Just Us Kids Pediatrics

Basic Information:

Name: _____ **DOB**: _____ **Male/Female**

Alternate First Name (If Applicable): _____

Primary Address: _____ **City**_____ **Zip code**_____

Mom's Telephone Number: _____

Dad's Telephone Number: _____

Primary Email Address: _____

Ethnicity (Check all that apply):

____ Unknown ____ Not Hispanic or Latino ____Hispanic or Latino ____ Decline to Specify

Race (Check all that apply):

____ American Indian or Alaskan Native ____ White ____ Asian

____ Black or African American ____ Hawaiian Native or Pacific Islander

____ Decline to Specify

Insurance Information: (This information will be updated at each visit)

Subscriber's Last Name: _____ DOB: _____

Subscriber's First Name: _____

Name of Insurance Carrier: _____

Subscriber ID: _____ Group Number: _____

Effective Date: _____

Family Contacts:

Mother's Name: _____ **DOB**: _____

Mother's Address (If different from patient): _____City_____Zip_____

Mother's Email Address: _____

Authority (Choose all that apply)

____ Joining ____ Exclusive ____ Financial Only ____ Emergency Only _____ None

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Father's Name: _____ **DOB**: _____

Father's Address (If different from patient): _____City_____Zip_____

Father's Email Address: _____

Authority (Choose all that apply):

____ Joining ____ Exclusive ____ Financial Only ____ Emergency Only _____ None

Names of any siblings that are also patients at Just Us Kids Pediatrics:

_____DOB: _____ M or F
Ethnicity (if different than sibling) _____
Race (if different than sibling) _____
Other parent if different than one of sibling's parents _____

_____DOB: _____ M or F
Ethnicity (if different than sibling) _____
Race (if different than sibling) _____
Other parent if different than one of sibling's parents _____

_____DOB: _____ M or F
Ethnicity (if different than sibling) _____
Race (if different than sibling) _____
Other parent if different than one of sibling's parents _____

_____DOB: _____ M or F
Ethnicity (if different than sibling) _____
Race (if different than sibling) _____
Other parent if different than one of sibling's parents _____

Just Us Kids Pediatrics

Authorization for Release of Medical Information

Patient Name:_____

DOB:_____/_____/_____

I, _____ hereby authorize the release of medical information to:

Just Us Kids Pediatrics
2462 Hwy 34 E Suite A
Newnan, GA 30263 770-683-5437

FROM:

Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone:_____ Fax:_____

Please release the following:

____ **All health information (including vaccination records)**

____ Lab Results ____ Vaccination Records

____ Radiology/Images ____ Other: _____

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

Signature:_____ Date:_____

Printed Name:_____

Relationship to patient:_____

POLICY ON CO PAY REQUIREMENTS WHEN A SICK VISIT IS ADDED TO A WELL VISIT

At Just Us Kids Pediatrics, we believe that Well Child Check visits are very important in addressing potential health concerns, keeping children properly protected against diseases, and discussing normal and unusual development. Generally speaking there are no co pay requirements for a well child visit. (That rule does not necessarily apply to a self funded insurance plan)

Acute or Chronic (sick) care performed with a well child visit will results in an additional office charge that most likely will result in a co pay charge required per your insurance policy. A typical well visit may include , but not limited to:

- Check Growth and Development
- Physical Assessment
- Immunizations
- Parental concerns about growth and development
- Age specific exams may include: hearing & vision screening, lead assessment and screening, M-CHAT questionnaire for Autism, and other developmental screens/questionnaires as necessary.

Acute (sick) illnesses include but not limited to- Bronchiolitis, pink eye, croup, common cold, dehydration, ear infection, rashes, eczema, fever, gastrointestinal infections/diarrhea, flu, sinusitis, urinary tract infections, medication modifications (Asthma, ADD/ADHD), and vomiting. Chronic illness includes but not limited to allergies, asthma, ADHD, and diabetes.

Generally speaking, just a a refill with no adjustment for chronic illness will not result in an additional charge. Changes in chronic illness health care medication will result in additional office visit charges for which a co payment may be required.

Just Us Kids Pediatrics is required under contract with your insurance carrier, to collect co pays at the time of medical service, most commonly sick visits. You will be charged a co pay if you either request, or approve treatment for an acute or chronic illness during a well child visit. Such a request constitutes a sick visit, in addition to the well child visit.

Your insurance policy determines the co pay requirements. If you are unable to or refuse to pay your co-pay, you may be asked to reschedule your appointment. Contact your insurance carrier if you have any questions specific to your policies co pay requirements plus any individual co insurance and deductible limits.

Signature_____

Date:_____

Patient Name _____

Relationship to patient _____

Just Us Kids Pediatrics
Notice of Privacy Practice

As part of my health care, Just Us Kids Pediatrics originates and maintains paper and or/electronic records describing patients health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning patient care and treatment
- A means of communication among the many health care professionals who contribute to patient care
- A source of information for applying my diagnosis and surgical/treatment information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Consent to Disclosure of Patients Protected Health Information

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I understand and have been provided with the practice Note of Privacy Practice before signing this document.

I understand that this practice has the right to charge their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used to disclosed.

I understand that by failing to sign or revoking this consent, the practice may refuse to treat me as permitted by section 164.506 of code of federal regulations.

I fully understand and accept the terms of this consent.

Guarantor recognition of fiscal responsibility

I understand that I am responsible at the time services are rendered. I also understand that even though the office, out of courtesy, may verify my benefits, this is not a guarantee of payment. All benefits and eligibility are subject to change without notice. The benefits we verify are only a general summarization and are not intended to to be used as an authorization of services provided. In the event my insurance does not cover all charges, I agree to pay the balance due in a timely manner. I am also responsible to notify the office of insurance changes.

Signature_____ Printed Name_____

Date:_____ Relationship to patient_____

Just Us Kids Pediatrics

Missed Appointments Policy

Effective Feb. 1, 2022

I understand that I will be charged the following fees for missed appointments. "Missed Appointment" includes arriving 15 minutes or more after your child's scheduled appointment time. Please call to cancel or reschedule in order to allow that time to be used by another patient.

Well Check: $50.00

Sick/Follow Up Appointment: $25.00

ADHD Appointment & Med Check: $25.00

Patient(s) Name: _____

_____

Parent/Guardian Signature: _____

Date: _____

Just Us Kids Pediatrics

Consent to Treat Form

Please complete form to give permission for any family member or other assigned representative to bring in child for a visit. This excludes mom and dad.

Name (First, Last):	Phone #	Relationship to child:

Child's Name (First, Last):	Date of Birth:

Parent Name (Print):_____

Parent Signature:_____ Date: _____