HEALTHY STEPS PEDIATRICS

Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

PATIENT DEMOGRAPHIC INFORMATION

Today's Date:_____

Name of Person Filling Out Form: **Relation to Patient:**

Patient Name:_____
Last First Middle Nickname

Street Address:_____

_____
City State Zip Code County

Primary Number: (____) _____ Home___ Work___ Cell___ Other___

Secondary Number: (____) _____ Home___ Work___ Cell___ Other___

Date of Birth:_____ Age: _____ Male: _____ Female: _____

Mother's maiden name? _____ How did you hear about us? _____

Please list all siblings including DOB and age: _____

_____

RESPONSIBLE PARTY INFORMATION

The adult that brings in the child is responsible for any fees at the time of service.

Parent/Legal Guardian 1:
Name:_____
Relation to Patient:_____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
DOB:_____
Driver's License #: _____ State: _____

Parent/Legal Guardian 2:
Name:_____
Relation to Patient: _____
Home Phone:_____
Employer:_____
Work Phone:_____
Cell Phone:_____
Email:_____
DOB:_____
Driver's License #:_____ State: _____

INSURANCE INFORMATION

Primary Insurance:
Insurance Company :_____
Member ID Number:_____
Group Number:_____
Cardholder/Subscriber's Name:_____
Subscriber DOB:_____

Secondary Insurance:
Insurance Company :_____
Member ID Number:_____
Group Number:_____
Cardholder/Subscriber's Name:_____
Subscriber DOB:_____

EMERGENCY CONTACT *(other than parents)*

Name:_____ Relation to Patient: _____

Phone #_____ Home___ Work___ Cell___ Other___ Email address: _____

PHARMACY INFORMATION

Name:_____ Address: _____ Phone #: _____

CONSENT FOR MEDICAL CARE AND ASSIGNMENT OF BENEFITS

I authorize *Healthy Steps Pediatrics, LLC* to provide medical care for my child/children. I authorize payment of medical benefits directly to *Healthy Steps Pediatrics, LLC* for services provided. I authorize provider to release any medical information required to process my claims.

Signature:_____ Print Name: _____ Date: _____

HEALTHY STEPS PEDIATRICS
Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

RECEIPT OF NOTICES OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT ACKNOWLEDGMENT FORM

I _____ (parent/legal guardian) acknowledge I have received a copy of the privacy practices and financial policies of *Healthy Steps Pediatrics, LLC*.

I have read and understand the Privacy Practices and Financial Policy of *Healthy Steps Pediatrics, LLC*, and agree to the terms and responsibilities as described in the documents. I authorize *Healthy Steps Pediatrics, LLC*, to release required medical and/or other information necessary to process my insurance claims. I also authorize payment of medical benefits directly to *Healthy Steps Pediatrics, LLC*.

Please print the names of all children, including DOB and age, below:

Name	Date of Birth	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Legal Guardian Signature: _____

Print Name: _____ **Date**_____

3911 Mary Eliza Trace, Suite 500, Marietta, GA 30064 | Phone: 678.384.3480 | Fax: 678.384.3481

HEALTHY STEPS PEDIATRICS

Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

PROXY PERMISSION FORM

Healthy Steps Pediatrics, LLC requires a parent or legal guardian to accompany all patients under the age of 18 for every office visit. All *Healthy Steps Pediatrics* patients who are not accompanied by a parent or guardian must have a completed PROXY PERMISSION FORM prior to their office visit.

List child(ren) DOB and age below:

Name	Date of Birth	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, _____, (parent/legal guardian) give the following person(s) permission to make medical decisions and to sign any appropriate documents related to my child(ren), in my absence.

Name:_____ Relationship:_____ Driver's Lic #/State:_____ Phone #: _____

Name:_____ Relationship:_____ Driver's Lic #/State:_____ Phone #: _____

Name:_____ Relationship:_____ Driver's Lic #/State:_____ Phone #: _____

I, _____, DO/DO NOT *(circle one)* give my child, _____, permission to seek medical treatment by themselves without a parent, caretaker or guardian in accompaniment. I acknowledge that my child is of driving age and has the ability and maturation to understand your medical recommendations.

Signature of Parent/Legal Guardian: _____

Print Name:_____

Relation to child/patient: _____

Date: _____

3911 Mary Eliza Trace, Suite 500, Marietta, GA 30064 | Phone: 678.384.3480 | Fax: 678.384.3481

HEALTHY STEPS PEDIATRICS
Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

NEWBORN INSURANCE INFORMATION

Please be sure to contact your insurance company to add your newborn to your insurance policy. Insurance companies typically cover newborns for the first 30 days. It is always the parent's responsibility to add a newborn within the mandated time frame. Healthy Steps Pediatrics strongly recommends you add the newborn within the first two weeks, so there is not a gap in coverage. **If the newborn is not added within the required time frame, you will be financially responsible for all medical charges incurred since birth.** *Please Note:* Each insurance company has unique policies regarding coverage for well child checkups, vaccines and ancillary pediatric services. Please contact your insurance company to verify your own benefits and a Healthy Steps Pediatrics provider is in-network on your HMO/POS plan. **If Healthy Steps Pediatrics cannot verify that your child has active insurance, you will be required to pay out of pocket for the visit.** If you have any questions, please contact your insurance company or our office for further details.

Child(ren)'s Name & DOB: _____

_____

Parent/Legal Guardian Signature:_____

Print Name:_____

Relationship to Child:_____

Date:_____

3911 Mary Eliza Trace, Suite 500, Marietta, GA 30064 | Phone: 678.384.3480 | Fax: 678.384.3481

HEALTHY STEPS PEDIATRICS

Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Healthy Steps Pediatrics as your health care provider. Our fees are based on the cost of delivering quality medical care. We ask that you read the following Financial Policy, initial each section, and sign that you acknowledge and accept our policy.

_____ initials

INSURANCE COVERAGE

You must provide your insurance card or proof of insurance at each visit. If you do not have insurance, are unable to provide proof of insurance, or are on a plan in which we do not participate, you will be considered a self-pay patient. Full payment for self-pay patients is required at the time of service. It is very important that you take an active role in understanding your insurance benefits. Certain plans have restrictions on certain services such as vision/hearing screening, immunizations, and timing of well child exams. It is your responsibility to be aware and understand your plans restrictions and limitations. If you have any questions regarding your coverage, health benefits, health restrictions and payment determination then you need to contact your insurance company directly.

_____ initials

PAYMENT METHODS

Payment for all services, including insurance co-payments and deductibles, are due at the time of service. These fees, by law, cannot be waived. For your convenience, we accept cash, most major credit cards, debit cards and Health Savings Account cards.

_____ initials

INSURANCE

Healthy Steps Pediatrics will bill insurance companies we participate with as providers. You will be responsible for all co-pays and deductibles at the time of service. Some of the services provided may be non-covered services and not paid by your insurance company. You are personally responsible for these services. You will also be responsible for all balances your insurance carrier does not pay within 90 days. You will receive a bill, which must be paid upon receipt. If we are not a provider on your current insurance plan or you do not have proof of insurance, you will be responsible for the entire bill at the time of service. If you have secondary insurance and did not inform us and provide your insurance card, you could be responsible for the entire visit. We can provide you with a detailed receipt of your visit (Superbill), upon request, for you to file with your insurance company.

_____ initials

MEDICAL RECORDS & FORMS

Medical records are the property of Healthy Steps Pediatrics, LLC. You may request copies of medical records by completing a records request form. We will provide copies of required medical records to specialists free of charge. All other copies will be charged per page to cover processing costs, as permitted by law (GA Code § 31-33-3). We will provide you with copies within 30 days of receiving your written request. We provide medical forms 3300, 3231 and Sports Physical forms for services performed during well child visits at the time of service. If you require an additional copy of a form at a later date, or bring in a form for a provider to complete, there will be a $5 charge per form. All form requests require a 72 hour notice for processing.

_____ initials

REFERRALS

If your insurance plan requires a referral prior to seeing a specialist or using a hospital service, you will likely need to be seen in our office **before** we can issue one. Referrals must be initiated by a primary care provider. We cannot issue a referral once services have been rendered. It is your responsibility to know your insurance company requirements.

_____ initials

MISSED APPOINTMENTS/ CANCELLING APPOINMENTS

Missed appointments have a negative impact on the efficiency of our practice, can potentially jeopardize the health of our patients, and disrupt the patient flow and scheduling availability. Healthy Steps Pediatrics requires a **minimum of 24 hours** notice when canceling or rescheduling an appointment. **If you fail to show up for your appointment, you will be charged a $50.00 no show fee.** Insurance does not cover these fees. Cancellations/rescheduling with less than 24 hours notice and missed appointments will be charged.

_____ initials

DELINQUENT ACCOUNTS

A payment can be made with our billing office for past due amounts. Failure to pay or to make payment arrangements of a past due amount may result in a referral to a collection agency. You agree to reimburse us the fees of any collection agency or attorney firm, and all costs and expenses, including reasonable attorneys' fees we incur in such collection efforts. If your account is referred to a collection agency for payment, you will be dismissed from our practice.

I have read and understand the Healthy Steps Pediatrics' Financial Policy and agree to the terms and responsibilities described above. I authorize Healthy Steps Pediatrics, LLC, to release required medical or other information necessary to process my insurance claims. I also authorize payment of medical benefits to Healthy Steps Pediatrics, LLC.

CHILD/CHILDREN'S NAME & D.O.B_____

PARENT/LEGAL GUARDIAN SIGNATURE & DATE_____

PRINT NAME_____

RELATIONSHIP TO CHILD_____

HEALTHY STEPS PEDIATRICS
Helping to GROW healthy children one step at a time

Mary Hammock, CPNP | Dr. Caroline Miller, MD | Meagan Darling, CPNP | Emily Drew, CPNP | Erin Ferguson, CPNP | Alyssa McCall, CPNP

NON-COVERED SERVICES

Each insurance company covers different procedures. At Healthy Steps Pediatrics, we utilize patient health questionnaires as screening tools at each of your child's well visits. We have implemented the screens that are specifically recommended by the American Academy of Pediatrics. These tools are critically important to assess your child's overall physical, emotional, nutritional, educational, and developmental progress.

In addition, hearing & vision screening is recommended by the American Academy of Pediatrics during a child's well visit a the ages of 3, 4, 5, 6, 8, 10, 12, and 15 years old. Most insurance companies cover these screenings when they are performed during a well child visit. If either or both hearing & vision screenings are performed outside of the child's well visit at the ages listed above, services may not be covered.

You understand that your insurance company may or may not cover these screening tools.

Patient(s) Name & D.O.B.:_____

_____

Parent/Guardian Signature:_____

Print Name:_____

Date:_____

3911 Mary Eliza Trace, Suite 500, Marietta, GA 30064 | Phone: 678.384.3480 | Fax: 678.384.3481