



Prenatal Patient Information

Patient Number

Pediatric Adolescent Surgical Associates, P.C. 5455 Meridian Mark Road . Suite 570 Atlanta . GA 30342

404.252.3353 FAX 404.252.0645

Patient's Legal Name _____ Race _____
First _____ Middle _____ Last _____

Date of Birth _____ Patient's SS# _____ - _____ - _____
Month _____ Day _____ Year _____ Marital Status Married Single
check one

Home Address _____ Home Phone _____ - _____ - _____
Street _____ Apt # _____
City _____ State _____ Zip Code _____
Cell Phone _____ - _____ - _____

Employer _____ Occupation _____ Work Phone _____ - _____ - _____

Address _____
Street _____ Suite # _____ City _____ State _____ Zip Code _____

Husband/Partner's Name _____ Race _____
First _____ Middle _____ Last _____

Date of Birth _____ SS# _____ - _____ - _____
Month _____ Day _____ Year _____

Address _____ Home Phone _____ - _____ - _____
if different from above Street _____ Apt # _____
City _____ State _____ Zip Code _____
Cell Phone _____ - _____ - _____

Employer _____ Occupation _____ Work Phone _____ - _____ - _____

Address _____
Street _____ Suite # _____ City _____ State _____ Zip Code _____

Person responsible for payment? _____ Relationship to Patient _____ Phone _____ - _____ - _____

Date of Birth _____ SS# _____ - _____ - _____
Month _____ Day _____ Year _____

Address _____
(if different from patient) Street _____ Suite # _____ City _____ State _____ Zip Code _____

Emergency Contact _____ Phone _____ - _____ - _____

Address _____
Street _____ Suite # _____ City _____ State _____ Zip Code _____

REFERRING PHYSICIAN

Name _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____

Address _____
Street _____ Suite # _____ City _____ State _____ Zip Code _____

PRIMARY CARE PHYSICIAN IF DIFFERENT FROM REFERRING PHYSICIAN

Name _____ Phone _____ - _____ - _____ Fax _____ - _____ - _____

Address _____
Street _____ Suite # _____ City _____ State _____ Zip Code _____

I attest that the above information is true and correct regarding me
(or another person for whom I have authority to sign).

Patient Print Name _____

Patient Signature _____ Date _____
Month _____ Day _____ Year _____ Witness Initials _____



Patient Name _____

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Consent for Release or Disclosure of Protected Health Information for Payment, Treatment and Healthcare Operations

By signing below, you hereby consent for Pediatric, Adolescent Surgical Associates, P.C. to release or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for Protected Health Information before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking for a copy of the Notice of Privacy Practices.

You have the right to request that Pediatric, Adolescent Surgical Associates, P.C. restrict how Protected Health Information is released or disclosed to carry out treatment, payment, or health care operations. Pediatric, Adolescent Surgical Associates, P.C. is not required to agree to requested restrictions, however; if Pediatric, Adolescent Surgical Associates, P.C. agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information released or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You authorize Pediatric, Adolescent Surgical Associates, P.C. to communicate with the following individuals regarding your (or another person for whom you have the authority to sign) condition or course of treatment. **Please identify those family member(s) or other person(s) which we may communicate with regarding you:**

Family members that we may talk with regarding you check all that apply

Husband/Partner

Other(s) that we may communicate with regarding you

Please list names

You authorize Pediatric, Adolescent Surgical Associates, P.C. to communicate confidential information regarding you (or another person for whom you have the authority to sign), to the following address and/or phone numbers: check all that apply

Home Phone _____ - _____ - _____

Cell Phone _____ - _____ - _____

Work Phone _____ - _____ - _____

email _____

US Mail

Street _____ Apt # _____ City _____ State _____ Zip Code _____

Other _____

Patient Signature _____

Date _____
Month Day Year

Patient Print Name _____

Witness Initials _____



Insurance Information

Patient Number

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Assignment of Insurance Benefits – Financial and Payment Policies

PRIMARY INSURANCE

Company Name _____ Phone _____ - _____ - _____

Address _____
Street City State Zip Code

POLICY HOLDER

Name _____ Effective Date _____ - _____ - _____

ID # _____ Group # _____

SECONDARY INSURANCE

Company Name _____ Phone _____ - _____ - _____

Address _____
Street City State Zip Code

POLICY HOLDER

Name _____ Effective Date _____ - _____ - _____

ID # _____ Group # _____

I hereby assign payment of medical benefits to Pediatric, Adolescent Surgical Associates, P.C. for medical treatment rendered to me (or another person for whom you have the authority to sign). I understand that payment for medical services rendered is expected at the time of service if I do not have proof of medical coverage or if Pediatric, Adolescent Surgical Associates, P.C. is not a contracted provider for my insurance company.

FINANCIAL POLICY

In order to accommodate the needs and request of our patients, we have enrolled in numerous insurance programs. However, due to the continually changing insurance industry, we are not a member of all insurance plans. **Therefore, it is the responsibility of the patient/insured to confirm the Physician's participation with a particular insurance plan, as well as to know if or when referrals are required to see one of our Doctors.**

REFERRALS

If you participate in an insurance plan that requires you to have a referral for your visit, you must coordinate getting that referral through your primary care physician prior to your appointment. You are responsible for making certain the referral is in our office prior to your visit.

Patients without valid referrals will be rescheduled or will be responsible for payment at the time of service.

INSURANCE CONTRACT REQUIREMENTS

By contract, all co-pays and / or co-insurance must be paid at the time of your visit. If your yearly deductible has not been met, a portion of this may be required at the time of your visit.

SELF PAY

If you do not have insurance or have insurance in which we do not participate or are not contracted with, payment is expected at the time of service. For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express.

We expect payment from the individual signing below as the responsible party for this patient.

FINANCIAL RESPONSIBILITY

If I choose to utilize out of network benefits, provide incorrect or incomplete insurance information or do not follow the guidelines as stated by my insurance company, I will be held responsible for any and all charges. As a courtesy, Pediatric, Adolescent Surgical Associates, P.C. will file an insurance claim when possible, but may still need my assistance to collect payment from my insurance carrier. I understand that my medical coverage is a contract between me and my medical insurance provider. If payment is not made from my medical insurance provider, I understand that I will be held responsible for any and all unpaid charges.

I attest that the above information is true and correct regarding me (or another person for whom I have authority to sign).

Patient _____
Print Name

Patient Signature _____ Date _____
Month Day Year Witness Signature _____