briarvista PEDIATRICS

Patient Registration Form

Today's date:	Previous PCP (if any):

PATIENT INFORMATION

Patient's Full Name (First, MI, Last, Suffix):	Date of Birth:	Social Security #:

Ethnicity? ❑ Hispanic ❑ Non-Hispanic	Race:	Nickname:	Age:	Sex: ❑ M ❑ F

Street address:	Home phone #:

City:	State:	ZIP Code:

Grade:	School:	Preferred Language:

How did you find us? Please check one:
❑Insurance Plan ❑ Google ❑ Referred by:_____
❑ Family: _____ ❑ Friend:_____ ❑ Close to home
❑ Other: _____

Siblings (names and birthdates):
#1: _____
#2: _____
#3: _____

EMERGENCY CONTACTS (OTHER THAN PARENTS):

#1: Name (First, Last):	Relationship to patient:	Mobile Number:

Address, City/State and ZIP:	Home phone number:

#2: Name (First, Last):	Relationship to patient:	Mobile Number:

Address, City/State and ZIP:	Home phone number:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No (Self-Pay)

Responsible Party:	Birth date:	Address:	Home phone:

Occupation:	Employer:	Employer address:	Employer phone:

Name of Primary Insurance Company:

Subscriber's name:	Birth date:	Group #:	Policy #:

Patient's relationship to subscriber:	❑ Self ❑ Child ❑ Other			
Name of secondary insurance (if applicable):		Subscriber's name:	Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self ❑ Child ❑ Other			

PHARMACY INFORMATION		
Pharmacy Name:	Address:	Telephone Number:

FAMILY/CONTACT INFORMATION	
Patient resides primarily with: ❑ Both Parents ❑ Mother ❑Father ❑Legal Guardian: _____ ❑Other: _____ Parents are: ❑ Married ❑ Divorced ❑Separated ❑Other: _____	
Mother's Name and Birth Date:	Home phone number:
Mobile number:	E-mail:
Occupation:	Employer & Work Number:
The best way to reach me is: ❑ Home Number ❑ Mobile Number ❑ E-mail	
Father's Name and Birth Date:	Home phone number:
Mobile Number:	E-mail:
Occupation:	Employer & Work Number:
The best way to reach me is: ❑ Home Number ❑ Mobile Number ❑ E-mail	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Briarvista Pediatrics, LLC or insurance company to release any information required to process my claims.

I give permission for Briarvista Pediatrics to contact me via e-mail and/or text message.

Patient/Guardian signature _____ Date _____

Authorization for Release of Medical Information

Patient Name: _____
DOB: _____

I, _____, hereby authorize the release of medical information **TO**:

Briarvista Pediatrics
2244 Henderson Mill Road, Suite 108
Atlanta, GA 30345
770.239.2500 (office) 404.745.8202 (fax)

FROM:
Doctor/Clinic/Hospital:_____

Address: _____

_____

Telephone: _____ Fax : _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify): _____

___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:

___ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient:_____

Consent To Treat Minor

I hereby give consent to Briarvista Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner, on the staff of Briarvista Pediatrics to the below named minor(s).

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Briarvista Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Minor #1: Name _____ Date of Birth _____

Minor #2: Name _____ Date of Birth _____

Minor #3: Name _____ Date of Birth _____

Signed: _____

Print Name: _____

Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and Briarvista Pediatrics, LLC, is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Briarvista Pediatrics, LLC, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Briarvista Pediatrics, LLC, to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Briarvista Pediatrics, LLC, on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Parent/Guardian Name & Signature Date

Names of all children:

_____

_____

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Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Copayments and Deductibles:
Depending on your insurance policy, a copayment and/or deductible or coinsurance may be required at the time of service. Payment may be made in cash, by check or by credit card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. Coinsurance may apply even after meeting your deductible. Please see our "Insurance 101" document on our website for a better explanation of these terms.

Patients Without Insurance Coverage/Non-covered expenses:
We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit. The same discount will be applied to any non-covered charges for patients with insurance, if paid at the time of service. This discount can not be applied toward the "patient responsibility" portion of covered charges, as those charges are already discounted through the contract we maintain with your insurer.

Financial Arrangements:
Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (Returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Appointments/Cancellations:
We gladly reserve appointment times for you and appreciate that you have chosen Briarvista Pediatrics for your care. As a courtesy, we will remind you of your appointment by calling and/or sending a text or email to remind you of your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment.

We reserve the right to charge $25 for regular appointments cancelled without advance notice of at least 1 business day. Appointments that are scheduled for the same day and then cancelled, as well as no-shows for an appointment, may be assessed a $50 charge. After three no-shows or same-day cancellations, your family may be dismissed from the practice.

Patient/Parent/Guardian Responsibility:

- I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed, *and is responsible for payment of medical services.*
- I acknowledge my responsibility for payment of all services provided by Briarvista Pediatrics in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:
I authorize payment to be made directly to Briarvista Pediatrics by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy:
Briarvista Pediatrics is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number is a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file can be used to pay copays and other charges (such as toward the deductible or for non-covered services) at the time of the visit.

Once processing the visit with your insurance, you may owe part of the patient responsibility fee. If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

For families who do not wish to leave a credit card on file, you will be obligated to maintain a $50 balance, per child, with the practice. That balance will be used for any unpaid patient responsibility, as outlined above, and will need to be replenished before a member of the family can be seen in the practice again.

By signing below, I give Briarvista Pediatrics permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Name (please print): _____ Date: _____

Patient's Name and Birth Date:

_____

Signature of Responsible Party (Guarantor):

_____

Relationship to Patient(s) (please check): ___ Parent ____ Self _____ Other: _____

Witness Signature:

_____

Note: *The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.*

Notice of Privacy Practices Written Agreement:

I also acknowledge that I have read a copy of Briarvista Pediatrics' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Briarvista Pediatrics has a link to the Notice of Privacy Practices on the practice website (www.briarvistapediatrics.com).

Name (please print): _____ Date: _____

Signature of Parent / Guardian / Patient:

_____

Waiver for Non-Covered Charges

We pride ourselves on providing only the **highest quality care** for your child and do this by following many of the American Academy of Pediatrics' clinical guidelines and other trusted sources for evidenced-based clinical outcome information.

However, insurers rarely keep pace with guidelines or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary.

Following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Vision Screening

Snellen Testing. This is a simple screening performed with the use of a Snellen eye chart used to measure visual acuity on older children.

Visual Evoked Potential testing (or VEP). This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia (or 'lazy eye') occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye.

As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount. For Snellen tests the discounted price is only $15.00, and for VEP tests the discounted price is $30.00.

Hearing Screening: Otoacoustic Emissions Testing (or OAE)

This is an important hearing test and can be used on newborns through adulthood. It does not require a soundproof room or the ability of the child to understand instructions or respond to sounds, which makes it a much more accurate screening tool for picking up on hearing issues at any age.

Not only do we believe that hearing screens should be performed every year, but testing is required for most preschools, public and private schools, and for some sports. As we consider this to be an important test for your child, and will routinely perform it at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $15.00 per test.

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Developmental Testing

Developmental screening (including standard pediatric developmental screening done at well-visits, Connors forms, Edinburgh post-partum depression screening, M-CHAT tool to detect autism, and more) are very important in the assessment of any development delays or potential problems. As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $10.00 per test. Please note that at some visits, there may be more than one screening tool used.

In-office lab tests

Often, patients want to know as soon as possible if their child has the flu, strep, etc. We can effectively and efficiently determine that by performing in-office testing. Many insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests out to external labs results in waiting days for results that we can provide to you much more quickly (in some cases, within minutes or overnight). We believe it is important to treat your child as quickly as possible, and therefore offer these services in-office.

In-office labs and fees include:

In-office Test	**Fee**
Rapid RSV	$25.00
Rapid Flu	$25.00
Rapid Strep	$15.00
Urinalysis	$10.00
Pregnancy Test	$10.00
Strep DNA PCR	$40.00

Ear Piercing

In addition to screenings and lab tests, we also offer ear piercing which is not a covered service by your insurance company. We charge $50.00, which includes a pair of plain stud earrings. You may select a different pair of earrings by paying in advance and covering any additional fees.

Sports Physicals

When done at the same time as a well-child check-up, sports forms are completed free of charge. We will also complete them free of charge if your child has been seen for a well-child check in the past six months. There will be a $10 fee for forms needed in < 3 business days.

Many of these forms require a vision test, so if it was not performed at the time of the check-up your child will be asked to return for a nurse visit. There will be a $15 fee for performing the visual acuity test.

If your child has never had a check-up with our practice, and/or their last check-up was greater than 6 months ago, we are happy to schedule a visit for a sports clearance. This is a non-covered visit and will incur a $40 charge.

Fluoride Varnish

Both the American Academy of Pediatrics and the American Dental Association agree that fluoride varnishes should be applied at every well-child visit beginning from the first tooth eruption until a child begins seeing the dentist regularly. We are happy to offer this service to help protect your child's teeth from cavities. If your insurance does not cover it, we will discount this service substantially and offer it for $10 per application.

Please sign the following waiver, indicating that you are aware that these charges may apply in the event that your insurance company does not cover these services.

Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does pay for these services.

Patient(s) Name [please list all in family]:

_____

_____

_____

Guarantor / Responsible Party's Name:

_____

Guarantor / Responsible Party's Signature:

_____

Date: _____

Thank you!

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