



Dear Parent(s),

Welcome to ABC Pediatrics, Fayetteville.

Thank you for selecting our practice for your child(ren). We look forward to providing excellent pediatric medical care to your child(ren).

Most of our office policies are published on the ABC Pediatrics website [www.myabcpediatrics.com](http://www.myabcpediatrics.com). Please take time to review our website and be sure to register for the patient portal/Healow app. This registration will allow you to schedule appointments online, check future appointments, correspond with the office, etc.

Our office sees patients **by appointment only**, and we reserve specific time slots based on each child's age and needs. Arriving even a few minutes late can delay other patients' appointments. Please plan to arrive **about 10 minutes before** your scheduled time.

If you anticipate being late, **call us before coming in** so we can check for another available time slot. Patients who arrive late **may need to be rescheduled** to avoid disrupting the schedule.

We also have an interface with CHADIS which allows completion of your child(ren)'s health and developmental questionnaires online when it is most convenient for you. Please be sure to complete CHADIS when you receive the link prior to your child(ren)'s appointment.

We look forward to developing a long-term physician/patient relationship with your family.



**Patient Registration Form**  
(Please print and complete all sections)

<i><b>Patient's Information</b></i>			<i><b>Patient's Information</b></i>		
<b>Child #1:</b>	DOB:	M/F	<b>Child #2:</b>	DOB:	M/F
Child's Race (circle one): White, Black, Hispanic, Other _____			Child's Race (circle one): White, Black, Hispanic, Other _____		
Child's Primary Language (circle one): English, Spanish, Other _____			Child's Primary Language (circle one): English, Spanish, Other _____		
Child's Ethnicity (circle one): Non-Hispanic, Hispanic			Child's Ethnicity (circle one): Non-Hispanic, Hispanic		
<b>Child #3:</b>	DOB:	M/F	<b>Child #4:</b>	DOB:	M/F
Child's Race (circle one): White, Black, Hispanic, Other _____			Child's Race (circle one): White, Black, Hispanic, Other _____		
Child's Primary Language (circle one): English, Spanish, Other _____			Child's Primary Language (circle one): English, Spanish, Other _____		
Child's Ethnicity (circle one): Non-Hispanic, Hispanic			Child's Ethnicity (circle one): Non-Hispanic, Hispanic		
<i><b>Mother's/Guardian's Information</b></i>			<i><b>Father's/Guardian's Information</b></i>		
Name:	DOB:		Name:	DOB:	
Primary/Day Phone#:	WK/HM/CELL		Primary/Day Phone#:	WK/HM/CELL	
Secondary Phone#:	WK/HM/CELL		Secondary Phone#:	WK/HM/CELL	
Address	Apt#		Address	Apt#	
City	State	Zip	City	State	Zip
Child(ren)'s Parents Are: Married   Divorced   Separated   Never Married Custodian of the Child: Mother, Father, Foster Parent, Grandparent, Other _____					
<b>Daytime Phone Number:</b> _____ <b>Email Address:</b> _____ Email Address Is Required for the Patient Portal. ABC Pediatrics may leave messages via home, cell or email. <b>Authorize Text Notifications: Yes No Authorize Voicemail: Yes No Authorize Email Notifications: Yes No</b>					

**Medicaid ID Number: Please provide the Medicaid ID Number**

**Child #1:** \_\_\_\_\_ **Child # 2:** \_\_\_\_\_

Amerigroup/Medicaid/Peachstate/CareSource (circle one)

**Child #3:** \_\_\_\_\_ **Child # 4** \_\_\_\_\_

Amerigroup/Medicaid/Peachstate/CareSource (circle one)

*I acknowledge the above information provided is correct. I authorize treatment and payment for all medical services rendered by the medical providers and staff of ABC Pediatrics, PC.*

**Please sign and date:** Parent/Guardian/Responsible Party \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_



**AUTHORIZATION TO TRANSFER / DISCLOSE HEALTH INFORMATION**

Revocation  
Date Revoked:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize \_\_\_\_\_ to transfer/disclose my child's health  
Name of Provider, Practice or Institution  
information as described below:

Previous Provider's Phone Number: \_\_\_\_\_ Previous Provider's Fax Number: \_\_\_\_\_

1. **Type of information:** The type of information to be used or disclosed is as follows  
(check the appropriate spaces and include other information where indicated):

- Entire medical record (all information)
- Physician and Professional Consult Progress Notes
- Diagnostic reports (lab, x-ray, etc.)
- History and physical
- Medication and treatment records
- Immunization Records
- Medical Summary
- Other (Describe as specifically as possible):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. **Recipient of information** - The information identified above may be transferred to, or disclosed to, the following individual(s) or organization(s):

**ABC Pediatrics, PC**  
**Attn: Medical Records**  
**735 Glynn Street South**  
**Fayetteville, GA 30214**  
**Phone: 770-461-4126 Fax: 770-461-8852**



3. **Purpose of use/disclosure** - This information described on the previous page will be used for the following purpose(s):

\_\_\_\_ Initiated at the request of the parent.

\_\_\_\_ Transferring to local provider

\_\_\_\_ Other (please describe): \_\_\_\_\_

**Authorization Statements/Signatures:**

4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ABC Pediatrics, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization.
6. Unless I specify differently, this authorization will **expire in one year from date or**  
\_\_\_\_\_.

\_\_\_\_\_  
**Signature of Patient or Parent or Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Patient**



## Annual Immunization Consent Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that it is medically recommended that my child receive immunizations as per the Center for Disease Control (CDC) immunization schedule and the American Academy of Pediatrics (AAP) guidelines.

I understand that each vaccine will be discussed with me prior to administration. I will be provided the Vaccine Information Statement for each vaccine and will be given the opportunity to ask questions.

The Vaccine Information Sheet(s) (VIS) from the CDC explain the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the **need** for the recommended vaccine(s)
- The **risks** and **benefits** of the recommended vaccine(s)
- If my child does not receive the vaccine(s), the **consequences** may include:
  - Contracting the illness the vaccine should prevent (the outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well)
  - Transmitting the disease to others
  - Requiring my child to stay out of child care or school during disease outbreaks
- My child's Physician or Nurse Practitioner, the American Academy of Pediatrics and the Centers for Disease Control all strongly recommend that these vaccines be given according to recommendations

I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC immunization schedule, including the influenza vaccine. ***I will be consulted on each vaccine prior to administration and I will have the opportunity to decline the vaccination if I choose to do so.*** While I will be given specific information for each vaccine, I will not need to sign individual consents for each vaccine. This consent will be renewed each year.

I understand that I may address this issue with my child's Physician or Nurse Practitioner at any time and that I may re-visit decisions on immunization for my child anytime in the future.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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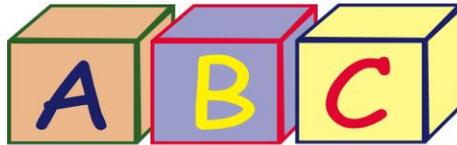
### IMMUNIZATION CONSENT IN THE ABSENCE OF PARENT OR GUARDIAN

I understand that this consent covers all routine, recommended immunizations, unless otherwise specified by me. This includes visits during which my child is not accompanied by a legal guardian.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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# Pediatrics

## AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR

### UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

In my absence, I \_\_\_\_\_, who has legal custody of my child, \_\_\_\_\_ and whose date of birth is \_\_\_\_\_ authorize the following individuals:

1. Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

to provide consent to ABC Pediatrics to render care under the supervision and advice of a licensed medical care professional. I understand that it may be necessary to perform diagnostic testing and/or to administer vaccinations in the course of the visit.

I consent to all medically services rendered during the visit in which I was absent for example, physical examination, hearing and vision testing, immunizations, treatment for illness, referrals to a specialist, etc. The above named person(s) may also receive any tests results and any additional medical information pertinent to the care and treatment of the minor child for the visit in which I was absent. The above named person(s) listed above may not request full medical records or make decisions about chronic conditions without written consent from the parents/legal guardians.

I do not consent to the following services:

\_\_\_\_\_.

This written consent is valid for the time period of: \_\_\_\_\_ to \_\_\_\_\_.

After a period of one year, a new consent form would need to be completed. This consent may be revoked by me at any time in writing.

_____	_____
Parent or Legal Guardian's Name	Date

_____	_____
Parent or Legal Guardian's Signature	Date

\_\_\_\_\_  
Phone Number Where Parent or Guardian Can Be Reached



## Standing Consent to Access External Prescription History

I, \_\_\_\_\_, whose signature appears below, authorize ABC Pediatrics, PC and its medical providers and staff to view external history via eClinicalWorks/RxHub software for the patient(s) listed below.

_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth
_____	_____
Patient's Name	Date Of Birth

I understand that prescription history is from other unaffiliated medical providers, insurance companies and pharmacy benefit managers and that it may be viewable by the providers and staff of ABC Pediatrics. The external history made include prescription history for several years.

**Please sign only after you have read and understand the above statements.**

_____	_____	_____
Parent/Guardian's Signature	Relationship to the Patient	Date Signed
_____		_____
Witness Signature		Date Signed



## **No-Show Policy**

Due to the frequency of patients failing to show up for scheduled appointments, it is the policy of ABC Pediatrics to assess a No-Show fee anytime the patient/responsible party fails to notify ABC Pediatrics in advance of a cancellation or change in a scheduled appointment.

**The No-Show fee is \$50.00 for failure to cancel or change a Well Child Visit (Physical) 24 hours in advance of the cancellation or change in this type of appointment. The No-Show fee is \$30.00 any time a patient/responsible party fails to notify ABC Pediatrics 1 hour prior to a sick or recheck appointment.** This allows the scheduling department to try to give the appointment to another patient. **To cancel an appointment before or after office hours or on weekends, please call the answering service at 404-935-6730.**

It is the policy of ABC Pediatrics to mail as few patient statements as possible, in an effort to reduce healthcare costs. When a no show fee is incurred, responsible parties are encouraged to mail the payment directly to ABC Pediatrics. It is the policy of ABC Pediatrics to mail one statement in an effort to collect the no show fee. If 30 days after the generation of the first statement it is necessary for ABC Pediatrics to mail a second statement because no payment has been received, an interest charge of a flat 12% of the balance, but not less than \$5, will be added to the account. If no payment is received 10 business days after the mail date of the third statement, the account will be reviewed and turned over to the collection agency. **All accounts turned over to the collection agency will also be responsible for the collection agency fees.**

Child's Name: \_\_\_\_\_ Child's DOB: \_\_\_\_\_

Signature of parent/responsible party: \_\_\_\_\_

Date: \_\_\_\_\_



# Patient Financial Policy

Welcome to ABC Pediatrics, PC.

We are committed to providing high-quality care to all of our patients. To ensure a smooth experience for you and your family, please review our financial policy. By bringing your child(ren) for treatment, you agree to the terms outlined below.

## 1. Payment for Services

Payment for all services provided is expected at the time of service, unless prior arrangements have been made. We accept the following forms of payment:

- Cash
- Checks
- Credit/Debit Cards (Visa, MasterCard, Discover, American Express)
- Health Savings Accounts (HSAs)
- Flexible Spending Accounts (FSAs)

## 2. Insurance Information

We participate with several insurance plans and will file insurance claims on your behalf. However, it is your responsibility to verify that we are an in-network provider with your insurance company prior to your appointment.

- **Insurance Verification:** Please provide us with the most current insurance information. This includes your child's primary and secondary insurance, as well as any changes to your coverage or policy.
- **Co-Payments/Co-Insurance:** All co-payments, co-insurance, and deductibles must be paid at the time of service. If your insurance requires a referral or pre-authorization, it is your responsibility to obtain this prior to your visit.
- **Non-Covered Services:** If services are not covered by your insurance, you will be responsible for the full amount.
- **Coordination of Benefits:** If you have a commercial insurance and have a Medicaid plan, the commercial plan will be processed first. You are responsible for updating Medicaid if you no longer have commercial coverage.

## 3. Self-Pay Patients

If you do not have insurance or choose not to use your insurance, payment for services is due at the time of service. We offer a prompt pay discount for patients without insurance. We will also offer a payment plan for established patients provided the parent has a positive payment history with the practice.

## 4. Billing

- **Statements:** You will receive a monthly statement for any outstanding balances. It is your responsibility to review and ensure the accuracy of the information on your bill.
- **Payment Plans:** If you are unable to pay your balance in full, we offer flexible payment plan options. Please contact our billing department to discuss available options.
- **Outstanding Balances:** Accounts that remain unpaid for over 90 days will be subject to collections. Collection fees may be added to the outstanding balance.
- **Delinquent and Collection Accounts:** You will receive up to three patient statements for any balances on your account after insurance payments and adjustments have been applied. Any unpaid delinquent debt, including no-show fees, owed to ABC Pediatrics may be referred to an outside collection agency. Failure to pay the balance or failure to abide by the approved payment arrangements may have a negative effect on your personal credit report. You will be responsible for all additional collection agency expenses incurred by ABC Pediatrics in the course of obtaining payment. The collection agency fee is currently 30% of the outstanding balance.

## 5. Missed Appointments & Cancellations

- **Appointment Cancellations:** We ask that you notify us at least 24 hours in advance if you need to cancel or reschedule your child's appointment.



- **No-Show Fee:** If you do not show up for a scheduled appointment or fail to cancel within 24 hours, a no-show fee will apply. No-shows fees are not covered by insurances, so the fee(s) will be the direct responsibility of the parent.

#### **6. Patient Responsibility**

It is important to note that you, as the parent or guardian, are ultimately responsible for the payment of your child's healthcare services, regardless of your insurance status or coverage.

- **Secondary Insurance:** If your child has secondary insurance, it is your responsibility to provide us with that information.
- **Legal Guardians:** If you are a legal guardian, you are responsible for all financial aspects of the care.

#### **7. Consent to Treatment & Financial Responsibility**

By signing this document, you acknowledge that you have read and understood our financial policy. You consent to treatment and understand that payment for services rendered is your responsibility, even if insurance is involved. You authorize ABC Pediatrics to submit insurance claims for services rendered to your child for payment. You authorize the release of any medical information necessary to process the insurance payment. You understand that you can revoke this authorization at any time, with the understanding, the revocation will result in your financial status being changed to self-pay. You also agree to promptly pay any balances owed after insurance has processed the claim.

#### **8. Patient Information Updates**

Please keep us informed of any changes to your personal or insurance information, including addresses, phone numbers, email addresses and insurance plans. It is your responsibility to provide up-to-date information.

#### **9. Financial Assistance**

If you are experiencing financial hardship, please contact our billing department to discuss possible options for payment plan arrangements. Within reason, we will work with you to create a manageable payment plan.

#### **10. Contact Us**

For any questions regarding your bill, payment options, or insurance issues, please contact our billing department at 770-415-2445 or kandkbilling@bellsouth.net.

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**Print Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Thank you for choosing ABC Pediatrics for your pediatric healthcare needs! We are dedicated to providing exceptional care to your family.**