MR#_____
CO-PAY_____

PEDIATRIC ACUTE CARE OF COLUMBUS, P.C.
5555 WHITTLESEY BLVD SUITE L1

PATIENT INFORMATION

Name (must be as it appears on policy): _____
Home Phone # _____Cell #_____
Date of Birth: _____Sex: Male/Female
Mailing Address: _____
City: _____ State: _____ Zip: _____
Pediatrician: _____ Complaint: _____
Allergies:_____

INSURANCE INFORMATION

Insurance Co. Name: _____
Insured ID #: _____Group_____
Policyholder's Name: _____ Date of Birth: _____
Employer: _____ Work # _____
Soc. Sec #: _____ Relationship to Pt: _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____
Insured ID #: _____Group_____
Policyholder's Name: _____ Date of Birth: _____
Employer: _____ Work # _____
Soc. Sec #: _____ Relationship to Pt: _____

PARENT/GUARDIAN

Name: _____Phone # _____
Date of Birth:_____ Soc. Sec. #_____
Mailing Address (If different from above) _____
City: _____ State: _____ Zip: _____

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISIT BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collection, the collection fees and/or legal fees shall be your responsibility. I herby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I herby authorize said assignee to release all information necessary to secure the payment, via Fax Transmittal or hard copy.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

In the course of doing business, we gather and maintain PHI (Patient Health Information) about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This Notice describes our privacy practices and how we protect the confidentiality of your PHI. We are obligated to maintain the privacy of your PHI by implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this Notice about our legal obligations to maintain the privacy of your PHI. We must comply with this Notice and any changes made to this Notice.

Treatment; Payment; Health Care Operations

Federal and state law allows us to use and disclose your PHI in order to provide health care services to you, as well as to bill and collect payments for the health care services provided to you by us. For example, we may use your PHI to authorize referrals to specialists. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you.

We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer, or to contact you to remind you of your appointments. We conduct these activities to provide health care to you, and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use your PHI in connection with population-based disease management programs. We may use your PHI to perform certain business functions and disclose your PHI to our business associates, who must also agree to safeguard your PHI as required by law.

Authorizations

All other uses and disclosures of your PHI must be made with your written authorization.

If you need an authorization form, we will send you one for you or your personal representative to complete. When you receive the form, please fill it out and send it to the following address:

Pediatric Acute Care of Columbus, P.C.
5555 Whittlesy Blvd, L1
Columbus, GA 31909

You may revoke or modify your authorization at any time by writing to us at the same address. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

Please sign below.

Signature_____ Date_____

Filing Insurance Claims
Notification of Patient Responsibility

As a courtesy to our patients, we file charges to your insurance so that you do not have to. In order for us to accomplish this successfully we must obtain correct information regarding name, date of birth, and insurance policy.

In the event we are provided incorrect information the claim will be rejected by your insurance carrier. Rather than going to the time and expense of determining the correct information we will bill you, leaving you to file your claim with your insurance company.

To make the process of reimbursement as simple and quick as possible, it is essential that you provide us with correct data, and that you update any corrections to your demographics (contact info, address, employment, policy changes, etc.).

Please initial the following:

_____I've provided the requested demographic information (date of birth, name as it appears with your insurance plan, etc.) and I hereby verify that it is correct.

_____I understand that if I've provided incorrect information and my claim is rejected then I will be billed by Pediatric Acute Care immediately and that payment will be expected promptly.

_____I understand that if my claim is rejected due to my failure to provide correct and updated demographic information then I will be responsible for filing my own claim with my insurance carrier.

_____If I'm an existing patient, I've made the staff at Pediatric Acute Care aware of any changes to my insurance health plan.

_____Because Pediatric Acute Care is an afterhours clinic, I realize that it is not usually possible to verify my benefits and that my co-pay and deductible can't always be determined. I understand that Pediatric Acute Care will collect the least amount possible and that I may be billed if my deductible hasn't been met or if my co-pay is higher than the amount determined during the visit.

*To be filed with patient chart.

PEDIATRIC ACUTE CARE

of COLUMBUS, GA

CHECK-IN/REVIEW of SYSTEMS FORM

PATIENT'S NAME: _____ ROOM: _____
PATIENT'S DOB: _____
ADDRESS: _____CITY:_____STATE:_____ZIP:_____
PHONE: _____RELATIONSHIP TO PT: _____
E-MAIL: _____
DATE OF VISIT: _____HOW DID YOU HEAR ABOUT US? _____

IN ORDER TO SERVE YOU BETTER, PLEASE COMPLETE THIS FORM FOR OUR STAFF. CIRCLE ANY SYMPTOMS YOUR CHILD MAY BE EXPERIENCING TODAY. IF YOUR CHILD HAS A SYMPTOM OR PROBLEM NOT LISTED, PLEASE ADD THIS INFORMATION IN THE SPACE PROVIDED.

CONSTITUTIONAL: Fever / Decreased Appetite / Decreased Fluids / Decreased Activity

EYES: Pink Eye(s)/ Clear Discharge / Mucous Discharge / Pus Discharge / Pain / Itching / Swollen

EARS, NOSE and THROAT: Ear Pain / Congestion / Runny Nose / Sore Throat / Teething /

CHEST: Chest Pain / Fainting / Heart Flutter

RESPIRATORY: Wheezing / Shortness of Breath / Chest Pain / Cough / Croup

GASTROINTESTINAL: Nausea / Vomiting / Diarrhea / Stomach Pain / Spitting up or Reflux / Constipation / Blood in Stool

GENITOURINARY: Diaper Rash / Painful Urination / Frequent Urination / Decreased Urination / Discharge / Scrotal Pain or Swelling / Genital Swelling

SKIN: Rash / Itching / Sores / Dryness or Eczema / Welts/ Burns / Animal Bite / Injury or Cut?
Where: _____ When: _____

NEUROLOGIC: Headache / Seizures / Head Injury / Loss of Consciousness

MUSCULOSKELETAL: Aching or Soreness / Injury? Where: _____ When: _____

ENDOCRINE/GLANDS: Weight Gain / Weight Loss / Other_____

PSYCHIATRIC:*Please List Psychiatric Symptoms your child has today*:

BLOOD/LYMPHATIC: Swelling / Bruising / Bleeding (chronic)

ALLERGY/IMMUNOLOGY: Welt or Raised Itchy Area (wheals) / Itching Eyes or Congestion

DOES YOUR CHILD HAVE *ANY* OTHER COMPLAINTS NOT LISTED OR DESCRIBED ABOVE?

PARENT/GUARDIAN's SIGNATURE: _____ DATE: _____
(PLEASE Show Photo ID to Front Desk)

******BELOW FOR OFFICE USE ONLY******

CC	VITAL SIGNS	PMHx
	TEMP:	
	PULSE:	
		FMHx
MEDICATIONS	***RESP:*** ***O2%:***	
	B/P:	
ALLERGIES		**SHx**
	WT (kg):	