PATIENT'S FAMILY INFORMATION & SERVICE/PAYMENT AGREEMENT

Mother's Name: ______________________________ D.O.B: ______________
SS No.: ____________________ Marital Status: ______________
Employer: ______________________________ Work Tel.#: ______________

Father's Name: ______________________________ D.O.B.: ______________
SS No.: ____________________ Marital Status: ______________
Employer: ______________________________ Work Tel.#: ______________

Permanent Mailing Address: ____
(Apt. No./ No. & Street Name, City, State, ZIP Code)
Res. Tel. No.: ______________ **C/Phone No.:** ______________ **E-mail:** ______________

Patient-Child(ren)'s Names:	D.O.B.	SS No	Allergies, (if any)

Emergency Alternative Contact Person (Relative or Friend) NOT living with you:
Name:____________________ **Home Phone #:**______________ **C/P #:**______________

Patient's Insurance Information:

Primary Insurance Co.: ______________ Policy No: ______________ PCP: ______________
Policy Holder's Name: ______________________ D.O.B.: ____________ SS#: ______________
Relationship to Patient, if not the Patient: ______________________

Secondary Insurance Co:______________ Policy No.: ______________ PCP:______________
Policy Holder's Name: ______________________ D.O.B.: ____________ SS#: ______________
Relationship to Patient, if not the Patient: ______________________

Pharmacy Information:

Pharmacy Name:______________________________ Tel. No.: ______________
Address/Location: ______________________________ Zip Code: ______________

Consent to Care/Treat plus To Bill & Collect:

My signature on the last page of this 'Agreement' also signify that I do hereby give permission for Dr. Shilpa J. Vernekar, dba Columbus Children's Clinic, LLC(CCC) &/or any of her support Clinical Staff, to care &/or treat my above-mentioned child(ren). I likewise, authorize Dr. Vernekar or CCC to bill &collect from the above-named Insurance Co(s)., all the corresponding charges due. When any of the service charges are not paid by the said Insurance Co(s)., I agree to ultimately be the one responsible to fully pay for it.

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Dear Parent(s)/Guardian(s),

The following CCC Key Operating Policies & Guidelines are intended to help us effectively & efficiently carry out our commitment of providing consistent, reliable, competent & friendly quality pediatric primary care & services, which we are passionately committed to undertake all the time. Please read them thoroughly:

(PLEASE CONTINUE AT THE BACK)

1.0 **All 'Co-Payments' & 'Service Charges' not covered by Patient's insurance are due at the time of service.** "Previous Unpaid Balance", "Co-Pays", "Deductibles" &/or "Self-Pay" charges is/are to be paid by the Patient's parent/guardian while checking-in. *Misrepresentation, non-payment of long outstanding accounts or charges due, the difficulty of relating and/or effectively communicating, non-compliance, plus absence of mutual trust & confidence, shall be enough grounds for terminating the existing "Patient-Physician" relationship.* Parents who opted to transfer their child to another Physician or those who were terminated "for cause" will no longer be accepted back.

2.0 **Patient's parents/guardians are required to promptly inform us when there are changes to their mailing address, contact phone numbers, insurance carrier, co-pays/deductibles &/or ins. benefits coverage.** This is to facilitate communication, coordination of care, & timely payment of your child's care or treatment services. *When parents/guardians do not let us know or fail to give us their child's correct insurance coverage information promptly, and it was the main cause of the service charges' reimbursement claim's denial or non-payment, the said unpaid obligation shall be borne and paid by the parent(s).*

3.0 **Except for sick patients needing urgent care, all Doctor's visit is "By Appointment" only.** When they can't make it to their child(ren)'s scheduled appointment, p*arents/guardians are required to call to make changes &/or cancellations at least four (4) hours before, or it will be considered a "NO SHOW".* ***A "No-Show" fee" of up to $20.00 will be assessed per incident. In addition, two (2) consecutive or a total of four (4) "NO SHOWs", shall mean permanent expulsion from Columbus Children's Clinic(CCC).***

4.0 **It is always the Patient's parents/guardian's primary responsibility to remember and keep their child(ren)'s appointment(s) and make sure that their child(ren)'s insurance coverage is/are active or current.** *Parents/Guardians are also required to bring their current government issued picture ID and their child(ren)'s valid/current insurance cards for presentation at every visit.* As courtesy service, we will try our best to help you keep your child(ren)'s appointment(s) by calling & reminding you a day before.

5.0 **Priority will always be given to those with scheduled appointment & who come on time.** Patients who come in later than 15 minutes from their scheduled appointment time will be pushed back to a later time, in favor of those who come in on time. *Those Patient(s) who are 'late' by thirty (30) minutes or more maybe rescheduled.* Except when immediate critical care is direly needed, all sick Patient without scheduled appointments (*Walk-ins*) maybe seen/attended to but after those with appointments have been cared for.

6.0 **A nominal reproduction &/or handling service fee (Please ask or refer to our published 'Schedule of Fees") will be assessed for each request for a Patient's:** a) Medical Records, b) Lost Prescription, c) Head Start form, d) Sports Physical form, e) FMLA, Disability/Other Insurance Reimbursement forms, f) Adoption forms, g) Other Administrative forms required by a 3rd party other than the Insurance Carrier and, h) a 2nd or more copy of the 'same' Patient's Shot/Immunization Record. All of these aforementioned records/documents/forms shall be made available as follows:

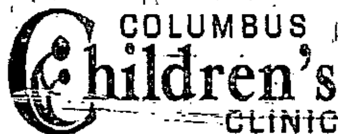
6.1 Medical Records = at least five (5) working days after receipt of written "Authorization for Medical Records' Release" or written notice/advice from Patient's parents/guardians.

6.2 All other requested records/documents/forms = at least one (1) day after actual receipt of request. During peak periods, a request for a shot record may require more days to be available. *A higher processing & handling fee will be assessed for "Same Day" request of records/documents.*

7.0 **The following are NOT allowed inside Columbus Children's Clinic and its premises:** a) deadly weapons, b) smoking, c) food &/or drinks (except for baby's formula), d) using or talking on your mobile phone while the Care Provider is with you inside the Exam Room, e) cursing or shouting, f) horse playing/arguing and h) throwing dirty diapers inside trash cans (see us for this) &/or littering inside the clinic or its vicinity.

Read, Understood & Accepted By: ______________________________ Date______________

(Parent/Guardian's Signature Over Printed Name)



PATIENT'S MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME: ______________________ **D.O.B.:** ______________ **AGE:**____ **SEX:**_____

Form Completed By: ______________________ **Relation to Patient:** ______________

*If the Mother & Father are not living together or if the Patient does not live with Parents, what is the Child's custody status?*____________________; *Total No. of Household Members:* ____*Adults,+*____*Kids; Pt. Attending Day Care/ School? / /Yes. / /No. ; Type Of Dwelling Place: / /House,/ /Apart/Condo.; No. of Smoking Household Members:*___.

Patient's Birth History:

Birth Weight: ______________. Was the Baby born at term? / /Yes. / / No. ____No. of Weeks / / Early. / /Late.

Did Mother have any illness or problem(s) during her pregnancy? / /Yes. / /No. Explain: ______________

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Did your baby have any problem(s) right after birth? / /Yes. / /No. Explain: ______________

Did Baby go home with Mother from the hospital? / /Yes. / /No. Explain: ______________

Patient's General Medical Information:

Do you consider your Child in good health? / /Yes. / /No. Explain: ______________

Does your Child have any serious illness or medical condition? / /Yes. / /No. Explain: ______________

Has your Child had any serious injuries or accidents? / /Yes. / /No. Explain: ______________

Has your Child had any surgery? / /Yes. / /No. Explain: ______________

Has your Child ever been hospitalized? / /Yes. / /No. # of Times ___. Explain: ______________

Is your Child allergic to any medicines/drugs? / /Yes. / /No. If Yes, What? ______________
(Please specify)

Patient's Family Medical History:

Did any Family members (Mother, Father, Siblings, Paternal or Maternal Grand Parents) have the following:

			If Yes, Who				If Yes, Who
-ADHD	__Yes	__No	______	-Smoking	__Yes	__No	______
-Anemia	__Yes	__No	______	-Heart Disease (Before 50 y.o.)	__Yes	__No	______
-Asthma	__Yes	__No	______	-High BP (Before 50 y.o.)	__Yes	__No	______
-Alcohol Abuse	__Yes	__No	______	-High Cholesterol	__Yes	__No	______
-Bleeding Problem	__Yes	__No	______	-Immunity Problem, AIDS	__Yes	__No	______
-Diabetes (Before 50 y.o.)	__Yes	__No	______	-Kidney Disease	__Yes	__No	______
-Deafness	__Yes	__No	______	-Liver Disease	__Yes	__No	______
-Drug Abuse	__Yes	__No	______	-Mental Illness	__Yes	__No	______
-Epilepsy or Convulsions	__Yes	__No	______	-Nasal Allergies	__Yes	__No	______
-Cancer (Any form)	__Yes	__No	______	-Tuberculosis	__Yes	__No	______
-Unhealthy Wt. (Obesity)	__Yes	__No	______	-Thyroid /Other Endocrine Prob.	__Yes	__No	______

Additional relevant Family Medical History: ______________________________

(*PLEASE CONTINUE TO THE BACK*)

PATIENT'S PAST MEDICAL HISTORY:

-Chicken Pox __Yes __No When: ____________________

-Frequent Ear Infections __Yes __No Explain: ____________________

-Problems with Ears or Hearing __Yes __No Explain: ____________________

-Problems with Eyes or Vision __Yes __No Explain: ____________________

-Asthma, Bronchitis, Bronchiolitis or Pneumonia __Yes __No Explain: ____________________

-Nasal Allergies __Yes __No Explain: ____________________

-Anemia or Bleeding problem __Yes __No Explain: ____________________

-Heart Problem or Heart Murmur __Yes __No Explain: ____________________

-Blood Transfusion __Yes __No Explain: ____________________

-Bladder or Kidney Infection __Yes __No Explain: ____________________

-Bed Wetting (after 5 y.o.) __Yes __No Explain: ____________________

-Frequent Abdominal Pain __Yes __No Explain: ____________________

-Chronic Constipation Requiring Doctors Visit __Yes __No Explain: ____________________

-Frequent Headaches __Yes __No Explain: ____________________

-Convulsions or Other Neurologic problem __Yes __No Explain: ____________________

-Diabetes __Yes __No Explain: ____________________

-Thyroid or Other Endocrine problem __Yes __No Explain: ____________________

-Chronic or Recurrent Skin Problem(s) (Eczema, Acne, Etc.) __Yes __No Explain: ____________________

-Use of Alcohol or Illegal Drugs __Yes __No Explain: ____________________

-Liver problem __Yes __No Explain: ____________________

-For Girls, Has she started her menstrual periods __Yes __No Explain: ____________________

-For Girls, Are there problems with her periods __Yes __No Explain: ____________________

-Any other significant medical problem(s): __Yes __No Explain: ____________________

Please specify: ____________________ Explain: ____________________

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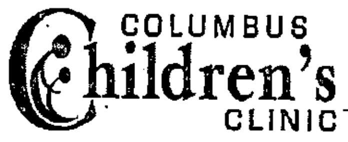
-End-

Certified True & Correct By: ______________________________ Date: ____________________

(Parent/Guardian's Signature Over Printed Name)



PARENT/GUARDIAN'S AUTHORIZATION FOR USE & DISCLOSURE OF
<u>PATIENT'S PROTECTED HEALTH INFORMATION</u>

By signing this authorization, I authorize ***Columbus Children's Clinic*** *c/o Dr. Shilpa Vernekar,* to use and disclose my child's Protected Health Information (PHI) for reasons other than treatment, payment or health care operations, only for the following specific purpose(s) as I have indicated below:

/ / Return to School/Nursery Excuses / / Calling Home for Laboratory Results

/ / Return to Work Excuses / / Calling Home for Appointment Reminders

/ / Others: ____
(Please specify)

This authorization will expire on ______________________________. After the stated expiration date, it is automatically renewed unless I say otherwise. Columbus Children's Clinic will not in any way receive payment or other remuneration from a third party in exchange for using or disclosing my child's Protected Health Information (PHI). I do not have to sign this authorization in order for my child to receive treatment from ***Columbus Children's Clinic***. In fact, I have the right to refuse to sign this authorization. When my child's PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that *Columbus Children's Clinic* has acted in reliance upon this authorization. My written revocation must be submitted to the above-mentioned Care Provider's *Privacy Officer* at 1546 10th Ave. Suite A, Columbus, GA 31901.

Patient's Name: ______________________________ **D.O.B.:** ______________

______________________________ **Relationship to Patient:** ____________
(Parent/Legal Guardian's Printed Name)

Signature: ____________________________ **Date:** ________________________