

PEDIATRIC HEALTH CENTER
AUTHORIZATION FOR USE/RELEASE OF
HEALTH INFORMATION

By signing this form, I authorize Pediatric Health Center to Use, Release or Disclose the Protected Health Information described below:

Name of Person and/or organization to whom information should be sent:

PEDIATRIC HEALTH CENTER
2213-A Exchange Place, Conyers, GA 30013
770-483-4431 Office 770-760-7200 Fax

Please send this information on:

(PATIENT'S NAME AND DATE OF BIRTH)

(ADDRESS)

(TELEPHONE NUMBER)

(DATE)

Purpose of Disclosure: _____

Expiration Date: _____

I authorize the following information to be sent to the above address:

- COPIES OF ALL MEDICAL RECORDS FOR THE PERIOD OF ___ TO ___
 COPIES OF THE INFORMATION DESCRIBED BELOW FOR PERIOD ___ TO ___
 HISTORY & PHYSICAL EXAM. ___ LAB, X-RAY, ETC. REPORTS
 REPORTS FROM OTHER PHYSICIANS
 OTHER (PLEASE SPECIFY) _____

I understand that this information may include a history of AIDS, Sexually Transmitted Diseases, HIV Infection, Behavioral Health Service/Psychiatric Care, Treatment for Alcohol and/or Drug Abuse, or similar conditions..

The following should not be released, even if occurring during dates above:

I understand that there may be information in these records that I would not want released. I have been provided a copy of Pediatric Health Center's "Notice of Privacy Practices" and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my health information with Pediatric Health Center's Privacy Officer or other appropriate office personnel.

I understand that Pediatric Health Center assumes no responsibility for the use or misuse by others of my Health Information disclosed under this authorization. I release Pediatric Health Center from all legal liability that may arise from this authorization.

(PARENT OR LEGAL GUARDIAN'S SIGNATURE AND DATE)

(RELATIONSHIP TO PATIENT)

The patient or their representative may revoke this authorization by notifying in writing Pediatric Health Center's designated privacy officer. Federal Law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the privacy rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to re-disclosure by the recipient.

(PREVIOUS PHYSICIAN)

(ADDRESS)

(TELEPHONE NUMBER)

PEDIATRIC HEALTH CENTER

CONYERS, GEORGIA 30013

MEDICAL HISTORY FOR 1-18 YEARS

PATIENT'S NAME _____ DOB _____
 DRUG ALLERGIES _____ WHO REFERRED? _____
 PREVIOUS PHYSICIAN _____ CITY _____ MAJOR COMPLAINTS LAST 6 MOS:
 ALLERGIES(DRUGS,FOOD,OTHER) _____

FAMILY HISTORY

PLACE AN "X" BESIDE ANY ILLNESS
 THAT ANY BLOOD RELATIVE HAS HAD.
 THIS INCLUDES PARENTS, SIBLINGS,
 GRANDPARENTS, AUNTS, UNCLES, OR
 COUSINS OF THE PATIENT. NA FOR
 NONE KNOWN

<u>CONDITION</u>	<u>RELATIVE</u>	<u>DESCRIPTION</u>
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ALLERGIES		
(hay fever, ETC.)		
BIRTH DEFECTS		

BLOOD DISORDERS		
(anemia, bleeding)		

BONE OR JOINT		
DISEASE		
(arthritis)		

CANCERS OR TUMORS		
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CYSTIC FIBROSIS		
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DIABETES		
(before age 40)		

EARLY CHILDHOOD		
DEATHS		

EYE OR EAR		
DISORDER		

HEART TROUBLE		
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HEART ATTACK		
(before age 60)		

HIGH BLOOD		
PRESSURE		

KIDNEY DISORDER		
(urinary disorders)		

LUNG DISEASE		
(asthma, bronchitis)		

MENTAL		
RETARDATION		

PSYCHIATIC PROBLEMS		
HISTORY OF DRUG ABUSE		

SEIZURES		
TUBERCULOSIS		

SEE HIGH RISK QUESTIONNAIRE

NSE REVIEWING HISTORY _____

DATE: _____

HOW MANY TIMES PER YEAR DOES YOUR CHILD HAVE THE FOLLOWING ILLNESSES:

ASTHMA ___ BRONCHITIS ___ COLDS ___ DIARRHEA ___ EAR INFECTIONS ___

ECZEMA ___ HIVES ___ SEIZURES ___ TONSILLITIS ___ UTI ___ VOMITING ___

SIGNATURE OF PERSON COMPLETING FORM _____ (rev 7/09)

ARE YOUR CHILD'S IMMUNIZATIONS
 UP TO DATE? ___ DID YOU BRING
 ENTIRE HEALTH RECORDS _____

OPERATIONS? _____

ACCIDENTS? _____

HOSPITALIZATIONS? _____

SERIOUS ILLNESSES OR PROBLEMS? _____

CHRONIC DISEASES _____
 (under treatment) _____

CURRENT MEDICATION _____

BEHAVIORAL HISTORY

DEVELOPMENTAL PROBLEMS _____

FEEDING PROBLEMS _____

TEMPER TANTRUMS _____

SUCKS THUMB _____

EXCESSIVE ACTIVITY _____

WETS OR SOILS PANTS _____

SLEEP PROBLEMS _____

NIGHTMARES _____

OVERLY SHY _____

DISCIPLINE PROBLEMS _____

EXPLAIN ANY PROBLEMS ON BACK
OF THIS SHEET

ILLNESS HISTORY (please write in)

PEDIATRIC HEALTH CENTER CONYERS, GEORGIA 30013
MEDICAL HISTORY FOR BIRTH TO 1 YEAR

PATIENT'S NAME _____
DRUG ALLERGIES _____
PREVIOUS PHYSICIAN _____
ADDRESS _____

D.O.B _____
MAJOR COMPLAINTS LAST 6MOS : _____

FAMILY HISTORY

PLACE AN "X" BESIDE ANY ILLNESS
THAT ANY BLOOD RELATIVE HAS HAD.
THIS INCLUDES PARENTS, SIBLINGS,
GRANDPARENTS, AUNTS, UNCLES, OR
COUSINS OF THE PATIENT.

NA IF NONE KNOWN.

CONDITION RELATIVE DESCRIPTION

ALLERGIES _____
(hay fever, ETC) _____
BIRTH DEFECTS _____

BLOOD DISORDERS _____
(anemia, bleeding)

BONE OR JOINT
DISEASE _____
(arthritis)

CANCERS OR TUMORS _____

CYSTIC FIBROSIS _____

DIABETES _____
(before age 40)

EARLY CHILDHOOD

DEATHS _____

EYE OR EAR
DISORDER _____

HEART TROUBLE _____

HEART ATTACK _____
(before age 60)

HIGH BLOOD
PRESSURE _____

KIDNEY DISORDER _____
(urinary disorders)

LUNG DISEASE _____
(asthma, bronchitis)

MENTAL _____

RETARDATION _____

PSYCHIATIC PROBLEMS _____

HISTORY OF DRUG ABUSE _____

SEIZURES _____

TUBERCULOSIS _____

WHO REFERRED? _____

NSE REVIEWING HISTORY _____

DATE _____

SIGNATURE OF PERSON COMPLETING FORM

Rev 6/08

ARE YOUR CHILD'S IMMUNIZATIONS
UP TO DATE? (PLEASE PROVIDE
SHOT RECORD) _____

Did you bring records/complete rec req? _____
OPERATIONS? _____

ACCIDENTS? _____

HOSPITALIZATIONS? _____

SERIOUS ILLNESSES OR PROBLEMS? _____

CHRONIC DISEASES _____
(under treatment) _____

CURRENT MEDICATION _____

BIRTH HISTORY

DID WE SEE YOUR BABY
IN THE HOSPITAL? YES ___ NO ___

NAME OF HOSPITAL _____

LENGTH OF PREGNANCY _____

DELIVERY TYPE _____

(vaginal or c-section)

PROBLEMS DURING PREGNANCY OR
DELIVERY _____

LENGTH OF LABOR _____ hrs.

CONDITON AT BIRTH

WEIGHT _____ LENGTH _____

PROBLEMS AT DELIVERY _____

TROUBLE BREATHING _____

BIRTH DEFECTS? _____

PROBLEMS IN NURSERY _____

JAUNDICE _____ THERAPY _____

BREAST FED ? _____ FORMULA? _____

FORMULA BRAND _____

HEARING SCREEN ___ P ___ F

PKU RESULTS ___ Y ___ N

PEDIATRIC HEALTH CENTER
2213 A EXCHANGE PLACE
CONYERS, GA 30013
770-483-4431

PATIENT NAME _____ SEX _____ DOB _____
(FIRST) (MIDDLE) (LAST)
NAME YOU CALL YOUR CHILD _____

FATHER'S NAME _____ DATE OF BIRTH _____
S.S.# _____ EMPLOYER _____ OCCUPATION _____
EMP. ADDRESS _____ EMP. PHONE _____
CITY _____ STATE _____ ZIP CODE _____ PGR/CELL # _____

HOME ADDRESS _____ HOME PHONE # _____
CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

MOTHER'S NAME _____ DATE OF BIRTH _____
S.S.# _____ EMPLOYER _____ OCCUPATION _____
EMPLOYEE ADDRESS _____ EMP. PHONE _____
CITY _____ STATE _____ ZIP CODE _____ PGR/CELL# _____

HOME ADDRESS _____ HOME PHONE _____
CITY _____ COUNTY _____ STATE _____ ZIP CODE _____
EMAIL ADDRESS _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone other than parent):
NAME _____ RELATIONSHIP _____ PHONE# _____

INSURANCE INFORMATION

1. INSURANCE COMPANY _____ GROUP# _____
INSURED'S NAME _____ I.D.# _____
DATE OF BIRTH _____ IS THIS INS. THROUGH YOUR EMPLOYER? _____
2. INSURANCE COMPANY _____ GROUP# _____
INSURED'S NAME _____ I.D.# _____
DATE OF BIRTH _____ IS THIS INS. THROUGH YOUR EMPLOYER? _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC HEALTH CENTER OF ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, FOR HIS SERVICES PROVIDED FOR MY CHILD WHICH YOUR OFFICE MAY FILE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION. I UNDERSTAND THAT IF A BALANCE ON THIS ACCOUNT IS UNPAID AFTER THIRTY (30) DAYS ON OFFICE VISITS OR SIXTY (60) DAYS ON HOSPITAL CHARGES, I AM RESPONSIBLE FOR ALL COLLECTION FEES INCURRED IN ORDER TO COLLECT THE BALANCE. ALL OFFICE VISITS AND SERVICES ARE DUE AND PAYABLE AT TIME OF SERVICE, UNLESS, OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR VISIT. I UNDERSTAND THAT ALL CONTRACTED INSURANCE CLAIMS WILL BE FILED, BUT THE GUARANTOR IS ULTIMATELY RESPONSIBLE FOR ALL FEES INCURRED. I HEREBY AUTHORIZE RELEASE OF ANY RECORDS/ INFO FROM PREVIOUS AND REF HOSPITALS/PROVIDERS TO PHC NECESSARY FOR MEDICAL TREATMENT OR TO PROCESS ANY CLAIMS FILED ON MY CHILD'S BEHALF.

SIGNATURE _____ DATE _____
PARENT OR LEGAL GUARDIAN

Pediatric Health Center
2213 A Exchange Place
Conyers, Georgia 30013
770-483-4431

PLEASE BE ADVISED THAT IF ANYONE OTHER THAN THE PARENTS WILL BE BRINGING YOUR CHILD _____ TO THE DOCTOR FOR EXAMINATION, IMMUNIZATIONS OR LAB TEST, THEY MUST BE LISTED BELOW THAT THEY HAVE YOUR PERMISSION TO DO SO:

<u>Name</u>	<u>Relationship</u>	<u>Phone #</u>
1. _____		
2. _____		
3. _____		
4. _____		

SIGNATURE OF PARENT/GUARDIAN

DATE

Appointment and Financial Policy Pediatric Health Center

Purpose: This policy will govern our scheduling and cancellation of appointments. We hope this will eliminate scheduling issues and limit the wait time in our office.

- We pride ourselves in our 30 minute waiting room time. We accomplish this by proper staffing, timely scheduling, and organization.
- If your wait time is longer and we are not verifying insurance or there is no apparent reason, such as an emergency, please remind our patient coordinator how long you have been waiting.
- Since we work by **APPOINTMENTS ONLY**, notice must be given in advance to cancel an appointment in order for it not to be considered a "No Show".
- A \$40.00 office charge fee will be billed to you if you "**no show**" as explained above. If you are insured through by Peachcare, Medicaid or CMO, you must cancel timely or you will be given a warning. After 3 or more "no shows" you may be asked to find another pediatrician.
- We reserve the right to charge for after hours phone calls if it pertains to a new illness
- You will be notified by phone or mail and we will attempt to reschedule at your convenience. A patient **arriving late** will be seen after all other scheduled appointments, or if extremely late, you will be **rescheduled** to another day. Our Appointment Scheduler verifies all appointments the day before a previously scheduled appointment. If no contact is made, your appointment may be rescheduled.
- Occasionally, when a checkup is scheduled, the patient will also be sick. We reserve the right to charge for a brief sick visit if there is need to spend extra time. You, of course, have the right to be seen for the sick visit only and/or reschedule the checkup. The doctor recommends this for all complex illnesses.
- All co-pays are paid and any other fees for which you are responsible are paid at check out on the same day as service unless other arrangements have been made prior to the visit. There is a **\$25 fee** for all **returned checks**.

Thank you in advance for your consideration and understanding.

PEDIATRIC HEALTH CENTER MANAGEMENT

Parent's Signature

I have read the above and fully understand the policy.

Date

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PHI**

PEDIATRIC HEALTH CENTER
2213-A EXCHANGE PLACE CONYERS, GA 30013

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- . Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- . Obtain payment from third-party payers.
- . Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

With my consent, Pediatric Health Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my child's clinical care including laboratory results among others.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name

Relationship to Patient:

Signature:

Date:

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:

Initials:

Reason:

Pediatric Health Center of Conyers, PC
Aaron S. Goldberg, M.D.
Nazneen S. Desai, M.D.
Crystal B. Hood, M.D.
Kenneth Chen M.D.
2213 A Exchange Place
Conyers, Georgia 30013
770-483-4431
770-760-7200 fax
www.pediatrichealthcenter.com

Dear Family,

Welcome to our practice. We are excited about the opportunity to care for your children. To provide excellent medical care, our practice requires previous medical records and a thorough medical history. Please complete the necessary forms and return to our office prior to your first visit. This will make your first visit less stressful and time-consuming. Please visit our website for additional information and familiarizing yourself with our staff.

If you need assistance completing these forms, please feel free to call our patient coordinator, Aimee Sellars (aimees@pediatrichealthcenter.com) or our nursing staff with any medical questions. You may contact our office manager Sheldon Stewart for any issues you may have with the office staff or insurance questions.

As a reminder, please mail or fax the record request to your previous physician immediately because of the processing time. If you already have your child's records, please bring prior to the visit.

For your convenience, we have a contagious entrance for all patients with illnesses (fevers, rashes, chickenpox, colds, etc). The only exception is if your newborn is 4 months old or less, please enter the Well Entrance. Our patient coordinator will assist you with registering and information changes. Please remember that we pride ourselves in servicing all of our very sick patients the day they call, so if your wait is a little longer, it is because our doctors are being very thorough to diagnosis properly. If you wait more than 30 minutes in the waiting room, please ask our coordinator for an explanation. When leaving the office, please exit the door marked Exit, do not exit through waiting room areas.

Thank you very much for choosing our practice. We are extremely confident in our medical staff and look forward to developing a relationship with your family.

Sincerely,

PEDIATRIC HEALTH CENTER STAFF

(Rev 09/09)

PEDIATRIC HEALTH CENTER
2213 A Exchange Place
Conyers, Georgia 30013
770-483-4431 www.pediatrichealthcenter.com

CHECKUPS, IMMUNIZATIONS AND LAB
(Please Save for Reference)

CHECKUP AGE:	Please give Tylenol prior to visit if immunizations due
	PHYSICAL EXAM DONE ON EACH VISIT
1- Week.....	PKU AND HEP B DONE IN HOSPITAL
2 Weeks	Physical exam only/Educational materials
1 Month	Hepatitis B
2 Months.....	Pentacel(dpta,hib,ipv), Rotateq/Rotarix, Prevnar
4 Months.....	Pentacel, Rotateq/Rotarix, Prevnar
6 Months.....	Pentacel, Rotateq, Prevnar
9 Months.....	HEP B
12 Months.....	Prevnar, MMR, VZV , Lead Screen, (CBC)
15 Months.....	Pentacel, ,CBC, 3RD HEP B IF NEEDED
18 Months.....	Hepatitis A, or 5th Prevnar (if needed)
2 Years.....	Physical Exam, Hep A, Lead Screen
30 Month.....	Physical Examination
3 Years.....	Cholesterol
4 Years.....	IPV, DPTA, MMR, VZV, , Vision/Hearing
5 Years.....	Exam Only (Labs if indicated), Vision/Hearing
6 Years and every 2yrs after	Exam, updating immun/lab if indicated, Vision/Hearing 8, 10 yrs
11-14 Years.....	Tdap, Menactra, Gardasil Hep A, 2nd VZV for those who missed it Hearing at 12, 15, 18 years
THEREAFTER.....	TD Booster every 10yrs (5yrs if injury) Pneumovac if highrisk

Immunizations are covered under the VFC program if you have no or limited insurance coverage. Please inquire if you qualify. (rev 10/10)