Dear Parent/Guardian,

Thank you for scheduling an appointment with Dr. Billingsly or Dr. Jackson. It is our pleasure to welcome you to Premier Pediatric Associates in advance of your first visit.

Premier Pediatric Associates
3200 Highlands Pkwy, Ste 118
Phone: 404-220-7660
E-mail: office@ppa4kids.com
www.ppa4kids.com

Practicing Physicians
Dr. Tiffini Billingsly
Dr. Jessika Jackson

Business hours
Monday 9:00am-7:00pm
Tuesday/Thursday 9:00am-5:00pm
Wednesday 1:45pm-5:00pm
Friday 9:00am-3:00pm
Saturday-1st and 3rd of the Month 9:00am-12:00pm

If you have any questions after reading the enclosed information, we will be happy to answer them for you prior to your visit by telephone at 404-220-7660. Also enclosed are a patient registration form and a privacy form to be completed prior to your scheduled visit. These forms may be faxed to 770-803-9191, or you may bring them to your appointment.

Please bring the following information to your visit:

Insurance card(s) – **Please confirm with your insurance that we are in-network**
Driver’s license or other photo identification
Registration packet

We appreciate you selecting Premier Pediatric Associates for your child’s medical care!

Sincerely,

Premier Pediatric Associates Staff

CONSENT FOR TREATMENT OF MINOR CHILD

Patient for whom consent is given:

___________________________________ ______________________

Patient's Full Legal Name Birth Date

As the parent(s) of the minor child listed above, I (we) hereby consent to any radiology or lab testing, medical or surgical treatment, or other medical service rendered to my (our) minor child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Premier Pediatric Associates.

My (our) consent is given in advance of a specific medical diagnosis or treatment that may be required, and is given to encourage each physician as well any assistant, designee, or employee of Premier Pediatric Associates to exercise his/her best judgment in ordering tests or treatment appropriate to the child's medical needs.

This consent is effective on the date below and will be updated if the medical history or information of the child or parent(s) change.

Emergency Contacts, <u>other than parents</u>: Name & Relationship

1: _______________________________________ *Phone*: (_______) ________ - ___________

2: _______________________________________ *Phone*: (_______) ________ - ___________

Persons Age 18 or over authorized to bring your child (ren) to physician:

1: ____________________________ *Relationship to patient*: _________________ Phone Number________________

2: ____________________________ *Relationship to patient*: _________________ Phone Number________________

____ ____

Signature of Parent Date

Patient Medical History (please complete a separate form for each child):

Patient's Name: ____

MEDICATIONS: List all current medications and strengths your child is on:
____
____
____

ALLERGIES:
Drug/Other Allergies: List all and reaction
____

MEDICAL PROBLEMS/HISTORY (check and **list date of diagnosis** or pertinent information):
ALLERGY:
Allergic Rhinitis _____ Asthma _____ Urticaria (hives)_____
Eczema _____ Chronic dry skin_____ Food intolerance_____
Other ____

NEWBORN PERIOD:
Vaginal delivery_______ C-Section______ Difficult Delivery______
Term _____ Premature _____ Birth weight _____________
Jaundice_____ Phototherapy_____ Heart or lung problems_____
Feeding problems_____ Delayed discharge home from nursery_____
Other ____

FEEDING AND DIGESTION:
Breast fed_____ Bottle fed_____ Appetite Poor_____
Chronic vomiting____ Chronic loose stools____ Constipation issues_____
Other ____

INFECTIONS, DEVELOPMENT, MISCELLANEOUS PROBLEMS:
Dental problems_____ Developmental delays_____ Eye problems (glasses, etc)_____
Frequent sore throats_____ Frequent ear infections_____ Hearing loss_____
Heart problems_____ Elevated blood pressure_____ Seizures_____
Pneumonia_____ Pica (eating dirt, plants, etc.)_____ Orthopedic problems_____
Kidney or bladder infections_____ Bed wetting_____
Other: ____

SURGICAL PROCEDURES and HOSPITALIZATIONS
Tonsillectomy_____ Adenoidectomy_____ Ear tubes_____
Other surgical procedures____
Serious injuries (concussions, broken bones, etc)________________________________
Hospitalizations: ____

PSYCHOLOGICAL PROBLEMS
Antisocial behavior _____ ADHD issues_____ Drug use/abuse_____
Discipline problems_____ Breath holding_____ School adjustment problems_____
Peer relationship problems_____ Tics/ nervous habits_____ Learning disability_____
Mental retardation_____ Nightmares _____ Temper tantrums_____
Speech problems_____ Anxiety_____ Poor school performance_____
Other: ____

Family History

Patient'(s) Name(s):

Please indicate if the following illnesses have occurred in the patient's mother, father, siblings, or grandparents. Please indicate age at diagnosis (if known) and relation to patient.

Cardiovascular	Relation/Age	**Pulmonary**	Relation/Age	**Hematology/Oncology**	Relation/Age
Angina		Asthma		Anemia	
Heart Attack (age)		Chronic Bronchitis		Leukemia	
High Blood Pressure		Tuberculosis		Bleeding Disorder	
Congenital Heart Disease		Cystic Fibrosis		Cancer	
Irregular Heart beat/Arrhythmia		COPD			
Gastroenterology		**Neurological**		**Behavioral**	
Ulcers		Seizures		Autism	
Irritable bowel syndrome		CVA(stroke) age		Developmental Delay	
Crohn's Disease		Chronic Headaches		Intellectual Disability	
Enuresis(bed-wetting)		Migraines		Learning Disabilities	
Kidney Failure					
Kidney Stones					
Psychiatric		**Dermatology**		**Endocrine/Immunologic**	
Depression		Skin Cancer(Melanoma)		Diabetes	
Schizophrenia		Eczema		Thyroid Disorder	
Substance Abuse/Addiction		Psoriasis		Lupus	
		Severe Acne		Rheumatoid Arthritis	
		Seborrheic Dermatitis		Immune Deficiency	
Auditory/Visual		**Other:**		**Other:**	
Deafness					
Blindness					

Payment Policies

(Please initial all fields)

______**Payments:**
It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. This may only be your copayment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept all major credit cards.

______**No-shows:** A no-show is defined as missing a scheduled appointment without calling us in advance to cancel the appointment. The first incident you will not be charged. However, any subsequent incidence will result in a fee of $50. Please be mindful, after a consecutive no-show status, Premier Pediatric Associates has the right to terminate your child from the practice.

______**Claims:** We submit all claims/charges to your insurer and strive to assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be mindful that all charges are ultimately your responsibility regardless if they are covered by your insurance or not.

______**Well Visits:** Well visits are typically covered 100% of by most insurance companies. However, all services recommended by the American Academy of Pediatrics and Bright Futures may not be covered for your child's well visit. This includes but isn't limited to hearing screens, vision screens, and routine labs. Please note if your insurance doesn't cover these services for your child's well visit, you will be required to make payment within 30 days of receiving your bill. Additionally, if concerns are addressed outside of your child's Well visit you may incur a copay depending on your insurance plan.

______**Sick and Other Visit:** Insurance companies typically only classify visits as preventative (well) or office (sick/other/follow-up). These are the only 2 types of basic visits in our office. Please note that follow-ups are deemed as office visits. Your physician may recommend a follow-up based on your child's medical condition, including after an asthma attack, weight checks, lab follow-ups, etc. All co-pays and other requirements for an office visit, per your contract with your insurer, will apply.

______**Newborn Period:** The Bright Futures guidelines, which have been endorsed by the American Academy of Pediatrics, recommends that newborns have 2 well visits within the 1st month of life. This occurs within 2-3 days of discharge from the hospital and within 2-3 weeks of the initial visit. However, you may be required to return to the office for weight checks and follow-ups on any concerns. These visits will be deemed office visits (non-well visits) or sick/other visits on our schedule. Please be mindful these visits will require any co-pay or associated fees with an office visit, per your contract with your insurer. You must pay these fees in full at the time of your visit. Additionally, it is very important that you call your insurance company to have your newborn placed on your insurance ASAP. Please call the office with the updated insurance information as soon as it is received.

______ Self- Pay: All self-pay patients are expected to pay an upfront office visit fee of $200. The fee could change, depending upon the services rendered at the time of care**.**

______ **After Hours**: All calls prior to 10:00pm are FREE. I understand any calls, between 10:00pm and 8:45am, will incur a fee of $25 per call.

______ **Late Evening (after 5:00pm) and Weekend Visits:** I understand these visits may incur an additional fee. Some insurances cover it, while others may require the fee to be patient responsibility.

______ **Coinsurance and Deductible: Effective 1.20.2020, I understand coinsurances and deductibles will be due at the time of service.**

______ **Appointment Scheduling:** I understand I am unable to schedule an appointment without verifiable insurance at the time of scheduling.

______ **Collections:** I understand if I have an unpaid balance with Premier Pediatric Associates and satisfactory payment arrangements haven't been made, my account may be placed with an external collection agency, which could lead to reporting with credit bureau agencies as well. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred to collect on my account, and possibly any reasonable attorney's fees, if so incurred during collection efforts.

We greatly appreciate your adherence to these payment policies. We will work hard to serve your needs.

Thank You!

Premier Pediatric Associates Staff

Patient(s) Name(s): ____

Parent/Guardian's Name: ____

Parent/Guardian's Signature: _____________________ Date: ________________

Patient Registration

Child 1: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child 2: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Child 3: Last Name: ______________________ First Name: __________________ MI: _____

D.O.B.: _____/_____/_____ Sex: _______ Primary Language: __________________

Ethnicity: Hispanic / Non-Hispanic / Unknown Race: Asian / Black / Hawaiian / White

Mailing Address:

____

(Street or PO Box) (City) (State & Zip)

Home Phone: (______) ________ - ___________

Who lives at this household? ____

Insurance:

Primary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ___________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ____

ID# _______________________________________ Group # ____________________________

Secondary Policy: Policy Holder's Name: ____

Policy Holder's Birth Date: ___________________ Policy Holder's Sex: Male / Female

Insurance Carrier: ____

ID# _______________________________________ Group # ____________________________

Mother's Maiden Name: ____

Contact 1 (primary): Name: ________________________ Relation to Patient: _______________

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____

SSN: ____________________________ Driver's License / ID Number: ______________________

Work Phone: (_____) ______ - ____________ Cell Phone: (_____) ______ - __________________

Home Email: _________________________ Work Email: _________________________________

Employer: __________________________ Occupation: ___________________________________

How would you prefer to be contacted regarding (**please circle one**):

Recall Notices: Home Address / Home Phone / Cell Phone / Home Email / Text to cell

General Practice Notices: Home Address / Home Phone / Cell Phone / Home Email

Patient Portal Notifications: Cell Phone / Home Email / Work Email / Text to cell

Appointment Reminders: Home Phone / Cell Phone / Home Email / Work Email / Text to cell

Contact 2: Name: ________________________ Relation to Patient: _________________________

Lives with patient? Yes / No Date of Birth: ____ / ____ / ____

SSN: ____________________________ Driver's License / ID Number: ______________________

Work Phone: (_____) ______ - ____________ Cell Phone: (_____) ______ - __________________

Home Email: _________________________ Work Email: _________________________________

Employer: __________________________ Occupation: ___________________________________

Please list any restrictions as to who can obtain patient information:

____

Preferred pharmacy-please provide number and location:

____

How did you hear about us?

____

premier pediatric associates

Authorization to Release Medical Information

PREVIOUS PEDIATRICIAN:

____
Practice Name/Phone Number

____
Street Address

____
City State Zip Code

PREMIER PEDIATRIC ASSOCIATES:

3200 HIGHLANDS PARKWAY, SE

SUITE 118

SMYRNA, GA 30082

Patient's Name: _____________________________ Birth Date: ________________________

Patient's Name: _____________________________ Birth Date: ________________________

Parent Name: ____

Parent Signature: _____________________________ **Date:** ____________________________

INFORMATION TO BE RELEASED: (Check all applicable)

○ All Information ○ All Progress Notes ○ Lab Reports ○ X-Ray Reports

○ Electrocardiogram (EKG) ○ Allergy Records ○ Immunization Records ○ Other: __________

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By signing below, you are authorizing the office to release any and all information regarding:

○ Alcohol ○ Drugs ○ Mental Health ○ Sexually Transmitted Diseases ○ HIV ○ AIDS

Signature:

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

Patient Rights and Responsibilities

Patient Rights

1. You have the right to dignified and respectful care. You have the right to know about and understand your physical condition. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure. You have the right, at your own expense, to consult with another physician or specialist.

2. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal. You have the right to be treated in a safe environment that is free of physical and psychological threats. You have the right to privacy regarding visitors, mail, and/or telephone conversations. You have the right to expect that all communications and records regarding your care will be held confidential.

3. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.

4. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you. You have the right to request an itemized statement of all services provided to you through this practice. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.

5. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.

2. You will be responsible for participating in the development of your plan of care. You will be responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.

3. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice. You are responsible for following practice rules and regulations.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your stay treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

Parent/Guardian's Signature: ______________________________ Date: ________________________

Acknowledgement of Receipt of Notice of Privacy Practices

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ____, hereby acknowledge that Premier Pediatric Associates has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me, or my child, may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact: **Premier Pediatric Associates**

Patient's Name: ____ **DOB:** ______________________

Parent/Guardian's Signature: ______________________________ Date: ________________________