North Atlanta Pediatric associates

Phone: 404-256-3178
Fax: 404-256-3583

Parent / Guardian # 1: Guarantor (Parent / Guardian Holding Insurance) **Last Name:** **First:** **Middle:**	Parent / Guardian # 2: Guarantor (Parent / Guardian Not Holding Insurance) **Last Name:** **First:** **Middle:**
Date of Birth: _____/_____/_____ **Sex:** ☐ M ☐ F	**Date of Birth:** _____/_____/_____ **Sex:** ☐ M ☐ F
Address: _____ _____	**Address:** _____ _____
Email Address:	**Email Address:**
Phones: _____-_____-_____ ☐Home ☐ Work ☐ Cell _____-_____-_____ ☐Home ☐ Work ☐ Cell _____-_____-_____ ☐Home ☐ Work ☐ Cell **WHICH NUMBER LISTED ABOVE IS YOUR PRIMARY NUMBER?** ☐Home ☐ Work ☐ Cell	**Phones:** _____-_____-_____ ☐Home ☐ Work ☐ Cell _____-_____-_____ ☐Home ☐ Work ☐ Cell _____-_____-_____ ☐Home ☐ Work ☐ Cell **WHICH NUMBER LISTED ABOVE IS YOUR PRIMARY NUMBER?** ☐Home ☐ Work ☐ Cell
Mother's Maiden Name:	**Parents / Guardians are:** ☐ Married ☐ Divorced ☐ Other

The Following People are authorized to bring my child for any necessary treatment and may sign informed consent forms in my absence:

_____ _____

Child(ren)'s Information:

Last Name	First Name	Middle Name	Date of Birth	
			_____/_____/_____	☐
			_____/_____/_____	☐
			_____/_____/_____	☐
			_____/_____/_____	☐
			_____/_____/_____	☐

Who does your child(ren) live with?

Who is your child(ren)'s provider? (Doctor or Nurse Practitioner)

I certify that the information listed above is complete, accurate, and up to date:

_____ _____

Parent / Guarantor Signature: **Date:**

Please read the information on the following page and sign at the bottom.
******* TURN OVER FOR COMPLETION *******

NORTH ATLANTA PEDIATRIC ASSOCIATES, P.C.

FINANCIAL POLICY

Thank you for choosing North Atlanta Pediatrics as your healthcare provider. The following is a summary of our Financial Policy. We require that you read and sign our policy prior to treatment.
Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE
All co-payments, coinsurance, and deductibles are due at the time of service unless other arrangements have been made in advance. These fees cannot be waived. **If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan that we do not participate, full payment is required at the time of your visit.**

All co-pays not collected at the time of service will incur a $10 billing fee. Please also 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 / MasterCard, American Express and Discover. There is a service charge for returned checks. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. Please contact our business department for assistance.

Financial arrangements for balances due can be made through a payment program. Failure to resolve any past due accounts, including returned checks may result in referral to a collection agency. You may be responsible for any fees associated with the costs of collections in addition to the amount owed on the account. Any family whose account is forwarded to a collection agency may be discharged from our practice.

INSURANCE
We bill participating insurance companies for your visit. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. Please note that your insurance policy is a contract between you and your insurance company, therefore, you are responsible to be sure all charges are paid whether by you or your insurance company.
We do not bill secondary insurance companies.

MISSED APPOINTMENTS/LATE CANCELLATIONS
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. Excessive abuse of scheduled appointments may result in discharge from the practice.

MEDICAL RECORDS/FORMS
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. Effective September 1, 2005, we charge $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. Medical forms for insurance purposes will incur a minimum charge of $25. We require 72 business hours to complete all forms. “Rush” forms (including ADHD medication refills) incur a $20 rush fee.

Divorce, Separation, & Custody Agreements
North Atlanta Pediatric Associates collect copays and deductibles from the attending parent at the time of service. Copies of these charges are available at the request of the attending parent. Each parent is responsible for providing correct billing information for their child. Incorrect billing information or lack of billing information will necessitate billing the attending parent at the time of service.
If a parent is legally excluded from participation in any form of medical care for their child, North Atlanta Pediatric Associates requires documentation from the court as part of our medical record.

_____ _____
Parent/Guardian Signature **Date**

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. 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 costs of collections.

_____ _____
Parent/Guardian Signature Date

In the event that I am unable to be reached, I give my permission to North Atlanta Pediatric Associates to treat my children.

_____ _____
Parent/Guardian Signature Date