

Pediatric, Adolescent Associates, P.C.

Patient Number

Suite 570

5455 Meridian Mark Road

Atlanta, GA 30342

(404) 252-3353

FAX (404) 252-0645

Patient Legal Name

First

Middle

Last

Date of Birth

month

day

year

Patient's SS #

Address

Street

Apt #

Race

Marital Status

City

State

Zip

()

Home Phone

Cell # ()

Occupation

Employer

Work Phone # ()

Address

Husband's Name

SS #

Date of Birth

month

day

year

Occupation

Address (if different from patient)

Home Phone (if different from patient)

()

Cell #

()

Employer

Work Phone #

()

Who is responsible for payment?

Relationship to Patient

Address (if different from patient)

Telephone #

()

Emergency Contact

Address

Telephone #

()

Who Referred You To Our Office?

If this is your Primary Care Physician, Please Give Address

Telephone #

()

If not your Primary Care Physician, Please list Doctor and Address

INSURANCE INFORMATION

PRIMARY INSURANCE Name

Mailing Address

Telephone #

()

Policy Holder's name

Effective Date

ID Number

Group #

SECONDARY INSURANCE Name

Mailing Address

Telephone #

()

Policy Holder's name

Effective Date

ID Number

Group #

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

Patient Signature

Date

Patient Print Name

Witness Initials

PEDIATRIC, ADOLESCENT SURGICAL ASSOCIATES, P.C.

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT & HEALTHCARE OPERATIONS

By signing below, you hereby consent for Pediatric, Adolescent Surgical Associates, P.C. to use 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 used 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 used 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:

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: (initial all your requests)

_____ Home phone _____ Cell phone _____ mail
_____ Work phone _____ email _____ other _____

Signature of Patient

Date

Print Name of Patient

Witness Initials

Assignment Of Insurance Benefits – Financial and Payment Policies

I authorize 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.

Due to the constant changes in managed care, I understand that it is my responsibility as parent / guardian to verify with my insurance company whether or not a referral is needed or whether the physician is a participating provider in my plan.

If I choose to use 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.

Signature of Patient

Date

Print Name of Patient

Witness Initials