NORTH ATLANTA PEDIATRIC ASSOCIATES

Phone: 404.256.3178
Fax: 404.256.3583

Patient Demographics

All information must be fully completed to assure the best treatment of your child. Our providers and insurance carriers require this data before your child can be seen. Thank You!

Last Name: First: Middle:	Child lives with:
Nickname:	Mother's Maiden Name:
Date of Birth: Sex:	Parents are: Married Divorced Other
Guarantor (Parent holding insurance)	The Following people are authorized to bring my child for any necessary treatment and may sign informed consent forms in my absence:
Last Name: First: Middle:	
Date of Birth:	
Email Address:	
Address:	
Phones: Home: Work: Cell:	Who is child's Provider? (Dr or Nurse Practitioner)?
Other Parent (not holding insurance)	**Insurance**
Last Name: First: Middle:	Carrier: (i.e. BCBS, Humana, etc.)
Date of Birth:	Patient ID#:
Email Address:	Group Name and Number:
Address:	
Phones: Home: Work: Cell:	I certify that the information listed above is complete, accurate, and up to date.
Siblings	
Name Date of Birth Sex	
	Signature
	Date

Please read the information on the following page and sign at the bottom.

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Financial Policy

Thank you for choosing North Atlanta Pediatrics as your healthcare provider. Please understand that payment of your bill is part of your care. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit.

All co-payments are due at the time of service. These fees cannot be waived. All co-pays not collected at the time of service will incur a $10 billing fee. Please be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services. For your convenience we accept cash, check, Visa/Master Card (including debit cards), American Express and Discover.

If we are a participating provider, we will file your insurance for each visit. Should there be a dispute with your insurance company, our insurance department will attempt to resolve it for you. During this time, the balance may be transferred to your responsibility. Please note that your insurance policy is a contract between you and your insurance company, therefore, your balance is your responsibility.

Missed appointments for routine/preventive care are very disruptive to our office and deprive others from an appointment to see the doctor. Twenty-four (24) hour cancellation for routine check-ups is required to avoid the $80 charge.

Financial arrangements for large balances can be made through our payment program. Failure to resolve any past due accounts, including returned checks will result in referral to a collection agency. Any family whose account is forwarded to a collection agency will be dismissed from our practice.

Requests for transfer of medical records will incur an administrative fee of $15 per child up to two and $35 for 3 or more children. An immunization record can be provided at no charge for active patients.

There is a $5 administrative fee to complete forms (camp, school, sport, etc.) not associated with a routine visit. There is no charge for the required state forms, unless they must be replaced. We require 72 business hours to complete the forms. “Rush” forms incur a $20 fee.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

I authorize the release of any medical or other information necessary to process my child’s insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize payment of medical benefits to North Atlanta Pediatric Associates for services rendered and agree to abide to the financial policies of North Atlanta Pediatric Associates.

I acknowledge that I have read and understand the policies stated above. I agree to pay any monies due at the time of service and provide accurate insurance information to assist North Atlanta Pediatrics in timely filing and prompt payment of my claims.

______________________________________ ______________________

Parent/Guardian Signature   Date