Children's Surgical Associates, P.C.

Patient Profile

Patient Information

Patient Name: _____

Preferred: _____

Address: _____

_____

City/State/Zip: _____

Alt Address: _____

_____

Alt City/State/Zip: _____

Phone: _____ ( )Home ( )Work ( )Cell

Phone: _____ ( )Home ( )Work ( )Cell

Phone: _____ ( )Home ( )Work ( )Cell

Sex: ( )Male ( )Female

Date of Birth: _____

Social Security #: _____

Marital Status: ( )Married ( )Single ( )Divorced ( )Other

Referring/Primary Physician: _____

Physician Phone: _____

Pharmacy: _____

Phone: _____

Race: _____

Ethnicity: _____

Email Address: _____

Parent/Guardian Information

Name(s): _____

_____

Person who brought patient: _____

Best Contact Phone Number: _____

Emergency Contacts (Not Parent/Guardian)

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

Insurance Policy Holder Information

( )Same as Patient

Name: _____

Date of Birth: _____

Social Security # _____

Address: _____

_____

City/State/Zip: _____

Employer: _____

Employer Phone: _____

Alternate Phone: _____

Primary Insurance

Insurance Name: _____

Ins ID#: _____

Group #: _____

Insurance Phone # For Providers: _____

Medicaid

Medicaid/Peachstate/Peachcare/Amerigroup/Wellcare

Medicaid/Peachcare #: _____

Amerigroup/Wellcare #: _____

Secondary Insurance

Insurance Name: _____

Ins ID#: _____

Group #: _____

Policy Holder: ( )Same as Patient ( )Guarantor ( )Other

Policy Holder Name: _____

Policy Holder DOB: _____

Policy Holder Social: _____

Administrative Fees

I understand the services listed below are included in the $20.00 administrative services fee one time per fiscal year.
I am not required to pay the administrative fee; however, I understand that if I elect not to pay the administrative services fee, I will be responsible for the fees listed below:

Billable items on a requested basis-list include but are limited to:

1. $50.00 for completion of all forms:

    A. Disability

    B. FMLA

    C. Life Insurance

    D. Other miscellaneous administrative forms required by third parties other than your insurance company

2. $15.00 for patient requested computer generated reports

    (additional claims, statements, payments histories, etc.)

3. $38.00 for copying medical records

4. Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at the time of request.

Records to the Primary Care/Referring Physician are FREE of charge and are not included in the $20.00 administrative fee.

All of these activities add to the cost of caring for the patients. Still, we are committed to providing you with the best possible care. We thank you for your understanding and cooperation.

____ I **ACCEPT** the $20.00 calendar year administrative service fee.

****** NOTE: Multiple requests may result in additional charges******

____ I choose **NOT** to pay the administrative service fee. I understand that if I elect not to pay this fee; I will pay for the services as I need them.

_____ _____

Patient Signature (if patient is a minor then Guardian Signature) Date

PATIENT NAME:_____

Children's Surgical Associates Financial Responsibility Policy

Co-payments _____ (Initial)

All office visits require a co-payment from your insurance company. Exceptions may include post-operative visits for a determined period of time for some surgical procedures. Some insurance plans require co-payments for post-operative visits.

Deductible _____ (Initial)

A deductible is a portion of the bill that is the responsibility of the patient to pay before an insurance company will cover the service. An office visit with our physicians will include a face-to-face encounter and evaluation. Generally, a co-payment is required for the visit. In addition, some services and ALL procedures performed in the office require the patient to meet their deductible before insurance pays benefits. If you have not met your deductible, you will be responsible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery to the insurance company, and are billed as surgery.

No Show _____ (Initial)

Patients who fail to show for their scheduled appointment, procedure, surgery, or did not notify the office within 24 HRS PRIOR to the appointment, shall be subject to a No Show penalty. These penalties are as follows: $25 for missed appointments, $150 for office procedures, and $150 for surgery if 72 business hours' notice is not given.

Guarantee of Payment for Services & Assignment of Benefits _____ (Initial)

It is the policy of the office that you must pay for services when rendered except in the cases of surgery where a prepay may be required. If this applies to you, we will file your claim and you will be expected to pay only the portion that is not covered by your insurance. If you have any questions, please ask about this before leaving the office.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. This includes all charges related to office visits, procedures performed, co-payments and deductibles. If this account is placed in collections, the undersigned agrees to pay the balance plus a $25 surcharge for collections.

I hereby authorize insurance benefits to be paid directly to the physician, and I am financially responsible for non-covered services. I also authorize the physician to release my medical information in the processing of this claim.

Insurance Coverage _____ (Initial)

I am aware that my insurance has been verified and that there is a disclaimer which states my insurance does not guarantee payment, even though I may be **eligible** for benefits at the time of service. If it is determined that I am not eligible for coverage or the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referral Waiver _____ (Initial)

I understand that if my insurance requires a referral for my visit, I am responsible for making sure that the referral is obtained from my primary care physician. I also understand that if the referral from the primary care physician's office is not received before/on the day of my appointment, I agree to pay for all services rendered on the day of the visit.

_____ _____

Patient Signature (Guardian if patient is a minor) **Date**

PATIENT NAME:_____
(Please Print)

Children's Surgical Associates, P.C.
Privacy Policy Acknowledgement Statement

I hereby acknowledge that I have been made aware that Children's Surgical Associates has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability ACT of 1996(HIPAA).

As a patient of Children's Surgical Associates, I understand and acknowledge the following:

1. Children's Surgical Associates has a privacy policy in effect in their office.
2. Children's Surgical Associates has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room, and/or by placing a poster of this policy in the waiting room or similar common area with patient access.
3. Children's Surgical Associates has made me aware, that as a patient, I am entitled to a copy of this privacy policy if I desire a copy for my personal file.

Upon review of the above statements, please sign below acknowledging that you have been advised of the privacy policy implemented by Children's Surgical Associates and have read and understood the acknowledgement form,.

If you desire a copy of the Privacy Policy, please request one at this time.

___ No, I do not want a copy, but acknowledge the Privacy Policy exists.

___ Yes, I do want a copy of the Privacy Policy

_____
Patient Signature (Guardian if patient is a minor)

Patient Agreement for Communication

I understand that as part of my healthcare, Children's Surgical Associates will need to contact me in order to remind me of an appointment, provide test results, give instructions, or provide other information.

I authorize Children's Surgical Associates to contact me in the following ways (check those which you authorize):

_____ Home phone ---------- _____Voicemail OK

_____ Work phone ---------- _____ Voicemail OK

_____Cell phone ---------- _____Voicemail OK

_____Fax _____

_____E-Mail Email Address: _____

Children's Surgical Assiciates does not use secure server for e-mail communication. Because a secure server is required by law for e-mail communication with patients, Children's Surgical Associates does not endorse the use of email communication with patients.

I understand that Children's Surgical Associates will use the minimum necessary information needed when communicating with me indirectly. I understand that I may revoke or modify this agreement at any time. Any revocation or change will not apply to past communications.

I further authorize Children's Surgical Associates to discuss matters related to my condition/care with the following:

_____ _____
(Please Print) Relationship to patient

_____ _____
(Please Print) Relationship to patient

_____ _____
Signature (Guardian if patient in a minor) Date

Patient # _____ **Today's Date** _____

Children's Surgical Associates, P.C.

755 Mount Vernon Hwy NE, Suite 460 Atlanta, GA 30328 404-252-7900 Fax 404-252-7905

PLEASE PRINT LEGIBLY

Child's Full Legal Name _____

Age _____ Date of Birth _____ Birth Weight _____ **Nickname** _____

Sex _____ Current Height _____ Current Weight _____

Who referred you to our office? _____

Who is your child's Pediatrician? (if different from above) _____

Why are you here today? _____

When did you first notice/problem begin?

_____

The CHILD'S general health is: (circle) GOOD FAIR POOR

Are the CHILD'S immunizations up to date? (circle) YES NO

If NO, please specify: _____

MEDICATIONS

List all medications, including supplements your CHILD is currently taking: _____

_____

List all medications your CHILD is ALLERGIC to: _____

PAST MEDICAL HISTORY

List all surgeries your child has had, when, and where: _____

_____

_____

List all hospitalizations other than for surgery indications why, when, and where: _____

_____

FAMILY HISTORY

Please check the appropriate disorder that is found in your family history

___ Bleeding Problems/Prolonged Bleeding
___ Problems with Anesthesia/Sedation
___ Cancer
___ Genetic Disorders/Syndromes
___ Sickle cell anemia or Sickle cell trait
___ Other

Please specify if any of the above are checked: _____

_____

List siblings and ages _____

Is there a smoker living in the home of the child? (circle) YES NO

Are there pets living in the home of the child? (circle) YES NO If yes, please list: _____

Does your home utilize: (circle) CITY WATER WELL WATER

Reviewed by _____ M.D.

REVIEW OF SYSTEMS **CHILD'S NAME** _____

Please check the appropriate line if your child has any of the following

BIRTH HISTORY

___ Prematurity: weeks gestation _____ OR weeks early _____
___ C-section
___ Apnea Monitor
___ Other _____

HEART OR BLOOD PROBLEMS ___YES ___ NO
___ Heart Defect
___ Bleeding Problems
___ Sickle Cell Diseast/Trait
___ HIV Positive
___ Other _____

LUNG OR BREATHING PROBLEMS ___YES ___ NO
___ Asthma/Wheezing
___ Croup
___ Chronic Bronchitis
___ Cystic Fibrosis
___ Other _____

DIGESTIVE SYSTEM PROBLEMS ___ YES ___ NO
___ Hepatitis
___ Intestines/Bowels
___ Liver
___ Gastro-esophageal Reflux
___ Stomach
___ Other _____

NERVOUS SYSTEM PROBLEMS ___ YES ___ NO
___ Convulsions, Seizures, or Fits
___ Cerebral Palsy
___ Hydrocephalus
___ Down's Syndrome
___ Myelomeningocele
___ Developmental Delay
___ Learning Disability
___ Other _____

MUSCLE OR BONE/JOINT PROBLEMS ___ YES ___ NO
___ Muscle Disorder
___ Bone Disease
___ Joint Disease
___ Rheumatoid Arthritis
___ Other _____

KIDNEY OR BLADDER PROBLEMS ___ YES ___ NO
___ Explain _____

GLANDULAR PROBLEMS ___YES ___ NO
___ Diabetes
___ Thyroid
___ Other _____

HAS MENSTRATION STARTED? ___ YES ___ NO
Date of last menstrual period: _____

CANCER/CHEMOTHERAPY ___ YES ___ NO
If yes, please explain: _____

OTHER PROBLEMS OR SYNDROMES ___ YES ___ NO
If yes, please explain: _____

Reviewed by _____ M.D