Children's Information (List all of your children below)

Child #1: Last Name: ______________________ **First Name:** _____________________ **MI:** ____

Preferred Name: ____

DOB: _____/_____/______ **Sex:** M / F **Preferred Language:** __________________

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Unknown or Decline

Race: African American / American Indian or Native Alaskan / Asian / Hawaiian or Pacific Islander / Caucasian / Other or Decline

Child #2: Last Name: ______________________ **First Name:** _____________________ **MI:** ____

Preferred Name: ____

DOB: _____/_____/______ **Sex:** M / F

Child #3: Last Name: ______________________ **First Name:** _____________________ **MI:** ____

Preferred Name: ____

DOB: _____/_____/______ **Sex:** M / F

Child #4: Last Name: ______________________ **First Name:** _____________________ **MI:** ____

Preferred Name: ____

DOB: _____/_____/______ **Sex:** M / F

How did you hear about us? ____

Insurance: (Skip if we have a copy of your card)

Primary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: _____/______/_______ Sex: M / F

Relationship to patient: ____

Insurance Carrier: ____

ID#: ____________________________________ Group#: ___________________________

Parent Information:

Child(ren)'s parents are (to each other): Married / Divorced / Never Married / Separated / Widow / Other

Parent #1:

Name: ______________________________________

Relationship to Patient: ______________________

Date of Birth: ______/________/_________

Gender: Male / Female

Cell #: _____________________________________

Home #: ____________________________________

Work #: ____________________________________

Email: ______________________________________

Address: ____________________________________

____

Parent #2:

Name: ______________________________________

Relationship to Patient: ______________________

Date of Birth: ______/________/_________

Gender: Male / Female

Cell #: _____________________________________

Home #: ____________________________________

Work #: ____________________________________

Email: ______________________________________

Address: ____________________________________

____

Who do(es) your child(ren) live with? Both / Mom / Dad / Other ________________________________

Who will pay your child(ren)'s medical bills? Both / Mom / Dad / Other _________________________

If parents are divorced, separated or not married, please fill out this section:

May all contacts have access to the patient's records? Yes / No

Who has custody? ____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical

treatment for the child or from obtaining information about the child's medical treatment? Yes / No
If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

____

Emergency Contact, other than parents: **Name & Relationship**:

1: ____

Phone: _____________________________ Email: ____

2: ____

Phone: _____________________________ Email: ____

Office Policy

Please initial on each line

_______*(initial)* **Well Check-ups are Required**

At One Family Pediatrics, we feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the following ages:

- Newborn period
- 3-5 days of life
- 1 month of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 24 months of age
- 30 months of age
- 3-21 years of age – on a yearly bases

We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children. Failure to do so may result in being discharged from the practice. We request that *only* primary caregivers bring children in for well checkups.

_______*(initial)* **Appointments will be provided in a timely manner**

All routine new and established patients are accommodated within five days; all urgent appointments for established patients will be attempted to be scheduled on a same-day basis if requested prior to 2:00 p.m., and on a next day basis if requested after 2:00 p.m., unless the family prefers another appointment.

_______*(initial)* **Mutual Respect of Time**

We pride ourselves on punctuality at One Family Pediatrics. Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. We may have to reschedule or squeeze you in whenever there is space if you arrive more than 15 minutes late.

2. If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time with you.

3. We will provide you with all of the time that you need, but you must tell us when making the appointment ALL of the reasons you would like your child to be seen. This prevents us from running out of time and having to schedule another appointment to address other concerns.

4. If you are running late, call the office. We may be able to accommodate you with advanced notice.

_______*(initial)* **Payment is required at the time services are rendered**

This includes applicable coinsurance, co-payments and payments for services not covered or denied by the insurance company. If you participate in a High Deductible Insurance plan, we require a minimum of $70 payment at the time of service. If your insurance company has the ability to adjudicate claims at the time of service, 100% of the adjudicated balance is expected at the time of service.

_______*(initial)* **Self-pay accounts**

If you do not have insurance, please come prepared to pay for your visit in full. We offer a 30% discount for all self-pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a budget agreement can be made to have the service paid within 90 days with the first payment payable the day the service is rendered.

_______*(initial)* **Copays**

We are required by our insurance contracts to collect all co-payments at the time of service. Failure to collect co-payments puts the responsible party and One Family Pediatrics in default of the insurance contract.

_______*(initial)* **Confirm Appointment**

Confirmations will be sent via email, text, and phone. If you do NOT confirm your appointment in at least one manner, we will assume you are out of the country or unavailable and will automatically cancel said appointment on the scheduled date.

_______*(initial)* **Missed Appointment Fee**

Broken appointments represent a cost to us, you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of $50 and may result in dismissal from the practice. This fee must be paid before a new appointment is scheduled. Patients with ***three*** missed appointments in a twelve-month period will be asked to transfer their records to another practice. Your child's appointment time will be confirmed via an automated email, phone or text. If you do not confirm the appointment within 24 hours, we will cancel your appointment and request that you reschedule to a later time.

_______*(initial for Commercial Insurance only)* **Credit Card on File Policy**

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. As a result, we require that all patients need to have a credit or debit card number on file with our office. Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

One Family Pediatrics accepts cash, debit cards, HSA cards, Visa, Master Card, Discover and American Express.

_______*(initial for Medicaid only)* **Georgia Medicaid Insurance Policy (Medicaid Only)**

If your child has Georgia Medicaid (Medicaid/Peachcare, Wellcare or Amerigroup) and is also covered under a private health insurance, we are required by law to file claims with the private insurance policy first. Georgia Medicaid plans are **always** considered as secondary insurance.

If Georgia Medicaid is not informed that your child also has private insurance, they have the right to retract payment from previously paid claims. If this occurs, then the entire balance will be the **responsibility of the parent/guardian on file**.

By signing this notice, you acknowledge receipt and understanding of the Office Policy as outlined above and understand the consequences. You also understand that you are ultimately responsible for the charges incurred by your child/children as their legal parent or guardian.

PLEASE BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

Signature of Parent/Guardian: ________________________________ Date: _________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CREDIT CARD ON FILE POLICY

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, Privacy Policy Statement and Security Policy Statement that explain how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement 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 Credit Card on File Policy, Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement. 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, Privacy Policy Statement and Security Policy Statement. 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, Privacy Policy Statement or Security Policy Statement or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that One Family Pediatrics has offered or provided me with a copy of its Notice of Privacy Practices, Privacy Policy Statement and Security Policy Statement, 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: **HIPAA Compliance Officer Dr. Hiral Lavania at (678) 962-7337.** I also understand that I am entitled to receive updates upon request if One Family Pediatrics amends or changes its Notice of Privacy Practices, Privacy Policy Statement or Security Policy Statement in a material way.

____ _________________________

Signature of patient or patient's representative Date

____ ___________________________

Printed name of patient/patient's representative 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, Privacy Policy and Security Policy from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (Specify): ____

______________________________________ ________________________________ _________________

Name and Title of Employee Signature Date

REQUEST FOR TRANSFER OF HEALTH INFORMATION / MEDICAL RECORDS

I HEREBY REQUEST THE TRANSFER OF RECORDS FOR:

Full Name of Patient(s): ___________________________ Date of Birth: _____/_____/_____

Full Name of Patient(s): ___________________________ Date of Birth: _____/_____/_____

Full Name of Patient(s): ___________________________ Date of Birth: _____/_____/_____

Address: ____

City/State/Zip Code: ____

Daytime Phone Number: (   ) ______ - _________ □ Cell # □ Work # □ Home #

TYPE OF RECORD REQUESTED: ☑ Copy of the entire medical record, as allowed by law.

TO BE TRANSFERRED FROM:

Practice Name: ____

Address: ____

City/State/Zip Code: ____

Phone Number: (_______) _______-_________ Fax Number: (_______) _______-_________

TO BE TRANSFERRED TO:

Dr. Hiral Lavania
One Family Pediatrics
2575 Peachtree Parkway, Suite 301
Cumming, GA 30041
Phone: 678.962.7337
Fax: 844.662.3114
info@onefamilypeds.com

Requestor's Signature: _______________________________ Date: _____/_____/________

Requestor's Full Name ________________________________

By my signature I certify that I am the parent or legal guardian of the patient named here.