Our electronic medical record system allows us to set aside appropriate time slots for different ages of children as well as allows for you to have electronic access to confirm appointment times. Arriving even a few minutes late, will wipe out all our hard work and good intentions. Please plan to arrive about 10 minutes ahead of your scheduled time. If you are running late, call before you come so we can check for another available time slot. **If you arrive late, you will need to be rescheduled.**

We have recently upgraded our patient portal with CHADIS. CHADIS allows you to complete health and developmental questionnaires online when it is most convenient for you. Filling out the CHADIS questionnaires before the visit gives you and your provider more time to talk about issues that you may want to make sure get addressed. Visit appropriate questionnaires must be completed prior to the child's visit. If not, your appointment time will be delayed.

Remember, you need to bring your identification, your child's insurance card, the appropriate co-pay, or self-pay, and a list of the child's current medications to every visit.

While this may sound like a lot of rules, they are for your child's and your benefit. We do not want any of our patients to have 1 to 2 hour waiting times! We hope you will appreciate all our efforts.

The Providers and staff of ABC Pediatrics.

Revised: October 2020

Patient Registration Form

(Please print and complete all sections)

Patient's Information	*Patient's Information*
Child #1: DOB: M/F	**Child #2:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____________	Child's Race (circle one): White, Black, Hispanic, Other _____________
Child's Primary Language (circle one): English, Spanish, Other _______	Child's Primary Language (circle one): English, Spanish, Other _______
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Child #3: DOB: M/F	**Child #4:** DOB: M/F
Child's Race (circle one): White, Black, Hispanic, Other _____________	Child's Race (circle one): White, Black, Hispanic, Other _____________
Child's Primary Language (circle one): English, Spanish, Other _______	Child's Primary Language (circle one): English, Spanish, Other _______
Child's Ethnicity (circle one): Non-Hispanic, Hispanic	Child's Ethnicity (circle one): Non-Hispanic, Hispanic
Mother's Information	*Father's Information*
Name: DOB:	Name: DOB:
Primary/Day Phone#: WK/HM/CELL	Primary/Day Phone#: WK/HM/CELL
Secondary Phone#: WK/HM/CELL	Secondary Phone#: WK/HM/CELL
Address Apt#	Address Apt#
City State Zip	City State Zip

Parent/Guardian Information:

Mother's Name: ____ **Father's Name:** ___________________________________

Child(ren)'s Parents Are: Married Divorced Separated Never Married

Preferred Daytime Phone Number: ______________________ **Preferred Email Address:** _____________________________

Email Address Is Required for the Patient Portal. ABC Pediatrics may leave messages via home, cell or email.

Authorize Text Notifications: Yes No Authorize Voicemail: Yes No Authorize Email Notifications: Yes No

Primary Insurance Information

Policy Holder's Name: ____

Policy Holder's DOB: __________________________________ Policy Holder's SS#:__________________________________

Primary Insurance Company: ___________________________ Customer Serv Phone#:______________________________

Insurance Address: ____

Policy Number: ____ Group Number: ___________________________________

Employer's Name: ____ Employer's Phone#:_________________________________

Secondary Insurance Information

Policy Holder's Name: ____

Policy Holder's DOB: __________________________________ Policy Holder's SS#:__________________________________

Primary Insurance Company: ___________________________ Customer Serv Phone#:______________________________

Insurance Address: ____

Policy Number: ____ Group Number: ___________________________________

I acknowledge the above information provided is correct. I authorize treatment and payment for all medical services rendered by the medical providers and staff of ABC Pediatrics, PC.

Please sign and date: Guarantor/Responsible Guardian ____

Relationship to Patient _____________________________________ Date____

Revised October 2020

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Revocation Date Revoked:

Patient Name: ________________________ DOB:_______________ Account #:____________________

I authorize ABC Pediatrics, PC to use or disclose my child's health information as described below.

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate spaces and include other information where indicated):

____ Entire medical record (all information)
____ Physician and Professional Consult Progress Notes
____ Diagnostic reports (lab, x-ray, etc.)
____ History and physical
____ Medication and treatment records
____ Immunization Records
____ Medical Summary
____ Other (Describe as specifically as possible):

____
____
____

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2. **Recipient of information** - The information identified above may be used by, or disclosed to, the following individual(s) or organization(s):

Name: ____________________________________ Name: ____________________________________

Address: __________________________________ Address:__________________________________

____ ____

Phone Number:_____________________________ Phone Number: _____________________________

Fax Number: ______________________________ Fax Number: ______________________________

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):

   ____ Initiated at the request of the parent.

   ____ Transferring to local provider

   ____ Other (please describe): ____

Authorization Statements/Signatures:

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

5. I understand that ABC Pediatrics will not charge for copies of immunization records or medical summaries. We will charge $5.00 for forms: 3231, 3300 or 3189 and $20.00 for any form requiring a provider's review/signature: sports, camp, college or physical forms. There will be a $50.00 charge for a copy of the full medical records of the first child and $25.00 for each additional charge, payable on the day this form is signed. The fee will not exceed $75.00 per family.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ABC Pediatrics, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization.

7. Unless I specify differently, this authorization will **expire in one year from date or** ______________.

8. I understand that ABC Pediatrics, PC will not condition the provision of treatment or payment on the provision of this authorization.

____ ____________________________

Signature of Patient or Parent or Legal Guardian **Date**

____

Print Name

____

Relationship to Patient

October 2020

Annual Immunization Consent Form

Patient Name:_______________________________________ Patient DOB________________________________

I understand that it is medically recommended that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule, and American Academy of Pediatrics guidelines.

I understand that each vaccine will be discussed with me prior to administration. The Vaccine Information Statement for each vaccine will be provided and I will be given the opportunity to ask questions.

The Vaccine Information Sheet(s) (VIS) from the Centers for Disease Control (CDC) explain the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's medical provider or staff member, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the need for the required and/or recommended vaccine(s)
- The **risks and benefits** of the required and/or recommended vaccine(s)
- If my child does not receive the vaccine(s), **the consequences** may include:
  - contracting the illness the vaccine should prevent (the outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well)
  - transmitting the disease to others
  - requiring my child to stay out of child care or school during disease outbreaks
- My child's medical provider, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations.

I understand that by signing this form, I give consent for my child to receive required and/or recommended immunizations as per the CDC Immunization Schedule, including the influenza vaccine. ***I will be consulted on each vaccine given prior to administration and I will have the opportunity to decline the vaccination if I choose to do so.*** While I will be given specific information for each immunization, I will not need to sign individual consents for each vaccine. This consent will be renewed each year.

I understand that I may address this issue with my child's doctor or nurse at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature____________________________________ Date________________________

Witness____ Date________________________

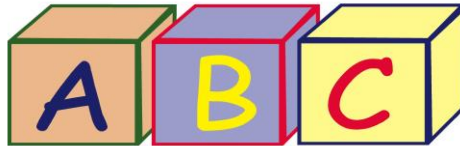
Immunization Consent in the Absence of Parent or Guardian

I understand that this consent covers all routine, required and/or recommended immunizations, unless otherwise specified by me. This includes visits during which my child is not accompanied by a legal guardian. The Vaccine Information Sheet will be provided.

Parent/Guardian Signature________________________________ Date__________________________

Witness____ Date__________________________

Revision: October 2020



AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

In my absence, I ____, who has legal custody of my child, ________________________________ and whose date of birth is ___________________ authorize the following individuals:

1. Name:________________________________ Relationship to the Patient:_________________
2. Name:________________________________ Relationship to the Patient:_________________
3. Name:________________________________ Relationship to the Patient:_________________

to provide consent to ABC Pediatrics to render care under the supervision and advice of a licensed medical care professional. I understand that it may be necessary to perform diagnostic testing and/or to administer vaccinations in the course of the visit.

I consent to all medically services rendered during the visit in which I was absent for example, physical examination, hearing and vision testing, immunizations, treatment for illness, referrals to a specialist, etc. The above named person(s) may also receive any tests results and any additional medical information pertinent to the care and treatment of the minor child for the visit in which I was absent. The above named person(s) listed above may not request full medical records or make decisions about chronic conditions without written consent from the parents/legal guardians.

I do not consent to the following services:

____.

This written consent is valid for the time period of: ______________ to _____________________.

After a period of one year, a new consent form would need to be completed. This consent may be revoked by me at any time in writing.

_______________________________________ __________________________________

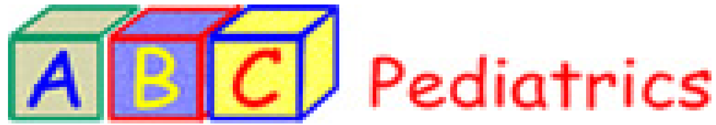
Parent or Legal Guardian's Name Date

_______________________________________ __________________________________

Parent or Legal Guardian's Signature Date

____

Phone Number Where Parent or Guardian Can Be Reached



Standing Consent to Access External Prescription History

I, ____________________________, whose signature appears below, authorizes ABC Pediatrics, PC and it's medical providers and staff to view external history via eClinicalWorks/RxHub software for the patient(s) listed below.

______________________________________	__________________
Patient's Name	Date Of Birth
______________________________________	__________________
Patient's Name	Date Of Birth
______________________________________	__________________
Patient's Name	Date Of Birth
______________________________________	__________________
Patient's Name	Date Of Birth

I understand that prescription history is from other unaffiliated medical providers, insurance companies and pharmacy benefit managers and that it may be viewable by the providers and staff of ABC Pediatrics. The external history made include prescription history for several years.

<u>Please sign only after you have read and understand the above statements.</u>

__________________________________	_______________________	_________________
Parent/Guardian's Signature	Relationship to the Patient	Date Signed

____________________________________	__________________
Witness Signature	Date Signed

No-Show Policy

Due to the frequency of patients failing to show up for scheduled appointments, it is the policy of ABC Pediatrics to assess a No-Show fee anytime the patient/responsible party fails to notify ABC Pediatrics in advance of a cancellation or change in a scheduled appointment.

The No-Show fee is $50.00 for failure to cancel or change a Well Child Visit (Physical) 24 hours in advance of the cancellation or change in this type of appointment. The No-Show fee is $30.00 any time a patient/responsible party fails to notify ABC Pediatrics 1 hour prior to a sick or recheck appointment. This allows the scheduling department to try to give the appointment to another patient. **To cancel an appointment before or after office hours or on weekends, please call the answering service at 404-935-6730.**

It is the policy of ABC Pediatrics to mail as few patient statements as possible, in an effort to reduce healthcare costs. When a no show fee is incurred, responsible parties are encouraged to mail the payment directly to ABC Pediatrics. It is the policy of ABC Pediatrics to mail one statement in an effort to collect the no show fee. If 30 days after the generation of the first statement it is necessary for ABC Pediatrics to mail a second statement because no payment has been received, an interest charge of a flat 12% of the balance, but not less than $5, will be added to the account. If no payment is received 10 business days after the mail date of the third statement, the account will be reviewed and turned over to the collection agency. **All accounts turned over to the collection agency will also be responsible for the collection agency fees**.

Child's Name: ___________________________ Child's DOB: ____________________

Signature of parent/responsible party: ____

Date: ___________________________

February 2014

Summary of Financial Policy and Authorization

Thank you for choosing ABC Pediatrics as the provider of your child(s) healthcare needs. ABC Pediatrics is a participating provider for most insurance plans however it is important that you verify participation with your insurance company. Please read the following summary of our financial policy and sign where indicated. You may also ask for a copy of the ABC Pediatrics' detailed financial policy or review it on our website at www.myabcpediatrics.com

PAYMENT POLICY

Payment is expected at the time of service. We accept cash, check, and credit cards- American Express, MasterCard, Visa, and Discover.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers and will file insurance claims on your behalf. CO-PAYMENTS, any ESTIMATED CO-INSURANCE and/or your DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE. Charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore, it is your responsibility to know your benefits. We ask that you contact to your insurance carrier prior to any visit and that you follow-up with your insurance company in the event of any dispute or issues with a claim.

SELF PAY

In the event you do not have insurance coverage, payment is expected in full at the time of service. Payment is expected at the time of service and we offer a prompt pay discount if paid at the time of the visit. We do offer a payment plan for established patients provided you have a positive credit history with ABC Pediatrics and have submitted your request in advance of treatment.

DELINQUENT AND COLLECTION ACCOUNTS

You will receive up to three patient statements for any balances on your account after the insurance payments and adjustments have been applied. Any unpaid delinquent debt (no payment received after 90 days of services rendered), including no-show fees, owed to ABC Pediatrics will be referred to an outside collection service. Failure to pay the balance or failure to abide by approved payment arrangements will have a negative effect on your personal credit report.

You will be responsible for all additional collection agency expenses incurred by ABC Pediatrics in the course of obtaining payment. The collection agency fee is currently 30% of outstanding balance. The family on the account will not be able to schedule visits until the balance is paid in full.

AUTHORIZATION

- I hereby certify that the information I have provided regarding my (child(ren)'s insurance, our address and phone numbers is correct.
- I understand that fees charged are due at the time of service and charges are ultimately my responsibility, regardless of my insurance.
- I hereby authorize ABC Pediatrics to apply for benefits on my (child(ren)'s behalf for covered services rendered. I request payment from my insurance carrier be made directly to ABC Pediatrics.
- I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time by submitting a request to ABC Pediatrics in writing.
- I acknowledge by my signature that I have read and do understand this financial policy and authorization. I also acknowledge that I will be responsible for payment of services, co-pays, co-insurances, deductibles, or non-covered services by my insurance company.

Print Child's Name: ____________________________________Date of Birth __________

Parent/Guardian Signature:____________________ Date__________________________

Revised: October 2020