KIDS FIRST PEDIATRICS, LLC

PATIENT AND FAMILY INFORMATION

Childs Last Name:_____ First Name:_____MI____ Sex:_____

Childs SS#_____ Birthdate:_____ Phone#_____

Mailing Address:_____City:_____State/zip_____

Responsible Party:_____Relationship to child:_____

Place of Birth:_____Name In Hospital: Baby Girl/Boy_____

Mother Last Name:_____First Name:_____ MI:_____

Birthdate:_____SS#_____Phone#_____

EMAIL ADDRESS:_____

Mailing Address:_____City:_____State/Zip_____

Employer_____Work/Cell Ph_____

Father Last Name:_____First Name:_____MI_____

Birthdate:_____SS#_____Phone#_____

Mailing Address:_____City:_____State/Zip_____

Employer_____Work/Cell Ph_____

Primary Health Ins Name_____ID#_____

Group ID#_____ADDRESS_____

Responsible Person for Account:_____Relationship to Patient_____

Newborn: Applied for insurance with Medicaid/Wellcare/Amerigroup/Peachstate?_____

Pharmacy:_____

INSURANCE IS FILED AS A COURTSEY TO THE PATIENT. However, the patient is responsible for all fees, regardless of insurance coverage. It's the parents responsibility to be aware of benefits that their insurance provides for well child care and sick visits. All insurance copayments and deductibles are due at the time of service.

Assignment and Release:

I authorize payment directly to KIDS FIRST PEDIATRICS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I authorized the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

DATE:_____ **SIGNATURE** _____

Kids First Pediatrics
530 North Cobb St. · Milledgeville, GA 31061
Phone (478) 453-1020 · Fax (478) 453-1093

Christopher Bowers , M.D. Prabhdeep Brar, M.D. Sokar Kendor, M.D.

Patient History:

Birth Weight:_____lbs_____oz. Full Term_____or Premature Birth_____

Allergies:_____

Medications:_____

Immunizations Up to Date: _____Yes_____No

Goes to Daycare: _____Yes _____No

Smokers in the Home: _____Yes _____No _____Inside _____Outside

FAMILY HISTORY (Parents, siblings & Grandparents) if yes, please list who.

Y/N _____	Diabetes	Y/N_____	Heart Attack
Y/N_____	High BP	Y/N_____	Developmental Delay
Y/N_____	SIDS	Y/N_____	MRSA/Staph
Y/N_____	Seizures	Y/N_____	Stroke
Y/N_____	Asthma	Y/N_____	Birth Defects

Hospitalizations:

Date:_____Reason_____

Date:_____Reason_____

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Signature of Responsible Party:_____**Date:**_____

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Christopher Bowers , M.D. Prabhdeep Brar, M.D. Sokar Kendor,

Kids First Pediatrics No-Show/Collection Policy/Late

No-Show Policy:

If you schedule an appointment and you realize you are unable to keep that appointment please call and reschedule or cancel at least 24hours in advance. This allows time for other patients that may need to be seen to schedule in that slot. Any three consecutive no-shows will result in your child(ren) being discharged from our practice and your insurance will be notified as well.

Collection Policy:

We make every effort to bill the insurance you provide us for the services that are rendered. It is your responsibility to follow up with your insurance and make sure those services are paid. It is also your responsibility to contact us with any patient information changes like insurance, address, phone numbers etc. Any/all copays or co-insurances must be paid at the time of the visit prior to seeing the doctor, unless other prior arrangements have been made. If your account goes into a delinquent status and is sent to collections, your child(ren) will be discharged from our practice.

Patient Name:_____

Guardian Signature:_____

Date:_____

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Consent For Use Of Health Information

This consent gives the physicians and office staff at Kids First Pediatrics permission to use and disclose your health information. Your health information will be used and disclosed to bill for your visits and collect payments from your insurance company. It will also be used to provide you treatment and care to perform necessary routine office operations.

Our "Notice of Privacy Practices" is posted in our waiting room and in each exam room and contains more detailed description of the uses and disclosures covered under this consent. You have been given a copy and we recommend you read it and ask questions prior to signing this consent. You may also ask for an extra copy at any time.

Our office reserves the right to change the privacy practices at any time. If at any time a change is made we will keep an updated copy in the waiting room.

You have the right to revoke this consent except to the extent that we have already taken action covered under this consent. If you decide to revoke this consent, you must do so in writing. You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

In signing this consent you are also agreeing to have treatment, care and/or diagnostic procedures or any other procedures provided by the staff of Kids First Pediatrics.

I have read and understood this consent form and have been given the opportunity to ask questions as needed.

Signature of Legal Guardian Date Relationship to Patient

KIDS 1st
Pediatrics

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

Kids First Pediatrics

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Christopher Bowers , M.D. Prabhdeep Brar, M.D. Sokar Kendor, M.D.

Patient Name: _____

As a resource to make the best decisions possible on our patients, we are asking for permission to view/receive your child's external prescription history. This is where our computer system checks with your pharmacy to let us know exact prescriptions and doses that your child is currently taking.

Do you grant permission for us to view prescription history from external sources? Yes No

Parent signature Date

Authorization for Disclosure of Health Information

1. I hereby authorize (name of provider) _____ to disclose the following information from the health records of:

   Patient Name _____ Date of Birth _____
   Address _____ Telephone _____
   _____ Patient Number _____
   Covering the period(s) of healthcare:
   From (date) _____ to (date) _____

2. Information to be disclosed:
   - o Complete health record(s)
   - o History & physical examination
   - o Consultation reports
   - o X-ray reports
   - o Discharge summary
   - o Progress notes
   - o Laboratory tests
   - o Photographs, videotapes, digital or other images
   - o Other (please specify) _____

I understand that this will include information relating to (check if applicable):
- o Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
- o Behavior health service/psychiatric care
- o Treatment for alcohol and/or drug

3. This information is to be disclosed to: Kids First Pediatrics Fax Number: 478-453-1093
   for the purpose of _____ 530 North Cobb St
   Milledgeville, GA 31061

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following day, event or condition:

5. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(patient) (date)

_____
or (legal representative) (relationship to patient) (date)

_____
(Signature of witness) (date)

Note: This sample form was developed by the American Health Information Management Association for discussion purposes only. It should not be used without review by your organization's legal counsel to ensure compliance with local and state laws.

It is recommended that blocks be initialed by the patient/legal representative rather than checked.
Georgia Risk Management Handbook for the Medical Office Practice- Medical Records No. 1-2000

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Christopher Bowers, M.D. Prabhdeep Brar, M.D. Sekar [illegible]

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Kids First Pediatrics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information	Description of information to be released
*Voice Mail	*Results of Lab test/X-Rays *Reminders of scheduled appointments *Referral appointments
*Give information to employer	*Appointment/absentee information
*Give information to school	*Appointment/absentee information

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Kids First Pediatrics**, at the address above.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient/legal guardian.

_____ Date_____
Signature of Patient/Legal Guardian

Assignment And Release

I hereby authorize payment directly to Kids First Pediatrics for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above practice and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurances submissions.

_____ Date_____
Signature of Responsible Party

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Immunization Consent Form

Patient Name:_____Patient DOB:_____

At each visit, you will be provided the Vaccine Information Sheets(s) (VIS) that is from the Centers for Disease Control (CDC) explaining the vaccine(s) and the disease(s) they prevent.

It is medically recommended that my child receives immunizations as per the CDC immunization schedule, and the American Academy of Pediatrics guidelines.

I understand that the purpose, need, and risk and benefits of the recommended vaccine(s) will be discussed with me. I also understand that if my child does not receive the vaccine(s), the consequences may include:

*Contracting the illness the vaccine should prevent. (the outcomes of these illnesses may include one or more of the following: pneumonia, illnesses requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well.)

*Transmitting the disease to others.

*Requiring my child to stay out of child care or school during disease outbreaks.

I will have the opportunity to discuss these with my child's physician or nurse, who will answer any of my questions regarding the recommended vaccine(s).

I understand that by signing this form, I give consent for my child to receive the recommended immunizations as per the CDC & ACIP Immunization Schedule, including the influenza vaccine. **I will be consulted on each vaccine given prior to administration and have the opportunity to decline the vaccine if I choose to do so.** It will not be a requirement to sign individual consents for each vaccine. If I decline, I will be given a "Refusal to Vaccinate" form to sign, understanding the risk involved.

I understand and acknowledge that I have read this document in its entirety and full understand it, and allowed to ask questions.

Parent/Guardian Signature_____Date_____