

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ___/___/___ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Primary Insurance _____ Secondary Insurance _____

RESPONSIBLE PARTY – POLICY HOLDER INFORMATION (if different from patient)

Name: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Relationship: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone No: _____

The above information is true to the best of my knowledge. I authorize treatment for the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills within 30 days for receipt of a statement, unless other arrangements are made. I authorize the physician and Sandy Plains Pediatrics to release any information required to process my insurance claims. I also authorize my insurance to directly pay Sandy Plains Pediatrics.

Responsible Party Signature

Date

Sandy Plains Pediatrics
3225 Shallowford Road Suite 1300
Marietta, GA 30066

678-560-7160, FAX 678-560-7185

Pediatric hours 8:00 to 4:30 pm Mon. thru Friday

Vince Ho hours 8:00 to 4:30 pm Mon. thru Thursday

EFFECTIVELY IMMEDIATELY - OFFICE POLICY UPDATE

If first appointment is not kept, the appointment will not be rescheduled and the child will be discharged from the practice.

Shot records are needed for all new patients.

It is expected that 24 hours or more notification be given for cancelled appointments.

Once an established patient, a No Show is an appointment cancelled in less than 24 hours and a fee of \$25 will need to be paid before the next appointment can be scheduled.

Co-pays are expected at time of service, if co-pays need to be billed, a \$15 accounting fee will be accessed.

Walk-in fee is \$20.

Copy of medical records are \$10.00 for CD, \$20.00 for paper.

Sandy Plains Pediatrics
The Practice
Health Insurance Portability and Accountability Act (HIPAA)
Policy 2

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR
PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS.

By signing below, you hereby consent for this Practice to use or disclose information that is protected under federal law, for the sole purposes of treatment, payment and healthcare operations for you or persons for whom you have the authority to sign for.

YOU MAY REFUSE TO SIGN THIS CONSENT FORM.

You should read the Notice of Privacy Practices for PHI. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Front Office.

You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions; however, if the Practice agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Offer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject re-disclosure by the receipt and may no longer be protected under federal law.

The individuals that you list below will have access to information regarding your condition and /or treatment:

You may communicate information, including invoices for services to the following address and or phone numbers:

Address: _____

Phone Number _____

Individual Signature _____ Date _____

As a Personal Representative, I have the authority to act for the individual because I am the individual's:

Name of Patient _____ Date of Birth _____