



PATIENT REGISTRATION

Primary Care Physician: Dr. Stone Dr. Behm Dr. Callan Dr. Williams Dr. Dammeyer Dr. McCullough

Patient Information (legal first, middle and last name required)

Last Name _____ First _____ Middle _____
Nickname _____ DOB _____ Sex: M F SS # _____ Preferred Phone # _____
Address _____ City/State/Zip _____

Parent/Legal Guardian Information (legal first, middle and last name required)

Mother _____
<input type="checkbox"/> Natural <input type="checkbox"/> Adoptive <input type="checkbox"/> Step-parent <input type="checkbox"/> Legal Guardian
SS # _____ DOB _____
Address _____
City/State/Zip _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____

Father _____
<input type="checkbox"/> Natural <input type="checkbox"/> Adoptive <input type="checkbox"/> Step-parent <input type="checkbox"/> Legal Guardian
SS # _____ DOB _____
Address _____
City/State/Zip _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____

Parents are: Single Married Divorced Widowed

Sibling Information

Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____

Emergency Contact & Relationship _____ Phone # _____

Preauthorization to Treat Minors

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. This may include, but is not limited to, a grandparent, babysitter, or family friend. Please be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making. Please also note that the person bringing in the child is responsible for payment.

- I authorize Coastal Pediatrics and it's personnel to provide medical care to this child in my absence. _____ Initials
- I **do not** authorize Coastal Pediatrics to provide medical care in my absence. _____ Initials

Insurance Information (you must also provide us with a copy of your current insurance card)

Primary Insurance

Insurance Company _____
Name of Insured _____
Member ID # _____
Employer (if applicable) _____
Relationship to Patient _____
Group # _____ Effective Date _____

Secondary Insurance

Insurance Company _____
Name of Insured _____
Member ID # _____
Employer (if applicable) _____
Relationship to Patient _____
Group # _____ Effective Date _____

Authorization of Treatment and Assignment of Benefits

I have completed this form to the best of my ability and verify that the information is correct. I understand I am responsible for full payment of any and all services. I authorize the release of any medical or other information necessary to process any insurance claims. I request and authorize payment of any benefits from any insurance or medical plan, including those listed above or attached to Coastal Pediatrics.

Parent/Legal Guardian Signature _____ Date _____



Authorization & Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information: I hereby certify that the insurance information I have provided is accurate, complete and current and I have no other insurance information. I assign my right to receive payment of authorized benefits under my insurance carrier(s) to the provider of any services furnished to me by that provider. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification: In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment: I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however, I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing) and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of their staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text: I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however, I may refuse any particular treatment or procedure.

I hereby acknowledge that I consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Coastal Pediatrics providers.

Patient's Name

Patient's Signature (if applicable)

Date

Parent/Guardian's Signature (if patient is a minor)

Date



Financial Policy

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

*****PAYMENT IS EXPECTED AT THE TIME OF SERVICE*****

Payment is required at the time services are rendered. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. Co-payments will be collected at the time of check-in. Coastal Pediatrics accepts cash, personal check (in-state only), VISA, and MasterCard. There is a \$30.00 charge for returned checks. Patients with an outstanding balance for more than 60 days must make arrangements for payment prior to scheduling an appointment. **Patients with an outstanding balance for more than ninety (90) days may be referred to an outside collection agency and charged any legal and collection fees in addition to the balance owed. Also, families of patients who have unpaid delinquent accounts may be discharged as patients and, if discharged, will still be subject to collections. Pending collections families may not be allowed to schedule additional services unless special arrangements have been made.**

We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation you seek your child's immunizations and/or medical care through a public health clinic or the Chatham County Health Department.

The parent/guardian/adult that brings the child in for treatment is responsible for payment. This includes divorced parents, grandparents, babysitters, etc. There are no exceptions.

INSURANCE:

We bill participating insurance companies as a courtesy to you. Therefore, we will request a copy of your insurance card at **each** visit. Please understand that insurance is a contract between you and your carrier. Therefore, you are ultimately responsible for your bill. **You are responsible for knowing the coverage, limitations and exclusions specific to your insurance policy, particularly concerning vaccinations and lab tests.** If charges have been filed and we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You will be expected to contact your insurance carrier for explanation of why payment is delayed. If you need assistance paying your account, please speak to the receptionist.

MEDICAID/PEACHCARE:

Medicaid and PeachCare insurance plans (Wellcare, Amerigroup, CareSource and Peach State CMOs) are not accepted as primary nor secondary insurance.

MINOR PATIENTS:

A parent, guardian or approved adult must accompany all minors before treatment can be provided.

REFUNDS:

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., HMO), you must ensure that we are selected as your child's primary care provider (PCP). You must also receive a referral from our office before seeing a specialist.

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 set aside for your child. We ask that you kindly give 24 hour notice for cancellation of your appointment. Three missed appointments in a family will result in discharge from this practice. First appointments missed by new patients will not be rescheduled.

I have read and understand the Coastal Pediatrics Financial Policy. I agree to assign insurance benefits to Coastal Pediatrics whenever necessary. I also agree that if I have an outstanding balance for more than ninety (90) days, it becomes necessary to forward my account to a collection agency. In addition to the amount owed, I will be responsible for any legal and/or collection fees. I also understand that if I have unpaid delinquent accounts, my child(ren) may be discharged as a patient(s) or may not be allowed to schedule any additional services unless payment arrangements have been made.

Signature of insured or authorized guardian:

Date: _____



Patient Consent for Use and Disclosure of Protected Health Information & Receipt of Practice Privacy Policy

I hereby give my consent for Coastal Pediatrics to use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO). Examples of such instances include, but are not restricted to: your medical insurance carrier, physicians to whom your child is referred, school health officials, etc. Coastal Pediatrics' 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. Coastal Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at any time by forwarding a written request to Coastal Pediatrics' privacy officer at 2 Wheeler Street, Savannah, GA 31405.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing Coastal Pediatrics to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, clinical care (including test results) and insurance issues. I understand that I have the right to request that Coastal Pediatrics restricts how it uses or discloses my PHI to carry out TPO. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form, I agree that they are allowed to receive PHI in the same manner as described above (with the exception of information relating to STD, HIV/AIDS, pregnancy testing and records relating to drug, alcohol or mental health treatment, which all require an additional release).

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, Coastal Pediatrics may decline to provide treatment to me/my child.

For patients under 18 years of age:

_____	_____	_____
Patient Name	Date of Birth	Date
_____	_____	_____
Signature of Parent/Legal Guardian	Printed Name of Parent/Legal Guardian	

ADDITIONAL HIPAA APPROVED CONTACTS

_____	_____
Name/Relationship to Patient	Name/Relationship to Patient
_____	_____
Name/Relationship to Patient	Name/Relationship to Patient

*****If the patient is over 18 years of age, they must sign for themselves.*****

For patients 18 years of age and older:

_____	_____	_____
Patient Name	Date of Birth	Date

Signature of Patient		

Now that you have turned 18, you get to choose who may have access to your medical information. Remember to add your "ADDITIONAL HIPAA APPROVED CONTACTS" above. By providing your email address and phone number, we will update the primary contact information on your account.

_____	_____
Patient Email	Patient Phone Number