HAMILTON MILL PEDIATRICS
3619 BRASELTON HWY, ST 103 DACULA, GA 30019
P: 770-513-8882 F: 770-513-3545

CHILD REGISTRATION FORM

Patient Name: _____ M / F Birth Date: _____ /_____ /_____

Patient Lives With: ( )Both Parents ( )Mother ( )Father ( )Other:_____

Father's Name:_____
( )Single ( )Married ( )Separated ( )Widowed ( )Divorced

Street Address:_____
City:_____ Zip:_____
DOB:_____
Hm Ph:_____ Wk Ph:_____
Cell Ph:_____
Email:_____
Sign up for Patient Portal: ( ) Yes ( ) No
Employer:_____
Communication Preference: ( ) Home ( ) Work ( ) Cell

Mother's Name:_____
( )Single ( )Married ( )Separated ( )Widowed ( )Divorced

Street Address:_____
City:_____ Zip:_____
DOB:_____
Hm Ph:_____ Wk Ph:_____
Cell Ph:_____
Email:_____
Sign up for Patient Portal: ( ) Yes ( ) No
Employer:_____
Communication Preference: ( ) Home ( ) Work ( ) Cell

PRIMARY INSURANCE INFORMATION
Subscriber Name:_____
Ins. Comp. Name:_____
Group Plan:_____
Employers Name:_____
Ins. Comp. Address:_____
Ins. Comp. Phone #:_____
Group #:_____
Insured ID:_____

SECONDARY INSURANCE INFORMATION
Subscriber Name:_____
Ins. Comp. Name:_____
Group Plan:_____
Employers Name:_____
Ins. Comp. Address:_____
Ins. Comp. Phone #:_____
Group #:_____
Insured ID:_____

BIRTH HOSPITAL:_____ State:_____
Previous Pediatrician:_____
Phone#:_____ Fax#: _____ (if available)

PHARMACY INFORMATION:
Pharmacy Name:_____
Phone#:_____ Fax#:_____
Address:_____ City:_____ State:_____ Zip:_____

EMERGENCY CONTACT:_____ (other than parent/guardian)
PHONE#:_____ RELATIONSHIP TO PATIENT:_____

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Financial Policy Statement

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

COPAYMENTS: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies.

RETURNED CHECK FEE: Hamilton Mill Pediatrics accepts cash, personal check (in-state only), VISA, and MasterCard. There is a $25.00 service charge for returned checks.

BILLING: A $5.00 service fee with be added to any co-payment that is to be billed unless the balance of the co-payment is paid before the last day of the month. An additional $5 fee will be charged EACH month that the co-payment balance is not received.

OUTSTANDING BALANCES: Patients with an outstanding balance of 60 days overdue must make at least a partial payment, or arrangements for payment prior to scheduling appointments. We realize that people sometime run into financial difficulty and we are willing to work out payment arrangements.

INSURANCE: There are numerous insurance plans that we are contracted with so that we may be able to assist your health needs. We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 90 days from the date of service, you will be expected to pay the balance in full. You are ultimately responsible for all charges.

REFUNDS: Overpayments will be refunded upon written request to the responsible party listed on the patient's account or will be held on the account as a credit for future payments.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time that was set aside for you. We feel that this is a very serious matter. Cancellations are requested 2 hours prior to the appointment. Any cancellation without at least a 2 hour notice will be considered a broken appointment. We reserve the right to charge for missed or late-canceled appointments. A $30.00 fee will be applied to the family account for each missed/late canceled appointment with in a family. Excessive abuse of scheduled appointments may result in discharge from the practice.

MEDICAL RECORDS REQUEST: There is a $15.00 charge for the copying and mailing/faxing of medical records for all patients (patients that have not been seen with in the last 2 years we will have to get their charts from storage). (Georgia General Assembly Unannotated Code 31-33-3)
Vaccination/Immunization records (3231 Form) retrieved from G.R.I.T.S. are $4.00 each

AGREEMENT

I have read and understand the Hamilton Mill Pediatrics Financial Policy. I agree to assign insurance benefits to the Hamilton Mill Pediatrics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

If you need assistance or have questions, please contact the Practice Administrator between 9:00 am and 5:00 pm, Monday through Thursday, 9:00am and 1:00 pm Friday at 770-513-8882.

Signature of Insured or Authorized representative: _____

Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information

Patient's Name: _____

I hereby give my consent for R. David Thomson, MD, LLC, doing business as Hamilton Mill Pediatrics, to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (R. David Thomson, MD, LLC'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. R. David Thomson, MD, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to R. David Thomson, MD, LLC at 3619 Braselton Hwy, Suite 103 Dacula, GA 30019.

With this consent, R. David Thomson, MD, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, lab result cards marked Personal/Confidential, and patient billing statements.

With the consent, R. David Thomson, MD, LLC may email to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminders, lab results, and patient statements. I have the right to request that R. David Thomson, MD, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to R. David Thomson, MD, LLC's use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, R. David Thomson, MD, LLC may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient of Legal Guardian

Acknowledgement of Notice of Privacy Practices

Patient's Name: _____ Date of Birth: _____

I, _____, have been made aware of the office copy of the Notice of Privacy Practices for R. David Thomson, MD, LLC doing business as Hamilton Mill Pediatrics.

I have also been given the opportunity to receive my own personal copy of the Notice of Privacy Practices.

I understand that the Notice of Privacy Practices, details how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

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Authorization for Release of Information

Authorization for release of information for _____
(Patient's Name) (DOB)

I, _____ hereby,
(Parent's name)

__ authorize Hamilton Mill Pediatrics to release information to:	__ authorize Hamilton Mill Pediatrics to obtain information from:
_____	_____
_____	_____
_____	_____

The following types of information from my records:
(ANY & ALL) / or:

_____

I understand this authorization includes release of all medical records including HIV records, Psychiatric Drug/Alcohol abuse records, venereal disease, and any other statutory protected diseases. All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that I may revoke this authorization and consent at any time except to the extent that action has been previously taken in reliance hereof.
I also understand that once I have medical records transferred from this office, I may no longer have the option to return to this practice for medical treatment, the decision will be to the discretion of the practice.

_____ _____
Patient's signature (if 18 years or older) Relationship to patient
Or Parent's signature (if patient under age of 18) (if not signed by patient)

_____
Date of Signature

*If transferring out of our office, Hamilton Mill Pediatrics, please state reason for leaving:

____Moving ____ Unsatisfied with practice _____ PCP Change _____Other
A Flat Fee of $15.00 is charged for all retrieval/copying/postage per patient medical record.

Paid: _____ Date: _____

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Authorized Chaperones

Today's Date: _____

I, _____ , the natural parent/guardian of _____, give the following people of legal age (18+) listed below, to bring my child to Hamilton Mill Pediatrics for medical care and treatment. This statement will remain in effect until I give written notice of any changes.

Thank you,

_____

People authorized to bring in child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Patient Eligibility Screening Record - Vaccines for Children Program

Today's Date: _____

My signature below verifies that Hamilton Mill Pediatrics, LLC has my full consent to administer any vaccine that is recommended for my child by the State of Georgia. My signature also gives permission for our office and the data exchange export to take place through Athena to GRITS (Georgia Registry of Immunization Transaction and Services).

Child: _____ Date of Birth: _____

_____ _____

Signature of Patient or Legal Guardian Printed Name of Patient of Legal Guardian

Vaccines for children program patient eligibility screening record:

Hamilton Mill Pediatrics, LLC participates in Vaccine for Children Program (VFC). If you meet the requirements of this program, we can provide your child's vaccinations at a reduced fee. In order to determine eligibility we must know if your child has insurance that pays for vaccinations.

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunization through the VFC program. The record may be completed by the parents, guardian or individual or record, or by the healthcare provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changes. While verification of responses is not required, it is necessary to retain this or similar record for each child receiving vaccines.

INSURANCE COVERAGE: (check statement that applies)

Ineligible for State-Supplied Vaccines

____ My child has insurance that pays for vaccinations.

Eligible for State-Supplied Vaccines

____ My child is enrolled in Medicaid.

____ My child is enrolled in PeachCare for Kids.

____ My child is American Indian or Alaskan Native.

____ My child does not have health insurance. (not insured)

____ My child has health insurance that DOES NOT PAY for vaccines. (underinsured)

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TB/Lead Risk Assessment Questionnaire

Patient Name: _____ Date of Birth: _____

These assessments will be used at all well child checkups. Start at the top by providing the date you are seen in the first blank column, next answer yes (Y) or no (N), and then initial on the line provided below the column. Please do this for each assessment.

Tuberculosis Risk Assessment

Dates of Service										
Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or an abnormal chest X-ray?										
Has the child been in close contact to a person sick with active TB?										
Was the child born outside the United States or has the child traveled outside the United States?										
Does the child have a household member who was born outside the United States or who has traveled outside the United States?										
Is the child exposed to a person who: is currently in jail or who has been in jail in the past 5 years? has HIV? is homeless? Lives in a group home? Uses illegal drugs? Or is a migrant farm worker?										
Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system?										
Is the child/teen in jail or ever been in jail?										

Initials: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Lead Risk Assessment

Date of Service										
Does your child live in or often visit a house that was built before 1978?										
Does your child live in or often visit a house that is being remodeled or is having paint removed?										
Does your child live with or often visit another child that has an elevated blood lead level?										
Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?										
Does your child chew on or eat non-food items like paint chips or dirt?										
Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?										
Does your child receive medicines such as great, azarcon, kohl, or pay-loo-ah?										

Initials: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____