Northside Pediatrics, PC

Pediatric and Adolescent Medicine

Holly A. Hoenes, MD
Caitlin Corley, CPNP

New Patient Welcome Packet

WELCOME TO NORTHSIDE PEDIATRICS!

We are pleased to have your family join our practice of patients!

Enclosed you will find essential paperwork that needs to be completed and submitted prior to your first scheduled appointment.

PLEASE RETURN THE MEDICAL RECORDS RELEASE FORM ASAP SO THAT WE MAY OBTAIN RECORDS FROM YOUR PREVIOUS PHYSICIAN. THIS WILL ENABLE US TO KNOW YOUR CHILD'S HISTORY PRIOR TO THE VISIT.

We encourage you to make use of our website as it has a wide range of resources for you are a parent.

www.northsidepediatricsmacon.com

WE LOOK FORWARD TO MEETING YOU AND YOUR CHILD!

145 N Crest Blvd * MACON, GEORGIA 31210 * PHONE: 478-477-4044 * FAX: 478-477-7076
NORTHSIDEPEDIATRICSMACON.COM * NORTHSIDEPEDS@YAHOO.COM

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Holly A. Hoenes, M.D.
Patient Information Form

Patient's Name (child) _____ SS#_____

Street Address _____

City_____ State_____ Zip _____

Home Phone _____ Alternate/Cell _____

Date of Birth _____ E-mail _____ Sex ____

Father's Name _____ SS# _____ DOB _____

Address & Phone (if different from patient)

_____

Employer _____ Work Phone _____

Mother's Name _____ SS# _____ DOB _____

Address & Phone (if different from patient)

_____

Employer _____ Work Phone _____

Insurance Information

Name of Insurance Company _____

Name of Insured _____

ID# _____ Group _____

List other children and birthdates.

1. _____DOB_____
2. _____ DOB_____
3. _____ DOB_____

Step Mother: _____ DOB_____Phone #_____

Step Father: _____ DOB_____Phone #_____

Today's date: _____

Child's Name: _____ **Date of Birth:**_____ **Sex:** M F

Person Completing This Form: _____ **Relationship to Child:** _____

Primary Insurance: _____**ID#:**_____

I. GENERAL HISTORY

1. Does your child have any of the following symptoms/ illnesses? (Please check all that apply.)

☐ GI Issues (Reflux, Ulcers, etc.) ☐ Learning/Developmental Disabilities (Autism, ADHD, etc.)

☐ Asthma ☐ Heart Problems ☐ Diabetes

☐ Other (Specify All)

_____

2. Does your child have any allergies? ☐ Yes ☐ No

If yes, please indicate:

_____

3. Please describe anything else we need to know:

_____

_____

_____

II. BIRTH HISTORY

1. Was your baby born within 2 weeks of his/her due date? ☐ Yes ☐ No

If not, at how many weeks gestation was the baby born? _____

2. How much did your baby weigh at birth? _____ **Born by:** Vaginal or Caesarian Section

3. Did you have any of the following problems with pregnancy, labor, or delivery:

☐ Gestational Diabetes ☐ Preterm Labor ☐ Eclampsia/Pre-eclampsia

☐ Abnormal Ultrasound ☐ Infection ☐ Other
(Specify)_____

Please describe:
_____

4. Did your baby have any of the following problems in the nursery?

☐ Gastroesophageal Reflux (GERD) ☐ Mechanical Ventilation ☐ Bronchopulmonary Dysplasia (BPD)

☐ Apnea ☐ CPAP Therapy ☐ Necrotizing Enterocolitis (NEC)

☐ Feeding and Growth Issues ☐ Tube Feedings ☐ Intraventricular Hemorrhage (bleeding in brain)

☐Other(Specify)_____

5. How long did your baby stay in the NICU? _____

III. PEDIATRIC CARE

1. Previous name, address, and contact number of primary physician/ pediatrician:

_____

2. Does your child currently see any specialists? ☐ Yes ☐ No - If yes, please list below:

Name of Specialist	Specialty	Location (city, state & phone #)	Date last seen

3. Please list your child's current medications. (Include vitamins and other over-the-counter medications):

Medication	Dose	How Often	Prescribing Doctor's name

4. Has your child ever been hospitalized or required surgery? ☐ Yes ☐ No

If yes, please give dates, reason, and facility name/location:_____

5. Are your child's immunizations up to date? ☐ Yes ☐ No

Name of physician or facility immunizations given by

_____

(Please bring copy of immunization record if out of state)

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FINANCIAL POLICY

Welcome to Northside Pediatrics, PC. In order to better serve you and your children, Northside Pediatrics would like for you to understand our financial policy.

Payment is required at the time of services unless other arrangements have been made in advance. This includes all applicable copayments and coinsurance payments for participating insurance companies. Northside Pediatrics, PC accepts cash, personal checks, VISA, and MasterCard. We offer a 20% courtesy discount for all self-pay patients paying in full at the time of service.

Because we cannot predict exactly what services will be provided to your child, we cannot precisely tell you ahead of time how much your charges will be. You may receive a printout of your charges at the end of your visit if you desire.

Insurance

We bill participating insurance companies as a courtesy to you. You are expected to pay your copay and deductible at the time of service. If we have not received payment from your insurance company within 45 days of the date of service we may bill you for the remaining balance. **It is the parent's responsibility to provide Northside Pediatrics, PC with a current insurance card at every visit.**

We do not bill secondary insurance companies. We can provide you with a receipt of service that includes all information necessary for you to submit a claim to your secondary insurance.
If you have questions or need assistance, please call the Billing Office between 8:30am and 5:00pm Monday through Friday at 478-477-4044.

Appointments

In order to stay on schedule, we appreciate that you be on time for your appointment. Please call 24 hours in advance if you are unable to make your scheduled appointment. Appointments not cancelled within 24 hours may be subject to a **$50 missed appointment fee.**

Refunds

Overpayments will be refunded to the responsible party within 30 days of written request.

Returned Checks

If your check is returned, a **$30 return fee** will be charged to your account.

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Walk-Ins

Patients who are not having a medical emergency and ask to be seen by a physician without having a scheduled appointment will be charged a **$25 walk-in fee**.

Price Increases

Our price schedule is reviewed on an annual basis.

Statements

Account statements are sent each month to patients with balances that are patient responsible. Insurance billable items are not billed to you until your insurance company informs us that the charges are your responsibility. If you believe that you are being billed in error, please let us know immediately.

Collections

Accounts with balances older than six months, which have not had a payment on the oldest balance for that period of time, may be turned over to an outside collection agency. We are willing to set up payment arrangements, if needed. Please call the Billing Office to set up arrangements.

I have read and understand the Northside Pediatrics, PC Financial Policy. I agree to assign insurance benefits to Northside Pediatrics, PC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for collection costs associated with my account.

Printed name and Signature of insured or authorized representative:

(Printed)_____ (Signature) _____

Date: _____

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NORTHSIDE PEDIATRICS' PRIVACY STATEMENT

Northside Pediatrics considers privacy fundamental to our patient relationships and adheres to the policies and practices described below to protect current and former patients' information.

Internal policies are in place to protect confidentiality, while allowing patient needs to be served. Only individuals who need to do so in carrying out their job responsibilities may access patient information. We maintain physical, electronic, and procedural safeguards that comply with federal standards to protect confidentiality. These standards extend to all forms of interaction with us.

In the normal course of business, patients give us nonpublic personal information such as patient history forms, shot records, records from other physicians, etc. We may use and disclose Personal Health Information (PHI) about you to provide, coordinate, or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. We may disclose PHI when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI when referring you to another health care provider. If you are referred to another physician, we may disclose PHI to your new physician regarding whether you are allergic to medications. We may disclose PHI to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health plan provider.

Any organization receiving patient information may only use it for the purpose designated by Northside Pediatrics.

If you have any questions about this notice, you may contact our Privacy Official.

This notice was published and first became effective on April 14, 2003.

Printed Name: _____ Signature: _____

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INSURANCE NON-COVERED SERVICES

Dear Parent or Guardian:

Insurance regulations suggest that I inform you in advance if I believe a service may not be covered of fully reimbursed by your insurance company. It is my professional judgment that all services, lab tests, and vaccines that are ordered are needed in order to give you quality care. All of these services may not be reimbursed by your insurance company. Each insurance company has its own formula for allowing and approving testing and each plan varies on which, if any, immunizations are covered. It is impossible to know each company's guidelines. It is **YOUR RESPONSIBILITY** to know if vaccines are covered under your particular policy.

Patient Agreement:

I, the parent or guardian of _____, certify that I have read and fully understand the above information. I understand that I am personally responsible for any charges not covered by insurance.

Parent or Guardian Signature _____ Date _____

Witness _____ Date_____

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AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

I hereby give permission for medical treatment to be rendered to the following minor:

Child's Name: _____ DOB: _____

I authorize the physicians and staff of **Northside Pediatrics, P.C., 145 N. Crest Blvd, Macon, GA 31210** to render any treatment deemed necessary.

I authorize the following person/persons to accompany the above named patient for medical treatment. This authorization will remain in effect until written notice of cancellation.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

I, _____, understand and agree that I am responsible for any and all charges for services rendered to said minor. I also understand that **NORTHSIDE PEDIATRICS, P.C.** will file primary insurance as a courtesy, and that all charges not covered by insurance will be my responsibility. I understand that it is my responsibility to present a current insurance card at every time of service.

Authorization given by: _____/_____

(Full Name) (Relationship)

Address: _____

Home Phone: _____ Alternate Phone: _____

Signature: _____ Date: _____

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Medical Records Release Form

I, _____, as parent or legal

guardian of _____, do hereby grant

_____

_____

permission for my child's medical & immunization records to be released to the physician indicated below. I understand there may be a charge for copying full medical records.

Please send my child's medical records to:

Northside Pediatrics, PC
145 North Crest Blvd
Macon, Ga 31210
Phone 478-477-4044
Fax 478-477-7076

PatientName: _____DOB:_____

Parent or Guardian's Name_____

Address: _____

Signature: _____Date:_____