MR # _____
Co-Pay _____
TRICARE AUTH # _____

Pediatric Acute Care of Columbus

5555 Whittlesey Blvd
Suite L-1
Columbus, GA 31909

PATIENT INFORMATION

Name (as it appears on insurance policy) _____
Home Phone # _____ Cell Phone # _____
Date of Birth _____ Sex: ☐ Male ☐ Female
Mailing Address _____
City _____ State _____ Zip _____
Pediatrician _____ Today's Complaint _____
Allergies _____ Pharmacy Choice _____

INSURANCE INFORMATION

Insurance Company Name _____
Insured ID # _____ Group _____
Policy Holder's Name _____ Date of Birth _____
Employer _____ Work # _____
Social Security Number _____ Relationship to patient _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name _____
Insured ID # _____ Group _____
Policy Holder's Name _____ Date of Birth _____
Employer _____ Work # _____
Social Security Number _____ Relationship to patient _____

PARENT/GUARDIAN INFORMATION

Name _____ Phone # _____
Date of Birth _____ Social Security Number _____
Mailing Address (If different from above) _____
City _____ State _____ Zip _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures. This is sometimes referred to as "Reasonable and Customary fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement with insurance). Also, some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance. In the event that your account may be turned over to collections, any collection fees and/or legal fees shall be your responsibility.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

Print Name _____ Signature _____ Date _____

MR # _____
Co-Pay _____
TRICARE AUTH # _____

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NOTICE OF HIPAA POLICIES AND PATIENT ACKNOWLEDGEMENT FORM

I acknowledge that Pediatric Acute Care (PACC) follows the guidelines set forth by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that the practice may use my personal health information to help provide health care to me with regards to billing and payment and/or other health care options. There may be no other uses or disclosures of this information unless I permit. I do, however, understand that sometimes the law may require the release of this information without my permission. I also understand that my health information is private and confidential. I understand that Pediatric Acute Care will strive to protect my privacy and preserve the confidentiality of my personal health information. I understand that PACC has established procedures that help them in protecting my personal health information. These procedures may include other signature requirements, written acknowledgement, authorizations, and reasonable time allowance for requested information. I understand there may be charges incurred for copying my health information and for non-routine information needs. I further understand that PACC will not use or disclose my health information without my authorization, except as described in this notice.

My signature below indicates that I understand and agree with the above use of my protected health information and that I have received a copy of the HIPAA Privacy Rule.

My signature below authorizes Pediatric Acute Care to obtain any medical records necessary to assist with the medical care of my behalf.

_____ _____

Signature **Date**

MR # _____
Co-Pay _____
TRICARE AUTH # _____

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CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

IMPORTANT: Do not sign this form without reading and understanding its contents. Mark out and initial any Procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types, diagnostic, or treatment procedures may be necessary. These procedures are performed by the physician or an assistant for the physician.
While usually performed without incident, there are potential risks associated with each of these procedures. It is not possible to list every risk for every procedure and this form will therefore list the most common possible risks. It is important to note that a simple act as taking a commonly used medication can rarely cause severe reactions that could lead to organ failure or even death.
If I have any questions or concerns regarding these procedures, I will ask my physician or his/her assistant to provide me with additional information. These procedures include:

- Needle sticks such as shots, injections, or intravenous lines to administer fluids or medications. Material risks include, but are not limited to infection, infiltration (fluid from an IV leaking into tissue), disfiguring scar, nerve damage with possible loss of limb function. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- Physical tests, assessments and treatments such as internal body examinations, wound cleaning and wound dressing. Material risks include allergic reaction and infection. Apart from using modified procedure and/or refusal of treatment, no practical alternative exists.
- Drawing blood or bodily fluids with a needle or taking tissue samples (biopsy). Material risks include but are not limited to infection, damage to joint or organ, nerve damage, and bleeding.
- Administration of medication whether orally, rectally, topically, or through the eye, ear, or nose. Material risks include, but are not limited to, allergic reaction, puncture, and perforation. Apart from varying the method of administration and/or refusal of treatment, no practical alternative exists.
- Insertion of internal tubes such as scopes, catheters, drainage tubes, etc. Material risks include but are not limited to internal injuries, bleeding, infection, and difficulty urinating after long term catheter placement. Apart from external collection devices or refusal of treatment, no practical alternative exists.

I understand that:

- The practice of medicine is not an exact science and that NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any procedures; and
- The Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the procedures, therefore, I agree to provide accurate and complete information about my medical history
- I may be asked to sign additional required informed consent documents for specific procedures and tests. By signing this form:
- I consent to Healthcare Professional performing procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, including those procedures that may be unforeseen and not known to be needed at the time this consent is obtained; and
- I acknowledge that I have been informed, in general terms, of the nature and purpose, the material risks and the practical alternatives of the procedures.

I understand that Pediatric Acute Care uses Nurse Practitioners in our office for those levels of practice that have been approved by the Georgia State Board of Medical Examiners. Your Signature on this approval form conveys that you are in agreement with being treated by our mid-levels whom act under our supervision.

_____ _____

Signature **Date**

MR # _____
Co-Pay _____
TRICARE AUTH # _____

Pediatric Acute Care of Columbus

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Financial Policy

Effective July 1, 2017

- As a courtesy to our patients, we file insurance on behalf of the patient. It is the **patient's responsibility** to make sure that the practice has the correct insurance information. If the patient does not provide the practice with the appropriate information so that the bills can be submitted to insurance within 30 days then the bill becomes the responsibility of the patient.
- **The patient is** responsible for obtaining all referrals for office visits prior to your visit. The practice will assist whenever possible.
- **The patient will be responsible for all co-payments, co-insurances and deductibles.** A $25.00 surcharge will be assessed for any co-payments not paid at the time of service.
- If after 60 days your insurance company has not processed the claim, it will become the **patient's** responsibility and they will receive a bill for the services.
- **We will bill the patient for any balances due (co-insurance and deductibles) and expect all accounts to be paid within the initial billing cycle.** A 2% monthly service fee will be assessed for unpaid balances after 60 days (2 billing cycles).
- If you are unable to pay your balance in full, please contact our billing office at **706.221.6116** to make payment arrangements. This plan will require a regular monthly payment and must be paid in full. If a payment is missed, the account will default to the collection process.
- **Accounts not paid in full after the second billing cycle and without an arranged payment plan with our billing office will be put into the collection process.** A 25% service fee will be added to all accounts sent to a collection agency.
- We participate with most insurance plans. However, it is the responsibility of the patient to who which providers are with their insurance plan. We are happy to assist in determining if we are on your provider panel.
- A $35.00 charge will be assessed for any check returned from the bank.

Please sign below indicating that you have read and agree to our Financial Policy.

Patient Name (please print) _____

_____ _____
Patient Signature or Guardian Date

Updated August 14, 2017

MR # _____
Co-Pay _____
TRICARE AUTH # _____

Pediatric Acute Care of Columbus

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Columbus, GA 31909

Welcome to Pediatric Acute Care of Columbus!

In order to serve you better, please complete this form entirely.

Patient Name _____ ☐ Male ☐ Female Date of Birth _____ Age _____ Room # _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Your Relationship to the patient _____
Primary Physician _____ Date of the last visit with primary physician _____
Preferred Pharmacy _____ Email _____
PARENT/GUARDIAN PRINT NAME _____ SIGNATURE _____ DATE _____

(Please show picture ID at the front desk.)

How does your child take medication? ☐ LIQUID ☐ TABLET

Please complete both columns below.

What is the reason for your visit today?
_____

Last visit here _____

What medications is your child currently taking?
_____

_____

Last known antibiotic taken? _____
Does your child have any allergies? _____

What is your child's past medical history? (Please include surgical history and any hospitalizations.)
_____

Is your child up to date on current vaccinations?
☐ YES ☐ NO

Does your child attend daycare, school or stay at home?
_____

Temp	Pulse	Resp	O2 Sat	Wt/Kg

☐ Strep _____ ☐ Flu A _____ ☐ Mono _____

☐ X-Ray _____ ☐ Flu B _____ ☐ UA _____ ☐ RSV _____

CONSTITUTIONAL:
Fever Fatigue Decreased Fluid Loss of Appetite
Other: _____

EYES:
Redness Itching Eye Drainage Swelling
Other: _____

EARS, NOSE and THROAT:
Ear Pain Congestion Sore Throat Teething
Other: _____

HEART:
Chest Pain Fainting Palpitations
Other: _____

RESPIRATORY:
Wheezing Shortness of Breath Cough Croup
Other: _____

GASTROINTESTINAL:
Nausea Vomiting Diarrhea Stomach Pain Constipation
Other: _____

GENITOURINARY:
Diaper Rash Painful Urination Frequent Urination
Decrease Urination Other: _____

SKIN:
Rash Sores Dryness or Eczema Welts Burns Bite
Laceration Other: _____

NEUROLOGIC:
Headache Seizures Head Injury Dizziness
Loss of Consciousness Other: _____

MUSCULOSKELETAL:
Aching Pain Soreness Injury Other: _____