VILLAGE PEDIATRICS
AT VICKERY

Patient Information

First Name: _____Middle Name: _____Last Name: _____

DOB:__/_____/_____ Sex: M / F Preferred Language: _____

Address:_____

City/State/Zip_____

Race: ☐African American ☐Asian ☐Caucasian ☐Hawaiian or Pacific Islander
☐Native Indian/Native Alaskan ☐Other ☐Decline
Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐ Unknown ☐Decline

Parent/Guardian Information

Child(ren)'s parents are: ☐Married ☐Divorced ☐Never Married ☐Separated ☐Widow(er) ☐Other

Parent/Legal Guardian #1:

Name:_____ Relationship to Patient:_____

DOB:_____/_____/_____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Best Contact Number is: ☐Home ☐Cell ☐Work
Village Pediatrics at Vickery may leave messages/lab results via: ☐Home ☐Cell ☐Work ☐Email

Parent/Legal Guardian #2:

Name:_____ Relationship to Patient:_____

DOB:_____/_____/_____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Best Contact Number is: ☐Home ☐Cell ☐Work
Village Pediatrics at Vickery may leave messages/lab results via: ☐Home ☐Cell ☐Work ☐Email

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Custodial Information

If parents are not legally married, which parent has legal custody of child: _____

*Please note, only the parent/guardian with custodial rights may consent to medical treatment and request medical records
*If there are legal documents that allow non-custodial parent to consent to medical treatment and/or request medical records, please provide that documentation to our office and sign/date below

_____ (Name)

_____ (Signature)

_____ (Date)

Billing Information

Name of Parent/Guardian to receive billing statements: _____

Address if different than Patient Address: _____

_____

_____

If a copy of your child's insurance card is on file with our office, you do not have to enter information here:

Insurance Company: _____

Guarantor: _____

Group Number: _____

Member ID Number: _____

Emergency Contacts

(please do not list Parents/Guardian)

1. Name: _____Relationship to Patient: _____

Best Contact Phone Number: _____

2. Name: _____Relationship to Patient: _____

Best Contact Phone Number: _____

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Authorization for Alternate Consent

Please list up to five (5) people that you authorize to bring your child (ren) to appointments and to make medical decisions about care received while in the office. These people must show legal identification with their name appearing exactly as written below. These people may not request medical records or make decisions about chronic conditions without written consent from the parents/guardians. These people are usually caretakers or family members who can bring your child (ren) in when you are unavailable.

1. Name: _____Relationship to Patient: _____

2. Name: _____Relationship to Patient: _____

3. Name: _____Relationship to Patient: _____

4. Name: _____Relationship to Patient: _____

5. Name: _____Relationship to Patient: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Miscellaneous

We are so excited you have joined our Village. We are a small office with a dedicated team of expert caregivers. If there's ever anything we can do to make caring for your child easier, please let us know!

Tell us how you heard about us: _____

_____

_____

_____

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Health History Form

Child's Name: _____ Date of Birth: _____/_____/_____

Preferred Name: _____Age: _____ Gender: _____

Your Name: _____ Relationship to Child: _____

Birth History

Birth Hospital:_____ City/State: _____

Is the child yours by: ☐Birth ☐ Adoption ☐ Stepchild ☐ Foster ☐ Other _____

Length of Pregnancy: _____ weeks Pregnancy Complications: _____

Type of Delivery: ☐ Vaginal ☐ C-Section If C-Section, reason for C-Section: _____

Birth Complications: ☐ No ☐ Yes If yes, what kind: _____

Time Spent in NICU ☐ No ☐ Yes If yes, how long: _____

Birth Weight: _____ Birth Length: _____

Any Birth Defects or Diagnoses (ex: Down Syndrome, Murmurs, Extra Digits etc): ☐ No ☐ Yes If Yes, please explain below:

_____

_____

Developmental History

Does your child have (or had) any developmental delays: ☐ No ☐ Yes If Yes, please explain below:

_____

_____

Does your child have any developmental/learning diagnoses (ex: Autism, Dyslexia, SPD etc) ☐ No ☐ Yes If Yes, please explain below:

_____

_____

_____

_____

_____

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Social History

Who lives in the home with the child:

Name	Age	Relationship to Child

Is your child exposed to any second-hand smoke in the house? ☐ No ☐ Yes

Does your child attend a daycare or school? ☐ No ☐ Yes If Yes, name of school: _____

Grade (if applicable): _____ Any concerns at school: _____

Allergies

Does your child have any allergies? ☐ No ☐ Yes If Yes, please list below:

_____

_____

Medications

Does your child take any medications? ☐ No ☐ Yes If Yes, please list below:

Name	Indication/Reason for Medication

Past Medical History

Has your child been diagnosed with any medical conditions? ☐ No ☐ Yes If Yes, please list below:

Diagnosis	Age at Diagnosis

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Past Surgical History

Has your child ever had surgery? ☐ No ☐ Yes If Yes, please list below:

Type of Surgery	Age at Surgery	Complications (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Partners in Care

Does your child see any other specialists or therapists regularly? ☐ No ☐ Yes If Yes, please list below:

Name of Provider	Name of Group	Reason for Care
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do we have your permission to communicate directly with those partners listed below to provide comprehensive care for your child?

☐ No ☐ Yes If No, please explain:_____

Family Medical History

Are there any significant medical diagnoses in your child's family(parents/sibling/grandparents)? ☐ No ☐ Yes

If Yes, please list below:

Diagnosis	Age at Onset	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Person Completing Form:

_____

Signature of Person Completing Form:

_____**Date:** _____/_____/_____

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Annual Immunization Consent/Refusal Form

Child's Name:_____ Date of Birth: _____/_____/_____

Person Completing Form: _____ Relationship to Child: _____

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. I will be given the Vaccine Information Statement (VIS) for each vaccine and 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 doctor or nurse, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the need for the recommended vaccine(s)
- The **risks and benefits** of the 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 doctor (s) and nurse (s), the American Academy of Pediatrics, 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 recommended immunizations as per Village Pediatrics at Vickery's 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 form represents consent for all vaccinations unless otherwise indicated.

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.

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I consent to Village Pediatrics at Vickery, through its agents or employees, including my child's doctor(s) and nurse(s) administering the recommended immunizations per the agreed upon schedule. I release Village Pediatrics at Vickery and its agents and employees from any and all liabilities in connection with the vaccines and the administration to my child. I acknowledge that no guarantee or assurance has been made to me concerning the results that may be obtained from the administration of the vaccines.

VILLAGE PEDIATRICS AT VICKERY, BY ADMINISTERING THE VACCINES TO MY CHILD PROVIDES NO WARRANTY WITH RESPECT TO THE VACCINES AND SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE CONCERNING THE VACCINES.

Georgia law requires health care providers to report all vaccinations to the Georgia Registry of Immunization Transactions and Services (GRITS). Patients are deemed to consent to reporting unless they have submitted a written request to "opt out" to the Georgia Department of Public Health.

☐ I represent that I have filed an "opt out" request with the Georgia Department of Public Health

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

☐ **Consent:**

I hereby agree and consent to allowing Village Pediatrics at Vickery to vaccinate my child per the recommended schedule or a modified schedule discussed with the physician.

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date: _____/_____/_____

☐ **Refusal:**

I hereby refuse vaccinations for my child. I understand all the risks and take full responsibility for any and all potential consequences of my decision. I release Village Pediatrics at Vickery of any liability related to my refusal. **I also understand that while vaccinations may not be mandatory, following the AAP schedule for well checks is. The core of overall health and development is preventative care and we will not see patients on a sick basis only.**

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date: _____/_____/_____

For Office Use Only:

Witness Name:_____

Witness Signature:_____ Date: _____/_____/_____

VILLAGE PEDIATRICS
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Assignment of Benefits

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Village Pediatrics at Vickery is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Village Pediatrics at Vickery for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Village Pediatrics at Vickery to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Village Pediatrics at Vickery on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general and health-related information about you. We have a Notice of Privacy Practices that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Copies are available on our website, in the waiting room, and personal copies can be requested from our staff. By signing below you are only acknowledging that you were offered or received a copy of the **Notice of Privacy Practices**. You may refuse to sign this acknowledgment if you wish. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment:

I acknowledge that Village Pediatrics at Vickery has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: **Privacy Officer [Chandra Ross, 678-990-3362].** I also understand that I am entitled to receive updates upon request if changes are made to this policy.

_____ _____
Signature of Patient or Parent/Guardian Date

_____ _____
Printed name of Patient or Parent/Guardian Relationship to Patient

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For OFFICE USE ONLY

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (Specify): _____

_____ _____
Name and Title of Employee Date

VILLAGE PEDIATRICS
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Financial Policy

Village Pediatrics at Vickery participates with most insurance plans however it is important to contact your insurance company if you have questions regarding your benefits and for you to know what your payment obligations will be at the time of service. We follow the American Academy of Pediatrics recommendations for all screenings at well visits. Not all insurance companies pay for these screenings even though they are part of a well visit. It is imperative for you to know your coverage benefits as it is impossible for us to determine what each policy does and does not cover.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are to be made at the time of service. Please note that the copayment is a contractual requirement from the insurance company and cannot be waived. Also, please be aware that a lot of insurance companies now offer cheaper plans with a High Deductible and if you have not yet met your deductible in full, it is likely that services (both preventative and non-preventative) may be applied to your deductible. Patient balances are billed on the 5th of each month. Your remittance is due by the end of the month. Any outstanding account balance will be paid with the credit card on file (see below). If there is no contact made to the office about a payment plan and credit card is declined, the account will be charged a $30 re-bill fee for each monthly cycle.

Collection Accounts

When an account remains unpaid after 90 days, we reserve the right to refer the account to an outside collection agency. If this happens, there will be a 50% surcharge added to your balance. We reserve the right to reschedule or deny any future appointments for delinquent accounts.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. Payment in full for all services rendered is due at time of service.

No-Show/Late Arrival Fee

Missing an appointment or coming late to an appointment deprives other patients of the chance to make an appointment in your time slot. Failure to provide 24 business hour notice of cancellation or arriving more than 10 minutes past your appointment time will result in a fee of $50. More than two (2) no-show or late arrivals can result in dismissal from the practice.

Form Fee

Annual physical exam forms completed at the time of your visit are filled out **free of charge**; any other forms or annual physical exam forms requested outside of your visit will incur a $25 charge per form. Examples of these forms: Sports participation forms, Immunization (form 3231), Hearing/vision (form 3300), 504 plans, Asthma/Allergy/Seizure Action Plans, & School Medication forms. We require payment prior to completion of the form(s) (this fee is **not** billed to insurance) and 48 hours to complete the forms.

Credit Card on File Policy

Village Pediatrics at Vickery requires that a valid Credit Card be kept on file. The policy allows us to streamline our billing process and to allow us to bill for TeleMedicine and Drive-Up Services when you are not in the office. The card information is stored electronically in an encrypted form & cannot be viewed by our office staff. How the policy works:
1. At the time of your registration or check-in, you will be asked for your credit card information to be electronically stored in encrypted form in our computer. Only the last four digits are visible to our staff. 2. We will bill your insurance carrier for all charges related to the visit. 3. When we receive an explanation of benefits (EOB) form your insurance, we will send you a statement on the 5th of the following month. If we have not received payment by month end, we will charge the credit card on file for the balance due. Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, please contact our office ASAP.

I have reviewed Village Pediatrics at Vickery's Financial and Credit Card on File Policies. I agree to provide my credit card information to Village Pediatrics at Vickery for the sole purpose of payment for my child(ren)'s medical care. I have the right to cancel this card and use another form of payment at any time.

Signature	Date
Print name as it appears on your credit card	Phone number of cardholder

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Credit Card on File

Until further notice, I _____ authorize Village Pediatrics at Vickery to charge the patient-responsible balances on my account to the following credit card. **I understand that my card will NOT be billed unless my account is past due.** I will still receive a monthly billing statement and may choose to pay the balance in any other way. If however, the statement remains unpaid, the balance will be charged to the credit card on file.

Credit Card #:
_____

Expiration date (mm/yy): _____

Security code: _____

Card type (circle one): Master Card Visa Discover American Express

*Once this information is recorded into our system, this piece of paper will be shredded. The card information is stored electronically in an encrypted form and cannot be viewed by our office staff.

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Authorization for Release of Medical Information

Patient Name: _____ DOB: _____/_____/_____

I, _____(Parent/Guardian) hereby authorize the release of medical information for continuation of care

TO:
Village Pediatrics at Vickery
7165 Colfax Avenue
Cumming, GA 30040
P: 678) 990-3362 F: 678) 341-9212
Please mail records to address listed above or email to: admin@villagepedsatvickery.com

FROM:
Name of Facility: _____

Address: _____

Address: _____

Phone:_____ Fax:_____

Please release the following information:
___ All health information
___ Growth Chart and Vaccination Record only
___ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until it is revoked in writing.

Signature: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____