primetime PEDIATRICS | primetime URGENT CARE

1618 Mars Hill Road; Watkinsville, GA 30677 PH:706-705-4543

Consent for Medical/Surgical Care/Emergency Treatment

Patient: ______________________________________ Patient DOB: ___________________

I, _______________________________, (patient/guardian/parent) hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized members of the staff of PrimeTime Pediatrics (PTP)/ PrimeTime Urgent Care (PTUC), as may in their professional judgment be necessary.

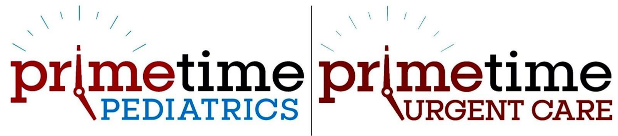
I hereby acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition. I have read this form and certify that I understand its contents.

I acknowledge that I am responsible for all reasonable charges in connection with the care and treatment rendered to the patient listed above by PTP/PTUC.

This consent form will be valid for 365 days from today, unless it is revoked in writing by the undersigned.

Signature: ____ Date: ___________________
(of patient/guardian/parent)

PTP/PTUC Witness: __________________________________ Date: ___________________



1618 Mars Hill Rd, Watkinsville, GA 30677 PH: 706-705-4543

New Patient Intake Form

Patient Name: ____ DOB: ______________

Date of Last Medical Visit: ____________________________________

Does the patient use tobacco? Yes / No

Past Medical History:

Please check any of the following that apply to the patient:

____ Anemia

____ Arthritis

____ Artificial Heart Valve

____ Asthma

____ Blood disorder

____ Cancer

____ Diabetes

____ Frequent Sinus Infections

____ Rashes/Eczema

____ Heart Disease

____ High Blood Pressure (hypertension)

____ Kidney Disease

____ Measles

____ Respiratory/Pulmonary Infections

____ Seizures

____ Urinary Infections

____ Thyroid/Endocrine Issues

____ Date of positive Covid-19 Test

____ None of the above

____ Other: Explain below

____

Medication Allergies:

____

____

____

Other allergies/reactions (foods, latex, tape, etc): _______________________________________

____

____

Patient Name: ___________________________________ **DOB:** _____________

Current Medications - Prescriptions and Over the Counter:

____

____

____

____

____

Hospitalizations and Surgeries:

____

____

Family History (Please circle/list any significant medical problems in the family):

Asthma Cancer Diabetes Heart Problems Hypertension/Blood Pressure

Kidney Problems Seizures Stroke Sudden Death Thyroid Issues

Other: ____

____

____

Birth History (if patient is under 3 yrs old):

Full Term? __Yes __No If early/premature how many weeks? _________ Birth Wt: __________

Delivery: ___ Vaginal ___ C-Section Pregnancy Medications: ______________________________

Problems with pregnancy or birth: ____

Signature:

Signature: ____ Today's Date:______________

Signed by (if different from patient): Name: ____

Relationship to patient: ____

Prime Time Urgent Care Visit Overview

Please note this form will be used to compose the visit note, but will not become part of the medical record. It will be destroyed after the visit.

Patient Name: ______________________________ **DOB:** ______________ **Today's Date:** ____________

Medicine or Food Allergies: ____

Current Medications: ____

____

Main reason for today's visit: ________________________ **When did the problems/symptoms begin?** __________

In the last month, has the patient traveled outside of the state and/or country? YES / NO If yes, where? ________________

In the last 14 days, has the patient been exposed to &/or tested positive for COVID-19? (circle all that apply) Exposed / Positive Test / Neither

Please circle an answer for each question (if applicable):

What is the location? Left side Right Side Both Sides Not Applicable

What is the pattern? Continuous Intermittent Chronic Acute Not Applicable

How severe are the symptoms? Mild Moderate Severe

What are the symptoms like? Worsening Improving Unchanged Sharp pain Dull pain

Has the patient had any of the following symptoms **during this illness?** Circle **YES or NO** for each symptom

Y / N	**Fever / chills**	**Y / N**	**Palpitations**	**Y / N**	**Pain in joints with swelling and redness**
Y / N	**Body aches**	**Y / N**	**Chest pain**	**Y / N**	**Back pain**
Y / N	**Fatigue**	**Y / N**	**Orthopnea (difficulty breathing when lying down)**	**Y / N**	**Rashes or dry skin**
Y / N	**Red eyes or eye discharge**	**Y / N**	**Nausea**	**Y / N**	**Change in gait or coordination**
Y / N	**Change in visual acuity**	**Y / N**	**Vomiting**	**Y / N**	**Numbness or tingling**
Y / N	**Runny and/or nasal congestion**	**Y / N**	**Diffuse abdominal pain**	**Y / N**	**Focal extremity weakness**
Y / N	**Sore throat**	**Y / N**	**Localized abdominal pain**	**Y / N**	**Difficulty sleeping**
Y / N	**Ear pain**	**Y / N**	**Diarrhea**	**Y / N**	**Change in appetite**
Y / N	**Dyspnea on exertion**	**Y / N**	**Urinary frequency**	**Y / N**	**Seasonal allergies (Pollens)**
Y / N	**Pleurisy**	**Y / N**	**Dysuria**	**Y / N**	**Food Allergies**
Y / N	**Productive cough**				
Y / N	**Dry cough**				

Patient's past medical history that is important for today: ________________________________

Does the patient attend work or school? YES / NO **Do you or anyone in your household smoke? YES / NO**

Are your immunizations UTD? YES / NO **For women: when was your last menstrual period?** ________________

Which pharmacy would you like to use today if a prescription is to be sent electronically? ________________

Have there been any changes to your insurance or contact information since your last visit? YES / NO

Would you like the provider to pray for you tonight after the visit? YES / NO

1618 Mars Hill Rd, Watkinsville, GA 30677 PH: 706-705-4543

New Patient Registration Form

Patient Information:

First Name: ___________________________ MI: _____ Last Name: _________________________________

Date of Birth: ________________________ Gender: M / F Age: ______ Language: ________________

Race: ____________________________ Hispanic or Latino _____ Non Hispanic or Latino ______

Address (Street): ____

City: _______________________________________ State: __________ Zip Code: ____________

Mobile Phone: _______________________________ Home Phone: _________________________________

Email Address: ____

Primary Care Physician: ____ Location: ____________________

Emergency Contact: _______________________________________ Cell Phone: _______________________

Preferred Pharmacy (please include street/city): ____

Parent/Guardian Information (if patient is less than 18 years old):

First Name: _____________________ Last Name: ______________________________ DOB: _____________

Relationship: _____________________ Does the child reside with this parent/guardian? ___ Yes ___ No

Please Circle Relationship: Biological Parent Foster Parent Adoptive Parent Legal Guardian

If parents are divorced/separated, who retains primary custody or joint custody? ____________________

Is contact information the same as provided above? ___ Yes ___ No **If not, please provide:**

Email Address: ____

Mobile Phone: ________________________________ Home Phone: _______________________________

Address: ____

Patient Name: ___________________________________ **DOB: ______________**

Parent/Guardian Information (please provide both parents' info if patient is less than 18 years old):

First Name: ____________________ Last Name: ____________________________ DOB: ____________

Relationship: ____________________ Does the child reside with this parent/guardian? ___ Yes ___ No

Please Circle Relationship: Biological Parent Foster Parent Adoptive Parent Legal Guardian

If parents are divorced/separated, who retains primary custody or joint custody? ___________________

Is contact information the same as provided above? ___ Yes ___ No **If not, please provide:**

Email Address: ____

Mobile Phone: ______________________________ Home Phone: _____________________________

Address: ____

By signing this form, I attest that the above information is true and accurate to the best of my ability. I acknowledge that some information may require additional information or verification. I will contact PrimeTime Urgent Care/PrimeTime Pediatrics in a timely manner if any of the above information requires change or modification. I acknowledge that I have been provided, and have reviewed, and understand the PrimeTime Urgent Care/PrimeTime Pediatrics Financial Policy. I acknowledge that I have received the Notice of Privacy Practices.

Signature: ____ Today's Date:__________________

Signed by (if different from patient): Name: ____

Relationship to patient: ____

primetime PEDIATRICS | primetime URGENT CARE

1618 Mars Hill Road; Watkinsville, GA 30677 PH: 706-705-4543

Patient Name: ____ DOB: ______________

Financial Policy

Thank you for choosing PrimeTime Pediatrics (PTP)/PrimeTime Urgent Care (PTUC) to care for you and your family today. Please understand that payment of your bill ensures the practice remains financially healthy and stable so that we may continue to provide care for future patients. If you have any questions regarding this financial policy, please do not hesitate to speak with management. We will be glad to assist you.

1. INSURANCE COMPANY: PrimeTime Pediatrics (PTP) and PrimeTime Urgent Care (PTUC) are currently in-network with most commercial insurance plans. It is the responsibility of the patient, however, to determine if the doctor you are seeing is in-network with your insurance company. Be sure to contact your insurance company to verify that we are in network with your current policy. We depend on you to provide us with correct insurance information so that we may file your claims appropriately. If you provide us with incorrect information and your insurance company denies payment you will be responsible for all of the resulting charges.
2. PAYMENTS: You are financially responsible for the cost of your care. If you have a copayment due, your insurance company requires us to collect it at the time of service. This is due from the patient or from the parent/guardian, in the case of a minor.
3. PROOF OF INSURANCE: PTP/PTUC must obtain a copy of your driver's license and current valid insurance information. If you are unwilling or unable to provide your ID information or current insurance information, your visit shall be paid in full by you at the time services are rendered.
4. NEWBORN INSURANCE: When a child is born, we understand that it may take time to have that new bundle of joy added to your insurance policy. Please contact the office as soon as your child's insurance is activated. After 30 days you will be responsible for any balances that are not paid by insurance.
5. CLAIMS SUBMISSIONS: We will submit your claims or assist you in any way we reasonably can to help get your claims paid. Please be advised that this is a courtesy provided by PTP/PTUC rather than a responsibility. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request.
6. COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. In the event that valid information is not provided to our office in a timely manner, PTP/PTUC will not be held to timely filing requirements by your insurance company.
7. DIVORCE AND SEPARATION ISSUES: In the case of a divorce or separation, it is imperative that we be notified as to who has primary responsibility, including financial responsibility, for the care of your children. The person with primary responsibility for the children will be responsible for payment of all charges not paid by insurance unless we are notified otherwise. Proof of responsibility may be requested in the form of copies of the divorce paperwork. It is the parents' responsibility to work together to ensure that all charges not paid by insurance are paid in a timely manner. We will not get involved in how these charges are allocated between parents/guardians.
8. RE-BILLING FEES: The policy of PTP/PTUC is to provide your first billing statement as a courtesy. After the first billing cycle, if payment has not been made in full, a re-billing fee may be applied to the account in the amount of $10. This re-billing fee will be added to each statement thereafter if no payments are received.

9. COLLECTIONS: Delinquent accounts that are greater than $60 and 60 days past due will automatically be sent to the first phase of our collections process. If the balance remains unpaid, your family may be permanently dismissed from the practice and the balance turned over to a collection agency. If this occurs, an additional fee of up to $100 may be added to your account. This will not be covered by insurance. You will be responsible for this cost.
10. STORAGE OF INFORMATION: By default, PTP/PTUC does not store payment information such as Credit Card Numbers or Bank Account numbers. When making payments through our online system, you may be given the option to save payment information on file with the credit card processor. This information is stored with the processor (authorize.net) and is not accessible by PTP/PTUC. This is done in an effort to maintain best practices with regards to handling financial information. This feature is offered to simplify payments in the future and is optional.
11. OTHER SERVICES:
    - Immunization records will be prepared within 48 hours and are at no charge to you.
    - Requests for medical records and specialized reports will usually be completed within 5 days and will incur a charge of $25, or as allowed by law. Some insurance companies may not cover this expense. In this case, it is the responsibility of the parent/guardian to pay for this charge.

Financial Responsibility:

With the exception of copays and self pay which are due at the time of service, who is financially responsible for any bills that may occur due to deductibles, coinsurance, or balances that insurance may deem to be the patient's responsibility?

Full Name: ____ Date of Birth: _________________________

SSN: __________________ Relationship to patient: ____________________ Phone: _____________________

Address (street/city/zip): ____

Insurance Information:

Primary Insurance: ____________________________ Secondary Insurance:_______________________________
Policy/Plan Number: ___________________________ Policy/Plan Number: ________________________________
Group Number: _______________________________ Group Number: ___________________________________
Name of Policy Holder: ________________________ Name of Policy Holder: _____________________________
Policy Holder DOB:__________________ Circle: M / F Policy Holder DOB:___________________ Circle: M / F
SS# of Policy Holder: __________________________ SS# of Policy Holder: ______________________________
Patient's relation to Policy Holder: _______________ Patient's relation to Policy Holder: ___________________

I affirm that the above information is true and correct to the best of my knowledge.

Patient Name: ____ Patient DOB: _________________

Signature:____ Today's Date:___________________________

Signed by (if different from patient): Name: ____

Relationship to patient: ____

primetime PEDIATRICS | primetime URGENT CARE

1618 Mars Hill Rd, Watkinsville, GA 30677 Ph:706-705-4543

HIPAA Release

Patient Information: (required fields marked with a *)

First Name*: ______________________________ Last Name*: ____

Date of Birth*: _____________________ Mobile Phone* (or best number) :______________________________

Email Address*: ____ Home Phone: __________________________

Section I:

I give my permission for PrimeTime Urgent Care/PrimeTime Pediatrics to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II Health Information:

I give permission to:

- ○ Disclose my complete health record, including, but not limited to, diagnosis, lab test results, treatment, and billing records for all conditions.
- ○ Disclose my complete health record except for the following information (Do NOT Disclose):
  - Mental Health Records
  - Communicable Diseases including, but not limited to, HIV and AIDS
  - Alcohol/drug abuse treatment records
  - Other: ____

Section III Reason for Disclosure:

Reason for Disclosure:

- ○ Continuing Care
- ○ Personal Use
- ○ Other

Section IV Who Can Receive My Health Information:

We will automatically share your information with your primary care doctor unless you notify us in writing that you do NOT want your records released.

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s). I understand that the person(s) listed below may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

First Name: ____________________________ Last Name: ______________________________________

Email: _________________________________ Phone (or best number): __________________________

Section V Duration of Authorization:

This authorization to share my health information is valid for:

- ○ All past, present, and future periods
- ○ 12 months from today
- ○ From today's date until: ____

Section VI Signature:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to PrimeTime Urgent Care/PrimeTime Pediatrics; 1618 Mars Hill Rd Ste A; Watkinsville, GA 30677.

I understand, in the event that my information has already been shared, that it may be too late to cancel permission to share my health data by the time my authorization is revoked.

I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of the authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Patient Name*: ____ Patient DOB*: ________________

Signature:* ____ Today's Date*: ____________________

Signed by (if different from patient): Name*: ____

Relationship to patient*: ____