Patient Registration

PATIENT 1 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____ Preferred name_____
Ethnicity: Hispanic / Non-Hispanic / Unknown / Prefer Not to Answer
Race: White / Black/ Hawaiian/Asian / Unknown / Prefer Not to Answer

PATIENT 2 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____ Preferred name_____
Ethnicity: Hispanic / Non-Hispanic / Unknown / Prefer Not to Answer
Race: White / Black/ Hawaiian/Asian / Unknown / Prefer Not to Answer

PATIENT 3 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____ Preferred name_____
Ethnicity: Hispanic / Non-Hispanic / Unknown / Prefer Not to Answer
Race: White / Black/ Hawaiian/Asian / Unknown / Prefer Not to Answer

PATIENT 4 - Last name:_____ First name_____ MI:____ Sex_____ DOB:_____
Primary Language:_____ Preferred name_____
Ethnicity: Hispanic / Non-Hispanic / Unknown / Prefer Not to Answer
Race: White / Black/ Hawaiian/Asian / Unknown / Prefer Not to Answer

Physical Address:
Name: _____
Street: _____City:_____State:_____Zip_____
Mailing Address (If different than physical address):
Name: _____
Street: _____City:_____State:_____Zip_____
Preferred Contact Name: _____ **Phone #**:_____
Preferred Contact Email: _____

Insurance:
Primary Insurance Carrier:_____**ID#**_____**Group#**_____
Primary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

Secondary Insurance Carrier:_____**ID#**_____**Group#**_____
Secondary Insurance Policy Holder:
Last name:_____ First name_____MI:____Sex_____DOB:_____SS#_____

I hereby assign all medical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I hereby voluntarily consent to treatment at Stepping Stones Pediatrics and authorize such treatments, examinations, medications, and diagnostic procedures (including, but not limited to the use of lab and radiographic studies as ordered by attending physicians).

PRINTED Name of Parent / Legal Guardian completing this form: _____

Signature of Parent / Legal Guardian _____ Date: _____

CONTACTS

Parent / Legal Guardian - Primary Contact:

Last name: _____ First name_____ MI: _____

Sex_____ DOB: _____SS#_____ Preferred name:_____

Relationship to patient: _____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email: _____ Secondary Email: _____

Parent / Legal Guardian - Secondary Contact:

Last name: _____ First name_____ MI: _____

Sex_____ DOB : _____SS#_____ Preferred name:_____

Relationship to patient:_____ Resides With Patient?_____

Employer:_____Occupation:_____

Primary Phone:_____ Secondary Phone:_____

Primary Email: _____ Secondary Email: _____

IF patient(s) is a minor child(ren) and PARENTS ARE DIVORCED OR SEPARATED, PLEASE FILL OUT THIS SECTION:

Who has physical custody of the child/children? _____

Are there any legal considerations that might restrict the non-custodial parent from consenting to medical treatment?

YES_____NO_____

If YES, please explain and provide legal documentation that supports the restriction(s). _____

_____

_____

_____

Signature of Parent / Legal Guardian _____ Date: _____

Medical Disclosure Authorization

I hereby certify that I am the patient or the legal parent/guardian of:

PRINT Patient #1. _____

PRINT Patient #2. _____

PRINT Patient #3. _____

PRINT Patient #4. _____

I hereby authorize the following person(s) to act as my legal proxy for the above-named patients with regard to:

1) Authorization for Medical Treatment [*may authorize medical treatments to be given, including shots*]
2) Access to Medical Information and Test Results [*may have full access to medical records for the above-named child(ren)*]
3) Release of Financial Information [*may have full access to account records and any financial information for the above-named child(ren)*]

	Name:	**Telephone:**	**Relationship To Child:**
Designee #1:	_____	_____	_____
Designee #2:	_____	_____	_____
Designee #3:	_____	_____	_____

	Authorization for Medical Treatment	**Access to Medical Info/Test Results**	**Release of Financial Information**
Designee #1:	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Designee #2:	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Designee #3:	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

I understand that I have the right as the legal parent/guardian of the above-mentioned child to amend this proxy listing at any time upon written notification to Stepping Stone Pediatrics.

PRINTED Name of Parent / Legal Guardian: _____

Signature: _____ **Date: _____**

Messages:

Please reach me at the following preferred phone number: _____

If I am unavailable to answer calls at this number (please check one):

( ) You may leave a detailed message.

( ) Please leave a message asking me to return your call.

( ) Please do not leave any message.

( ) Other_____

Privacy Practices Notice
Acknowledgment of Receipt

By signing below, I acknowledge that I have been given the opportunity to review or been provided a copy to review of Stepping Stone Pediatrics' Notice of Privacy Practices for protected health information.

Date: _____

Patient #1:

NAME_____DOB_____

Patient #2:

NAME_____DOB_____

Patient #3

NAME_____DOB_____

Patient #4:

NAME_____DOB_____

PRINTED Name of Parent / Legal Guardian: _____

SIGNATURE of Parent / Legal Guardian: _____

Relationship to Patient(s): _____

STEPPING STONE PEDIATRICS

LATE POLICY

Sick Patient Appointments

Patients who are 15 minutes or more late for their appointment will be seen as a "work-in" patient. Priority will be given to patients who arrive on time for their appointments, UNLESS A PATIENT IS IN DISTRESS (these patients are ALWAYS given priority).

Well Child Appointments

If patients who are 15 minutes or more late for their appointment, the front office staff will consult with the provider to determine if the patient can be worked in at that time. The provider will base the decision on the extent of additional wait time for the patient and the impact on the schedule. Patients that cannot be worked in will need to reschedule their appointment. Decisions made by the provider are final.

Signature: _____

Date: _____

PRACTICE AGREEMENT

Stepping Stone Pediatrics adheres to the "medical home" model of care, generally acknowledged to provide the best care for your child. We pride ourselves on offering both well child and sick visits so that your child's care is provided by those who already know him/her and have the medical history at hand. In keeping with the concept of a "medical home" for your child(ren), we strongly encourage parents to keep up with their child's checkups and reserve the right to refuse acute care visits to patients who have pursued Well Child care elsewhere. Our commitment to providing excellent medical care of your children comes with financial responsibilities. As such, Stepping Stone Pediatrics, LLC, has adopted the following policies. Please contact our billing office with any questions.

PAYMENT DUE AT TIME OF SERVICE

- Copays are due at the time of service, regardless of who brings your child in to be seen. Please make arrangements for payment prior to your child arriving at our practice.
- Payment is expected for any outstanding balance on the account at time of service. At your request, we will be happy to provide an itemized statement for your records.
- Self-Pay patients are expected to pay at time of service. A prompt pay discount will be applied to Self-Pay balances paid in full on the date of service.
- **For separated or divorced parents, the financial responsibility belongs to the guarantor of the family account. Copays and balances are due at the time of service. Stepping Stone Pediatrics will not be placed in the middle of any financial agreement or communication dispute between parents. We will be happy to provide you with a detailed receipt for reimbursement from the other party.**

INSURANCE (In-Network)

- Proof of insurance must be shown at check-in at **every** visit. Please make sure to bring your card to every visit. Without proof of insurance, you will be considered Self Pay and payment in full will be due at time of service.
- Newborn insurance – Getting your new baby on your insurance plan may require some effort on your part. Please see our Newborn Insurance Waiver for more details on expectations for new parents.
- If your insurance requires a primary physician (PCP) to be named (HMO and/or POS usually), please verify that Dr. Kim at *Stepping Stone Pediatrics* is listed as the chosen provider prior to your appointment. Failure to do so will cause a denial of the claim. Claims denied for incorrect PCP selection will become your financial responsibility.
- **While we file insurance as a courtesy, you are ultimately responsible for verifying that we are in network with your INSURANCE CONTRACT (not just insurance company). Please familiarize yourself with your plan's copayment, co-insurance, and deductible requirements annually. These charges are your financial responsibility.**
- We will file secondary claims once as a courtesy only for insurances for which we are In-Network. If your secondary insurance denies the claim or fails to respond within 30 days, the account balance will revert to your responsibility.
- Balances not paid by the insurance company through no fault of Stepping Stone Pediatrics will be billed to you directly for payment. These denials could include instances where the insurance company is waiting on you to contact them to coordinate benefits, pick a primary care provider, correct a date of birth, etc.

Initial and Date _____

INSURANCE (Out-of-Network)

- We can bill as an out-of-network provider if we do not participate with your insurance ***if*** you have out-of-network benefits, however, it is your responsibility to verify your out-of-network benefits. You will be financially responsible to pay for any visit denied as Out-of-Network and non-payable by your insurance company.

WELL/PREVENTATIVE CARE VISITS

- While many policies cover these visits in full, some insurance contracts are now applying copays and/or deductibles, regardless of our in-network status with the insurance company. It is ultimately your responsibility to understand your individual contract as we do not have access to the specifics of your contract with your insurance company.
- If during a well visit your child is sick or time is spent on a concern not related to normal growth and development, an office visit may also be charged in addition to the well visit. You will be responsible for any financial obligations incurred, including copays, co-insurance, and/or deductibles.

BALANCES ON ACCOUNT – In order to ensure that we can continue to provide the level of care you have come to expect from us, the information below outlines how we will be handling balances on the patient account.

- Financial statements will be mailed out approximately every 30 days. Payment is expected upon receipt of the financial statement. Failure to pay your account balance(s) could ultimately result in your account being sent to an outside collections agency and/or your family being discharged from our practice. Reinstatement, if allowed, will require payment in full plus any associated fees.
- If you have any special financial needs, please let us know as soon as possible by speaking with a member of our billing department, in person or by phone. We are willing to work with our parents to attempt to meet their needs and to continue providing care to our patients.
- Structured Payment Plans are available. All payment plans must be secured with a credit card and a payment plan agreement must be signed. The payment plan agreement will offer details on how your account will be handled during the duration of the agreement.
- Should your account become an in-house collections account, payment in full may be required before we will be able to schedule any further appointments.

HIGH DEDUCTIBLE PLANS –Many insurance policies now have high deductibles in exchange for lower premiums. It is within your rights to *not* file insurance and to pay out of pocket in an attempt to lessen the financial impact of these high deductible policies. Should you decide to be Self-Pay in order to avoid paying a high deductible, we will consider your family as Self-Pay for the duration of your insurance contract, ***regardless of visit type***. In general, it is in your best interest to file all claims to your insurance company, however, if needed we do offer payment plans for those who elect to go Self-Pay.

http://fairhealthconsumer.org/index.php - This is a great resource in helping the general public navigate their insurance and understand what everything means through videos, glossary, Health Insurance 101, and other educational materials.

Initial and Date _____

VACCINATION SCHEDULES – Stepping Stone Pediatrics adheres to the guidelines set forth by the CDC & the AAP in the vaccination of our patients. Any decision to alter this schedule will need to be discussed with and agreed upon by your practitioner on a case by case basis. In general, should an individualized vaccine schedule be agreed upon which varies from the traditional CDC schedule, noncompliance of the family with the negotiated schedule will result in either (a) immediate reversion to the CDC Catch-Up schedule or (b) discharge from the practice, at the practice's discretion. **Please be aware that some insurance companies are denying payment for immunizations administered in a manner that deviates from the CDC approved vaccination schedule**. You will be financially responsible for payment of a vaccination due to denial for this reason – and vaccines are extremely expensive!

MEDICATION REFILLS

Please provide 3 business days' notice for all refill requests to be authorized, especially those for controlled substances. Expedited prescription requests will be processed as quickly as possible but cannot be guaranteed and will be assessed a service fee of $50 per prescription.

MEDICAL RECORDS POLICY

One set of medical records requested from our office to be sent directly to another medical provider will be processed at no charge. Printed medical records will be charged according to state regulations. When the records have been printed, we will contact you to notify you that they are ready and the incurred cost. This must be paid in full before we will release the records to you. A copy of the state of Georgia regulations is available upon request. If the records need to be certified, there will be an additional $5 fee assessed per record.

Please note that by allowing us to provide care for your teenage (≥ 13yo) child, you are acknowledging and consenting that there is a presumption of privacy associated with patients in that age group and that therefore certain aspects of their medical record may be redacted or will otherwise not be accessible to parents.

RETURNED CHECKS

As a courtesy, we do accept personal checks. We do not accept third party checks. Any check that is returned to us for any reason will be subject to a service charge. The first returned check will be charged a fee of $25 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. The second returned check will be charged a fee of $50 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. A letter will be mailed to the family and all returned checks plus applicable fees must be paid by cash, cashier's check, money order, or credit card within 10 days of the receipt of the letter per Georgia law (Section 16-9-20 pf the Official Code of Georgia). After a second offense, we will no longer accept checks on your family account.

COST OF FORMS COMPLETION

Patient forms often take considerable time for our clinical staff to complete and removes that clinician from the ability to offer patient care. Please allow 5 business days for all paperwork requests. Most straightforward paperwork will be completed without charge, however there may be a document preparation fee, not to exceed $150, based on the degree of complexity involved in completing the requested form(s). We will contact you when all forms have been completed to arrange pick up.

Initial and Date _____

NO SHOW/MISSED APPOINTMENT POLICY

Because we do not "overbook" appointments, we are especially vulnerable to "No Shows" where someone has taken up an appointment slot but failed to show up for the appointment. This greatly impacts our ability to remain financially viable. As a result, we have implemented the following "No Show" policy:

- The policy covers the entire family, not just an individual child.
- A "No Show" is considered 1) a Well Check missed without notification at least 1 business day before the appointment date, 2) an Acute Care appointment that is missed with less than 2 business hours notification, or 3) any appointment missed without notification.
- New patients of families not already established with us who "No Show" their first appointment will not be eligible to schedule future appointments, nor will their siblings.
- For established families, the following guidelines apply:
- FIRST NO SHOW by any family member in a 12 month period – a notification letter will be sent advising the patient of the missed appointment and the "No Show" policy.
- SECOND NO SHOW by any family member in a 12 month period – a second notification letter will be sent alerting the parent/guardian of the missed appointment and that another "No Show" will result in discharge from the practice in accordance with this policy. In addition, a $50 "No Show" fee will be added to the patient's account.
- THIRD NO SHOW by any family member in a 12 month period – Dismissal from the practice will be suggested to the physician. If dismissed from the practice, a discharge letter will be mailed to the parent/guardian. If the family is not dismissed from the practice, a Reinstatement Fee of $250 will be assessed on the patient's account to help recoup revenue lost from unavailable patient access time and which must be paid in full prior to the next appointment being scheduled.
- "No Show" notification letters are a *courtesy* and are not a necessary condition to discharge a patient/family from the practice.
- We reserve the right to make appropriate adjustments to individual accounts.

Signature_____ **Date** _____

Print Name_____

Patient Name: _____

DOB: _____

Patient's Medical History

Please check all that apply:

_____ ADD/ADHD
_____ Allergies
Non-Medication Allergies: _____
Concerns
_____
Medication Allergies: _____
_____
_____ Anemia
_____ Asthma
_____ Autism Spectrum Disorder
_____ Cancer
_____ Cerebral Palsy
_____ Congenital Heart Disease
_____ Constipation
_____ Developmental Delay
_____ Diabetes Mellitus
_____ Eating Disorder
_____ GERD
_____ GYN Problems
_____ Head Injury/Concussion
_____ Headaches
_____ Inflammatory Bowel Disease
_____ Mental Health
_____ Otitis Media
_____ Pneumonia
_____ Scoliosis
_____ Seizures
_____ Sickle Cell Anemia
_____ Skin Problems
_____ UTI
_____ Vision Problems

Other significant medical history:

_____
_____
_____
_____

Surgical History (Please check all that apply):

_____Adenoidectomy
_____ Appendectomy
_____ Circumcision
_____ Ear tubes
_____ Fracture Surgery
_____ Heart Surgery
_____ Inguinal Hernia Repair
_____ Lymph Node Biopsy
_____ Tonsillectomy

Other significant surgical history:

_____
_____
_____
_____

Medications taken daily (Over the Counter or Prescription):

Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____
Name: _____ Dose: _____

Family History

Family Last Name: _____

Pharmacy Name: _____

Pharmacy Telephone Number: _____

	Biological Mother Name:	Biological Father Name:	Child Name: DOB:	Child Name: DOB:	Child Name: DOB:	Child Name: DOB:	Child Name: DOB:	Child Name; DOB:	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
No known medical condition												
Age of Death												
Cause of Death												
Alcohol Abuse												
Arthritis												
Asthma												
Birth Defects												
Cancer (type)												
COPD												
Diabetes												
Drug Abuse												
Hearing Loss												
Heart Disease												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Learning Disability (ex. Dyslexia)												
Mental Illness (ex. Depression)												
Intellectual Disability												
Miscarriages												
Stroke												
Vision Loss												
Other:												
Other:												

MEDICAL RECORDS RELEASE

Patient Name: _____

Phone: _____ Date of Birth _____/_____/_____

I authorize _____, (Fax) (_____) _____,

(Phone) (_____) _____ to release the following records:

_____ All Records* _____Office Notes (2 Years) _____ Lab Reports (2 Years)

_____ Billing Records _____ Prescription Records _____ Radiology Reports (2 Years)

_____ Other/Exclude: _____

*Could include privileged psychiatric, drug/alcohol, HIV/STD, pregnancy, or other protected health information unless otherwise excluded above.

Do these records need to be certified? YES or NO (circle one)

This authorization shall expire in one year unless otherwise noted here: Expiration _____/_____/_____

Please send the records listed above to:

Name: **Stepping Stone Pediatrics**

Address: **1770 Dennis Kemp LN NW**

Kennesaw, GA 30152

Phone: **770-515-9000**

Fax: **678-813-3355**

_____ I understand that any record obtained may include sensitive information (i.e. HIV status, ADHD, etc.)

_____ I understand there may be a cost associated with this request for medical records and agree to pay at time of pick up.

I understand that after the disclosure of my health information it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of Patient/Guardian/Representative Date

_____ _____

Printed Name of Patient/Guardian/Representative Relationship to Patient (Parent, POA, Guardian, etc…)