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Dear Parents:

Life for your daughter has been full of big steps. From first steps, to first grade, to her first job, each year has brought increased independence as well as responsibility. You have prepared her with the tools and knowledge needed to move forward successfully with each stage. Now, with the passage into adulthood another transition awaits her - the transition from pediatrician to adult healthcare provider.

It has been our honor to work with your family and do our part to guide and equip you for each stage of childhood. It is our hope that we can do the same for this next step. For our patients, the transition to an adult provider generally occurs once they have completed school and are living independently. For some that comes with graduation from high school, while for others they may stay with our practice through college graduation. By age 21, all patients should identify an adult health care provider and take the necessary steps to transition their care to that provider.

While this transition may still be a few years off for your daughter, it is good to begin preparing now for this move. To help you in this, we have provided a packet of materials for you to review with your teenager and begin to put a plan in place. Also, taking steps now to foster greater health-related independence in your teen will prepare her to be fully responsible for her own health. Here are a few suggestions:

- Have your teen fill out the *Know Yourself* form included in this packet and then review it together. If your daughter has any health conditions, make sure she understands these conditions, is comfortable explaining them to others, and can identify any warning symptoms that indicate a need to seek emergency medical attention.

- Along with her health history, make sure that your child knows about any medications that she takes (prescription and over-the-counter). Your teen should be confident about the name of her medicine, what the medicine does, the appropriate dose, and any expected side effects. This is especially important for any emergency medications, such as an EpiPen or Albuterol inhaler. If she has questions, encourage her to review her medications with us at the next visit. Also, teach her how to call in for medication refills and allow her to begin making the phone calls.

- Make certain your child knows what she is allergic to, how to avoid allergen exposures, and what to do if exposed. If your child has a food allergy, make sure she can read ingredient labels and ask appropriate questions about food items. It may be helpful to prepare a list together of safe foods for eating out when in restaurants or at a friend's house.

- Allow your teen to be as independent as possible for her own healthcare and involve her in the decision-making process. At age 18, healthcare decisions legally become her responsibility. During visits at Coastal Pediatrics, encourage her to do most of the talking, to ask questions, and to prepare a list of questions before the visit. It may also be appropriate for her to start calling and scheduling some of her own appointments. Provide her a copy of the health insurance card and have her bring any required co-pays to the appointments.

If you have individual concerns on preparing for this transition, please discuss these with us at your next visit. While this may seem like a big step for your teen, we are confident that we can take another successful stride towards growing up together.

Sincerely,

The Staff of Coastal Pediatrics

Transition Checklist

- ☐ Review with your teen their personal and family medical history *(use included worksheet)*.
- ☐ Review your health insurance policy with your teen and provide them with their own copy of the insurance card. It is important that they understand and can identify the subscriber, group number, and any expected co-payments.
- ☐ Ensure they have saved emergency contact information into their cell phone.
- ☐ Encourage them towards greater independence now by having them schedule their own appointments, carry their insurance card, refill prescriptions, etc.
- ☐ Work together to identify an appropriate adult healthcare provider.
- ☐ When ready to make the final transition, notify Coastal Pediatrics and request a copy of the medical records.

Know Yourself

Take a few minutes to sit down and fill out this sheet about yourself. After completing it, review it with your parents to help clarify any answers you were uncertain of. Then, keep it and use it as a guide to help you communicate your health history to your next healthcare provider.

My health condition(s):

My medications I take:

My allergies *(include reaction)*:

My past operations/hospitalizations:

Our family health history:

My emergency contacts:

My healthcare provider *(and their contact information; include any specialists)*:

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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 _____

☐ Natural ☐ Adoptive ☐ Step-parent ☐ Legal Guardian

SS # _____ DOB _____

Address _____

City/State/Zip _____

Email _____

Home Phone _____

Work Phone _____

Cell Phone _____

Father _____

☐ Natural ☐ Adoptive ☐ Step-parent ☐ 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 _____

Your Child's Medical History

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Child's Name _____ **DOB** _____ **Date** _____

Child's Past Medical History

Has your child ever been treated or diagnosed with: *(explain)*

☐ ADD/ADHD _____
☐ Allergies (seasonal) _____
☐ Allergies (food) _____
☐ Anemia _____
☐ Asthma or reactive airway disease _____
☐ Broken bone _____
☐ Cancer _____
☐ Chicken pox _____
☐ Constipation _____
☐ Depression/anxiety _____
☐ Diabetes _____
☐ Ear infections (recurrent) _____
☐ Eczema _____
☐ Heart murmur _____
☐ Kidney disease _____
☐ Migraines _____
☐ Pneumonia _____
☐ Sickle cell disease _____
☐ Seizures _____
☐ Urinary tract infections _____
☐ Wheezing or bronchiolitis _____
☐ Other chronic medical conditions _____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes

If yes, explain. _____

_____

_____

Past surgeries or procedures? ☐ No ☐ Yes

If yes, explain. _____

_____

_____

Please list any specialist your child has seen, dates and reason: _____

_____

_____

Allergies

List allergies to medicine:

_____

_____

_____

Medications

List current medications:

_____

_____

_____

Any concerns about your child's development/nutrition?

_____

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad

☐ step _____ ☐ siblings (#___) ☐ Grandparent(s)

☐ Other _____

Mom's age _____ Dad's age _____

Parents are: ☐ married ☐ unmarried ☐ divorced ☐ other

Do any household members smoke? ☐ No ☐ Yes

Family History

Do any family members have any of the following conditions?

	Family Member		
Condition	Mother	Father	Sibling(s)
ADD/ADHD	☐	☐	☐
Alcoholism	☐	☐	☐
Allergies	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Blood disorder	☐	☐	☐
Cancer	☐	☐	☐
Depression/anxiety	☐	☐	☐
Diabetes	☐	☐	☐
Heart attack/disease	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Kidney disease	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Other issues	☐	☐	☐

Please explain all positives:

_____

_____

_____

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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: _____

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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

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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