primetime PEDIATRICS | primetime URGENT CARE

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: _____

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# 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: _____

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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: _____

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# Consent for Medical/Surgical Care/Emergency Treatment And Financial Policy Agreement

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: _____

## Financial Policy Agreement

By signing below, I attest that I have been provided a copy of the PrimeTime Pediatrics/Urgent Care Financial Policy (paper copy or electronically) and understand/agree to the terms.

Name: _____
(of the adult financially responsible for the patient's bill)

Signature: _____ Date: _____

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# 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*: _____