WESTCARE VILLA RICA PEDIATRICS
626 Dallas Hwy
PO Box 1008
Villa Rica, GA 30180
Phone: 770-459-9378
Fax: 770-459-8613
Email: westcarepeds@aol.com

DATE_____

PATIENT INFORMAION

Child's Name_____Date of Birth_____Sex_____
Address_____City_____State_____Zip_____

Home Phone_____Childs SS#_____Date of Chicken Pox_____
List Allergies_____
Medical Condition_____Medications_____

PARENT INFORMAION

Mother's Name_____Maiden Name (Required)_____

Home Phone_____Cell Number_____DOB_____

Employer_____Work Phone_____SS#_____

Father's Name_____Address if different_____

Home Phone_____Cell Number_____DOB_____

Employer_____Work Phone_____SS#_____

INSURANCE INFORMATION (PARENT WHO PAYS FOR INSURANCE)

Parent's Name_____Insurance Co. Name_____

ID#_____Group #_____Ins. Co. Phone#_____

IS THERE ADDITIONAL COVERAGE ON YOUR CHILD, IF YES, CONTINUE

Parent's Name_____Insurance Co. Name_____

ID#_____Group #_____Ins. Co. Phone#_____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND YOUR DRIVERS LICENSE. CHILDREN UNDER 18 MUST BE ACCOMPANIED BY PARENT. ALL CHILDREN MUST BE ACCOMPANIED BY AND AUTHORIZED LISTED ADULT!!!!

Westcare Villa Rica Pediatrics
626 Dallas Hwy
Villa Rica, GA 30180
770-459-9378

I GIVE MY CONSENT TO WESTCARE VILLA RICA PEDIATRICS TO TREAT MY CHILD.

X_____

ASSIGNMENT OF BENEFITS

I the undersigned, assign directly to Westcare Villa Rica Pediatrics all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred and that Westcare Villa Rica Pediatrics will file a claim on my behalf as a courtesy. I further understand that any and all charges that are not paid by m insurance company are deemed my responsibility. I will remit payment immediately upon request to Westcare Villa Rica Pediatrics.

X_____

VERIFICAION OF BENEFITS AND INSURANCE COMPANY DISCLAIMER

When we verify your benefits, your insurance company gives the following disclaimer: This is only a verification of benefits and not a guarantee of payment. Actual benefits, eligibility and payment of a claim cannot be determined until a claim is received. This means you are still responsible for payment but we will file your claim as a courtesy.

X_____

PLEASE PRESENT YOUR INSURANCE CARD

Your insurance company requires that you present your insurance card at each office visit. We do not accept insurance verifications from your human resources department, only from and insurance company representative. Your child's birthday must be correct with the insurance or we will not accept your insurance. Your will be asked to pay for the visit and once the information is correct, a claim will be filed and you will be reimbursed the appropriate amount once payment is received.

X_____

CO-PAYMENT REQUIREMENT AND SECONDARY FILING

If your insurance plan requires a copay, that amount is due at each office visit, including next day of follow-up visits. If you have Primary Insurance and Medicaid, the primary Insurance is always billed first; Medicaid (WellCare, Peach State, Amerigroup) is always secondary.

X_____

ATTENTION: If your have Amerigroup, Peach State, WellCare, Peach Care for Kids, OR Medicaid AND ANY OTHER HEALTH INSURANCE, it is required that the other insurance be filled first. If we later find that you have any other insurance, YOU WILL BE RESPONSIBLE FOR THE TOTAL BILL

Sign here showing that you understand and agree. X_____

METHODS OF PAYMENT

Westcare Peds accepts cash or debit cards, Visa, MasterCard, American Express and Discover, as a method of payment for copays. If you do not have insurance, you are required to pay in full for services rendered. At that time, you may pay by check also. Your check will be guaranteed through Telecheck and must receive an acceptable approval code form Telecheck. If your check is deemed unacceptable, you must present cash or a major credit card that is accepted. Insufficient Funds Fee for returned checks is $3o.oo. Receipts are given at each office visit. If you need a detailed receipt, please request it at the same time of the visit. Please retain this receipt for your tax records. No addition copies will be given.

X_____

BALANCES ACQUIRED AFTER CLAIM SUBMISSION

There may be a portion of the charges or all the charges may be deemed your responsibility. This may be described as "deductable or Non-Covered Services Bill Patient". You will be billed for the charges submitted; this information will reflect the Explanation of Benefits received from your insurance company. Payment will be expected at the time of billing and no longer that 30d days from the bill date.

X_____

SELF PAY PATIENT WITH BALANCES

This office does not bill for services rendered. If a payment arrangement is agreed upon, to pay only a portion of your charges at the time of service, due to an exceptional circumstance, the balance of the charges are expected to paid within 30 days. THIS REQUEST MUST BE PRIOR TO APPROVED BY DR. EDIALE OR THE BILLING MANGER ONLY, EXT 15

X_____

DELINQUENT ACCONTS AND COLLECTIONS

ALL ACCOUNTS WITH BALANCES WILL BE BILLED FOR 90 DAYS. AFTER 90 DAYS, YOU WILL BE SENT A FINAL NOTICE AND WILL BE GIVEN AN ANDDIONAL 7-BUSINESS DAYS TO BRING YOUR ACCOUNT CURRENT. IF NO PAYMENTIS RECIVED DURING THE FINAL NOTICE PERIOD, YOUR ACCOUNT WILL BE FORWARDED TO COLLECTIONS. PLEASE NOT THAT IF A COLLECTION ACTION BECOMES NECESSARY, THIS DELAY ANY REQUEST YOU MAKE UNTIL THE ACCOUNT IS PAID IN FULL, FOR ANY CHILD IN YOUR FAMILY.

X_____

RELEASE OF MEDICAL RECORDS AND IMMUNIZATION CERTIFICATES

Medical Records are copied on Wednesday only. Medical Records are mailed without a charge when they are requested from Westcare Peds on your new Physician's Letterhead. Medical Records and Immunization Forms will not be faxed. If the documents are being requested and picked up by the parent, there is a charge of $25.00. Immunization records are $2.00 each payable upon pick up. There is no charge for immunization records on the day shots are given.

X_____

REQUEST FOR LETTERS AND COMPLETION OF FORMS

There is a charge of $15.00 for letters and/or completion of documents that require a physician's attention. The types of documents that require a Physician's attention include buy are not limited to, Letter's (any kind), Medical Leave Papers and Housing changes. Please allow 5-7 business days for completion. No fees will be waived.

REQUEST FOR UTILTY LETTER

We do not write letters to utility companies. However, on an individual case by case basis, an exception may be considered for a child with a document life threatening illness. No other reasons will be allowed! Utility letters will be directed to the utility company only, no exceptions. It will not be given to the parent. This measure is to prevent tampering with the letter. You must supply all necessary information as requested. The utility in question must be in the name of a list parent. No other relative names are acceptable and this must be the physical address that we have on file for the patient. There is a charge of $15.00 and payment must be received before the letter is written. Please not that your request requires approval by Dr. Ediale (owner) ONLY! If your request is approved, you will only be allowed one (1) letter per year, regardless of the utility season. Please allow 5-7 business days for approval and completion of your request. No fees will be waived.

X_____

Camp forms, Girl Scout forms, college forms, school medication forms or sports physical forms require a full history and physical. There is a charge of $5.00. Please allow 24- 28 hours for completion. No fees will be waived.

X_____

REFERAL TO A SPECIALIST, DIAGNOSTIC TESTING AND EMERGENCY VISITS

If it becomes necessary for your child to see a specialist, this is called a Referral. You must make sure that the information we have in our file is accurate. Also, if your child is in need of EMERGENCY after hours care, call the office first and speak with the answering service and if necessary they can page the doctor on call. Patients with insurance; if your insurance requires a referral for after hours urgent care, it is your responsibility to call the office the next business day to inform us of your emergency visit. Your insurance company will make the determination regarding payment to the urgent care center.

X_____

AUTHORIZATION TO REICEVE MEDICAL RECORD INFORMAION

I authorized Doctors, Hospitals, Employers or other persons whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records, which will be requested by Westcare Villa Rica Pediatrics.

X_____

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMAION (HIPPA PATIENT PRIVACY LAW)

By signing below your consent to the use, disclosure of your protected health information by Josephine Ediale MD, Nurse Practitioner, Medical Staff and business Associates for treatment, payment, and healthcare operations. Confidential patient information will not be release for any reasons for any reasons other than those started above. We do not release any information for medical surveys or any similar request.

HIPPA PATIENT PRIVACY LAW (CONT.)

You have the right to request that we restrict our uses or disclosure of protected health information which we are otherwise permitted to make for treatment, payment and health care operation, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken in action in reliance on it.

X_____

AUTORIZED PERSON'S IDENTIFICAION WILL BE REQUESTED FOR YOU CHILDS PROTECTION!

In my absence, I authorize the following person(s) to bring my child in for medical treatment, to pick up forms or to receive any requested information regarding my child:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Emergency Contact Name & Number:_____

Please list the names of other children that are seen at Westcare Villa Rica Pediatrics

_____,_____,_____

I HAVE READ ALL THE ABOVE INFORMAION AND I AGREE AND UNDERSTAND FULLY.

SIGNATURE_____DATE_____

RELATIONSHIP_____CHILD'S NAME_____

Initial History Questionnaire

Name

ID Number

Birth Date Age

Form Completed by Date Completed

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health Problems

Are there siblings not listed? If so, please list their and ages and where they live?

If mother and father are not living together or if not live with parents. What is the child's custody

If one or both parents are not living in the home he/she see the parent/parents not in the home

Birth History

Birth weight

Was the baby born at term? Early? Late?

If early, how many weeks gestation?

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain

During pregnancy, did mother

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No

What_____ When _____

Was the delivery ☐ Vagina? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain_____

_____

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain_____

_____

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain_____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

Has your child had any surgery? ☐ Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain_____

Are you concerned about your child's mental development? ☐ Yes ☐ No Explain_____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

How is his/her behavior in school?_____

Has he/she failed or repeated a grade in school?_____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes?_____

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problem, HIV OR AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

_____

_____

Past History

Does your child have or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When _____
Frequent ear infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Nasal allergies	☐ Yes	☐ No	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	Explain _____
Asthma, bronchitis, bronchiolitis	☐ Yes	☐ No	Explain _____
pneumonia	☐ Yes	☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____
Aneroia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____
Bladder or kidney infection	☐ Yes	☐ No	Explain _____
Bed wetting (after 5 years old)	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain _____
(For girls) Are there problems With her periods?	☐ Yes	☐ No	Explain _____
Any chonic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain _____
Frequent headaches	☐ Yes	☐ No	Explain _____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain _____
Diabetes	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain _____
Any other significant problem	☐ Yes	☐ No	Explain _____