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Betsy John, MD, FAAP Stacie Hamley, MD, FAAP Heather Bean, CPNP Stephanie Toole, CPNP

Children's WELLNESS CENTER
COMPREHENSIVE PEDIATRIC CARE

755 Mt. Vernon Hwy., NE, Suite 150
Atlanta, GA 30328 * Phone 404-303-1314 * Fax 404-303-1399
www.childrenswellnesscenter.com

PATIENT DEMOGRAPHIC INFORMATION

Date: Child's Primary Doctor:

Patient Name:_____
Last First Middle Nickname

Address:_____
Street Address

_____
City State Zip Code County

Primary Number: (____)_____ Secondary Number: (____)_____
Date of Birth:_____ Age:_____ Gender:_____
Social Security #:_____

How did you hear about us: _____
Please list all siblings with ages_____
_____

RESPONSIBLE PARTY INFORMATION

Whoever brings in the child is responsible for any fees at the time of service.

Parent/Guardian 1:
Name:_____
Relation to Child: _____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
Soc. Sec. No.:_____
DOB:_____

Parent/Guardian 2:
Name:_____
Relation to Child: _____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
Soc. Sec. No.:_____
DOB:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:
Insurance Company :_____
ID Number:_____ Group Number:_____
Cardholder's Name:_____ DOB:_____
SECONDARY INSURANCE:
Insurance Company Name: _____
ID Number:_____ Group Number:_____
Cardholder's Name:_____ DOB:_____

EMERGENCY CONTACTS (other than parents)

Name:_____ Relation to Patient: _____
_____
Phone #_____

CONSENT FOR MEDICAL CARE AND ASSIGNMENT OF BENEFITS

I authorize Children's Wellness Center to provide medical care for my child/children. I authorize payment of medical benefits directly to Children's Wellness Center for services provided. I authorize physician to release any medical information required to process my claims.

Signature:_____ Date: _____

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RECEIPT OF NOTICES OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT ACKNOWLEDGMENT FORM

I _____ (parent/guardian) acknowledge I have received a copy of the privacy practices and financial policies of Children's Wellness Center, LLC.

I have read and understand the Privacy Practices and Financial Policy of Children's Wellness Center and agree to the terms and responsibilities as described in the documents. I also authorize Children's Wellness Center to release required medical or other information necessary to process my insurance claims. I also authorize payment of medical benefits directly to Children's Wellness Center.

Child's/ Childrens Name and DOB

_____

_____

_____

_____

Parent/guardian signature _____ Date_____

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PROXY PERMISSION FORM

Children's Wellness Center requires a parent or legal guardian to accompany all patients under the age of 18 for every office visit. All Children's Wellness Center patients who are not accompanied by a parent or guardian must have a completed PROXY PERMISSION FORM prior to their office visit.

I, _____, give the following person(s) permission to make medical decisions and to sign any appropriate documents related to my child(ren), _____ in my absence.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I, _____, DO/DO NOT (circle one) give my child, _____, permission to seek medical treatment by themselves without a parent, caretaker or guardian in accompaniment. I acknowledge that my child is of driving age and has the ability and maturation to understand our medical recommendations.

Signature of Parent: _____ Mother/Father/Legal Guardian

Print Name:_____

Date: _____

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NEWBORN INSURANCE INFORMATION

Please be sure to contact your insurance company to add your newborn to your insurance policy. Insurance companies typically cover newborns for the first 30 days. It is always the parent's responsibility to add a newborn within the mandated time frame. Children's Wellness Center strongly recommends you add the newborn within the first two weeks, so there is not a gap in coverage. If the newborn is not added within the required time frame, you will be financially responsible for all medical charges incurred since birth. Please note, each insurance company has unique policies regarding coverage for well child checkups, vaccines and ancillary pediatric services. Please contact your insurance company to verify your own benefits and a Children's Wellness Center physician is in-network on your HMO/POS plan. If Children's Wellness Center cannot verify that your child has active insurance you will be required to pay out of pocket for the visit. If you have any questions, please your insurance company or our office for further details.

Child/Children's Name & DOB:_____

_____

Parent/Guardian Signature:_____Date:_____

Relationship to Child:_____

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Children's Wellness Center as your health care provider. Our fees are based on the cost of delivering quality medical care. We ask that you read the following Financial Policy and sign that you acknowledge and accept our policy.

INSURANCE COVERAGE
You must provide your insurance card or proof of insurance at the time of each visit. If you do not have insurance, are unable to provide proof of insurance, or are on a plan in which we do not participate, you will be considered a self-pay patient. Full payment for self-pay patients is required at the time of service. It is very important that you take an active role in understanding your insurance benefits. Certain plans have restrictions on certain services such as vision/hearing screening, immunizations, and timing of well child exams. It is your responsibility to be aware and understand your plans restrictions and limitations. If you have any questions regarding your coverage, health benefits, health restrictions and payment determination then you need to contact your insurance company directly.

PAYMENT METHODS
All co-payments and deductibles are due at the time of service. These fees by law cannot be waived. For your convenience, we accept cash, checks, ATM cards, and most major forms of payment.

INSURANCE
Children's Wellness Center will bill insurance companies for which we are providers. You will be responsible for all co-pays and co-insurance at the time of service. Some of the services provided may be non-covered services and not paid by your insurance company. You are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay within 90 days. You will receive a bill, which must be paid upon receipt. If we are not a provider on your current insurance plan or do not have proof of insurance, then you will be responsible for the entire bill at the time of service. We will provide you with an encounter form at each visit so that you can file the claim with your insurance company.

RETURNED CHECKS
There will be a returned check fee of $25. If you have more than one returned check you may be asked to pay by cash or credit card only. Unpaid fees may be subject to referral to a collection agency.

MEDICAL RECORDS
Medical records are the property of Children's Wellness Center. You can request copies of medical records in writing. We will provide copies of required medical records to specialists free of charge. All other copies will be charged per page to cover the costs of office staff and copying. We will provide you with your copies within 30 days of receiving your written request.

REFERRALS
If your insurance plan requires a referral prior to seeing a specialist or using a hospital service, then we will need greater than 24 hours' notice. We cannot issue a referral once services have been rendered. It is your responsibility to know your insurance company requirements.

MISSED APPOINTMENTS/ CANCELLING APPOINMENTS
Missed appointments seriously disrupt our practice. Therefore, please give us at least 24 hours' notice when canceling an appointment. If you fail to show for an appointment, then you will be charged a $50.00 no show fee by our billing service. Cancellations with less than 24 hours' notice and missed appointments will be charged.

DELINQUENT ACCOUNTS
A payment can be made with our billing office for past due amounts. Failure to pay or to make payment arrangements of a past due amount may result in a referral to a collection agency. You agree to reimburse us the fees of any collection agency or attorney firm, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts. If your account is referred to a collection agency for payment, then you may be dismissed from our practice.

I have read and understand the Financial Policy of Children's Wellness Center and agree to the terms and responsibilities as described above. I also authorize Children's Wellness Center to release required medical or other information necessary to process my insurance claims. I also authorize payment of medical benefits to Children's Wellness Center.

CHILD/CHILDREN NAME & D.O.B_____

PARENT/GUARDIAN SIGNATURE &DATE_____

RELATIONSHIP TO CHILD_____

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PATIENT HEALTH QUESTIONNAIRES

Children's Wellness Center utilize' s patient health questionnaires as screening tools at each of your child's well visits. We have implemented the screens that are specifically recommended by the American Academy of Pediatrics. These tools are critically important to assess your child's overall physical, emotional, nutritional, educational, and developmental progress. Your insurance may or may not cover these screening tools. Please contact our billing department with any billing questions that may arise at cwc@phsga.com or 770-516-2589.

Patient(s) Name & D.O.B.:_____

_____

Parent/Guardian Signature:_____

Date:_____