Patient's Name: ______________________________ Date of Birth: __________

Last First Middle

Male: _____ Female: _____ **Patient's Social Security Number:** _____-____-_____

Home Address: ________________________________

City: ______________ **State:** _______ **Zip Code:** __________

Home Phone: ______________ **Cell Phone:** ______________

Email Address: ______________________

Preferred Billing Method: Email or Mail

Race (Circle One): Black/White/Hispanic/Asian/Indian **Ethnicity**(Circle One): Hispanic or non-hispanic

Primary Language (Circle One): English, Spanish, Other: ________

Siblings: Name: ______________ Date of Birth: __________

Name: ______________ Date of Birth: __________

Father: ________________ Date of Birth: __________ Social Security Number: _____-_____-_____

Father's Employer: ________________ Work Phone: ______________

Mother: ________________ Date of Birth: __________ Social Security Number: _____-_____-_____

Mother's Employer: ________________ Work Phone: ______________

Emergency Contact: __________ Contact Phone Number: __________ Relationship to Patient: __________

Primary Insurance Company: ________________ Employer: ______________

ID #: ______________ *Group #:* ______________

Subscriber's Name: ______________ Date of Birth: ______________

Subscriber's Social Security Number: ____-____-____ Subscriber's Phone Number: __________

Subscriber's Address: ______________ City: __________ State: _____ Zip Code: __________

Secondary Insurance Company: ________________ Employer: ______________

ID #: ______________ *Group #:* ______________

Subscriber's Name: ______________ Date of Birth: ______________

Subscriber's Social Security Number: ____-____-____ Subscriber's Phone Number: __________

Subscriber's Address: ______________ City: __________ State: _____ Zip Code: __________

Please Circle Your Primary Provider:

Tift, MD Kacsoh, MD Smith, MD Slade, MD Payne, MD

Cowley, MD Waters, MD R. Ford, MD J. Ford, MD Kinnebrew, MD Milner, CPNP

If your child's primary care physician is not in our practice, please write in the doctor's name. ______________

Lab Waiver

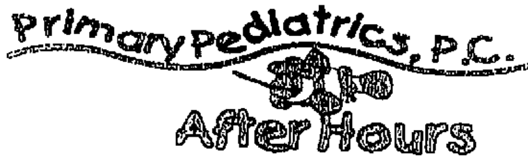
Certain lab specimens are sent to outside labs for processing. We will send the specimen to the laboratory that participates with your insurance carrier, to the best of our knowledge. If your specimen is sent to the wrong lab, Primary Pediatrics, P.C. will not be responsible for any fees incurred for processing. It is your responsibility to know your insurance policy and the facilities with which they are contracted. Please circle your lab below. If it is not listed, please write it in.

Quest Lab Corp Lab One Medical Center Other: __________

I attest that all information on this form is accurate to the best of my knowledge. I acknowledge I am responsible for any discrepancies.

Date: __________ **Guardian's Name:** ________________ **Guardian's Signature:** ______________

(Please Print)



Patient's Full Name: ____________

Date of Birth: ____/____/____

Authorization for Treatment

I, the undersigned certify that I (or my dependent) have insurance coverage as listed herein (assign directly to Primary Pediatrics, P.C. I understand that I am financially responsible for (charges whether or not paid by insurance. I remain responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by insurance within 30 days hereby authorize Primary Pediatrics, P.C. to release all information necessary to secure payme of benefits. I authorize the use of this signature for all insurance claims.

IF I AM NOT AVAILABLE, THE FOLLOWING PERSON(S) ARE AUTHORIZED TO SEEK TREATMENT FOR THE ABOVE REFERENCED PATIENT:

(The names listed below are the only people who will be able to bring your child to see the docto A photo i.d. will be required the day of service for identification purposes.)

Name: ____________ Relationship: ____________ Phone Number: ____________
Name: ____________ Relationship: ____________ Phone Number: ____________
Name: ____________ Relationship: ____________ Phone Number: ____________
Name: ____________ Relationship: ____________ Phone Number: ____________
Name: ____________ Relationship: ____________ Phone Number: ____________

Consent for Treatment

Having voluntarily presented myself (or my dependent) to Primary Pediatrics, P.C., I acknowledg ecognition of the fact that the evaluation and treatment received, advised or deemed necessar is entrusted to the judgment of the Physician.

Acknowledgement of Privacy Notice (HIPAA)

&

Disclosure of Information

By signing this form, you acknowledge that Primary Pediatrics, P.C., has informed you of its Privacy Notice, which explains how your health information will be handled in various situations. We at Primary Pediatrics, P.C., value, and do everything in our power to protect, your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant others) without your written consent.

(Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Date: ________ Guardian's Name: ____________ Guardian's Signature: ____________
(Please Print)

Primary Pediatrics, P.C.

Patient's Nam

Date of Birth

ACKNOWLEDGEMENT FORM

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

By signing this form, you acknowledge that you have been offered a printed copy of the *Notice of Privacy Practices* by Primary Pediatrics, P.C.. This *Notice of Privacy Practices* is for the purpose of providing you the information about how Primary Pediatrics, P.C. may use and disclose your protected health information. It is recommended that you read the *Notice of Privacy Practices* carefully. Primary Pediatrics, P.C. reserves the right to revise and materially change the contents of its *Notice of Privacy Practices*. To obtain the most current version of Primary Pediatrics, P.C.'s *Notice of Privacy Practices*, you may visit our website at www.PrimaryPediatrics.com or by contacting our office at any time.

I acknowledge that I have been offered a printed copy of the *Notice of Privacy Practices* of Primary Pediatrics, P.C.

Signature: ______________________________ Date: ______________________

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of provider representative: ______________________ Date: ______________

Reasons why acknowledgment was not obtained:

Patient Refused to Sign: __________

Other and/or Comments:

____

____

____

____

____

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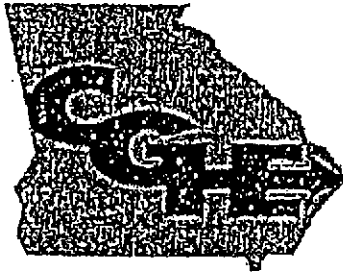

CENTRAL GEORGIA HEALTH EXCHANGE

Patient's Full Nam

____

Date of Birt

___/___/_

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Informati with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to sh your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record progr (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this docume and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record

☐ No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record

______________________ ______________________ ______________

Printed Name of Patient/Representative *Signature of Patient/Representative* *Date*

AUTHORITY OF REPRESENTATIVE:

I, ______________________, do hereby state that I am authorized to sign this permission on beha of the patient on the following basis (Relationship to Patient): ______________________

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared wit other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) an CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job i is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient ntake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

nformation disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and ecurity of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and isclosures: clinical care; obtaining reimbursement for health care services; ; for administrative functions related to the provision of and payment for care; uality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

ou can learn more about the *Central Georgia Health Exchange* by reading the information booklet, Guide To The Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

nderstand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Heath Exchange, 777 Hemlock Street, Hospital ox 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. is permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

nderstand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I ve refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) ough the *Central Georgia Health Exchange*.

o

New Patient Visit

Child's Name: ______________________ Parents: ______________________

What brings you in today? ______________________

Birth History: Weight______________, APGARS______________

Delivery Method: Vaginal or C-section Length of Pregnancy: ___________weeks

Pregnancy or Delivery Complications: ______________

Was the child in the ICU after birth?________, if yes, why______________________

Was there an oxygen requirement at birth?______________________

Past Medical History: ______________________

Surgical History: ______________________

Past Hospitalizations: ______________________

Current Medications: ______________________

Do you prefer tablets or liquid medication (if available)?______________________

What medical problems run in the family?______________________

Who lives in the house with your child?______________________

What grade is your child in?______ What school does s/he attend?______________________

Does your child have an IEP or 504 plan?______________.

Review of Systems: Does your child experience any of the following?

Headaches: yes/no
sleep problems: yes/no
nose bleeds: yes/no
muscle pain: yes/no
learning problems: yes/no

blurry vision: yes/no
excessive thirst: yes/no
sinus pain: yes/no
change in vision: yes/no

weight gain: yes/no
Hearing trouble: yes/no
Seizures: yes/no
Attention difficulty: yes/no

Fatigue: yes/no

Allergies yes/no