Tania Smith MD, FAAP
600 Pointe North Blvd
Albany, Georgia 31721

Office Hours
Monday - Friday 6AM – 3PM
(229) 903-4044 Office
(229) 903-4055 Fax

NEW PATIENT PROCESS

*****We DO NOT accept patients who choose not to vaccinate according to the CDC and American Academy of Pediatrics immunization schedule. *****

- Complete each page of the new patient packet & the medical records release.
- Please make sure to thoroughly read our policies.
- We process packets in the order they are received. Due to the number of new patient packets received daily, it may take up to a week for processing.
- We will fax the completed medical records release to the previous physician(s). We ask that you follow up with the previous physician's office to ensure that the records are sent to us in a timely manner. Please make sure that a release is filled out for each physician your child has seen.
- Once we receive all records, they will be reviewed, and we will call you to schedule an appointment. We must have complete records.
- Your initial scheduled appointment at Prestige Pediatrics will be to establish care. We are unable to provide medical care for your child on an urgent basis if they have not established care.

Please note:

The time it takes for the previous office to send us medical records varies. Therefore, we are unable to provide a time frame as to how long the process will take before your child's appointment is scheduled.

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Please Print

Child's Legal Name: _____ Date of Birth: _____ Sex: (circle) M F

Social Security No: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Parent/Legal Guardian Information (for example mother)

Name: _____Date of Birth: _____ Relationship to Pt._____

Address: _____ City: _____ _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____ _____

Employer Work Phone: _____ Occupation: _____

Social Security No: _____

Parent/Legal Guardian Information (for example father)

Name: _____Date of Birth: _____ Relationship to Pt._____

Address: _____ City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer Work Phone: _____ Occupation: _____

Social Security No: _____

Sibling Information (other child (ren) who received care from our office)

Siblings Legal Name: _____D.O.B _____ Sex: (circle) M F

Siblings Legal Name: _____D.O.B _____ Sex: (circle) M F

Siblings Legal Name: _____D.O.B _____ Sex: (circle) M F

Siblings Legal Name: _____D.O.B _____ Sex: (circle) M F

Primary Insurance - A copy of your card is required and it is your responsibility to keep us updated of any change.

Insurance Company: _____

Policy #: _____ Group # _____

Address: _____ City: _____ State: _____ Zip _____

Name of Policy Holder: _____ Date of Birth _____ Relationship to Pt._____

Please Circle one if you have: Peachstate Medicaid Wellcare

Emergency Contact Information (other than parents)

In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment (including Immunizations) for my child/children. I also realize that the person with my child may have access to pertinent protected health information if medically necessary.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Pharmacy

Name: _____ Address: _____ Phone: _____

Release of Protected Health Information

I give permission to release protected health information to: My daycare/school upon request. Other healthcare providers for purposes related to your care and treatment, or we may use and disclose your health information in order to bill and collect payment for services and items you receive.

X _____ Date: _____
Signature of Parent/Legal Guardian

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Authorization for Release of Medical Records

(MUST HAVE RECORDS FROM ALL PHYSICIANS. WE WILL SEND OFF ONE TIME AS A COURTESY)

Patient's Legal Name: _____ Date of Birth: _____ __

Address: _____ City: _____ State _____ Zip _____ __

Social Security No: _____ Home Phone: _____

I hereby authorize: _____

Phone: _____ Fax: _____

to release the following medical information to:

Prestige Pediatrics
600 Pointe North Blvd.
Albany, GA 31721

Please release:

( ) Complete Records

( ) Other: _____

Purpose of disclosure: ( ) Continuity of Care ( ) Personal file $30.00 fee ( ) other _____

I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS): sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse, or similar conditions.

I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the Prestige Pediatrics except to the extent that the practice has acted in reliance upon this authorization. I do not have to sign this authorization in order to receive treatment. I may inspect or obtain a copy of the information to be used or disclosed. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify expiration date, event, or condition, this authorization will expire on the following date, event, or condition, this authorization will expire in six months.)

X _____ Date: _____
Signature of Parent/Legal Guardian

X _____
Relationship to patient if acting for the patient

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Policy

It is our intention to provide your child (ren) the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you take a few moments to review policies that affect the way services are provided.

In the Office

- **Arrive early.** Please remember that all insurance plans require that your insurance data be updated prior to each visit. This usually takes a few minutes and we ask for your patience. If this is not done, your insurance company may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.
- **Schedule an appointment by calling (229) 903-4044.** Walk-in patients are strongly discouraged. If you have a sick child, we ask that you call the office and allow the office staff to triage your child to see if an urgent visit is needed or if the child can be treated with a prescription. Urgent visits are based on the nature of the illness and on a first available appointment basis. Please be mindful that some urgent visits require the patient to be seen before scheduled appointments and our staff will do their best to keep on schedule. We thank you for your understanding.
- **Siblings.** We will do our best to schedule siblings on the same day however that is not always possible for various reasons. If you are bringing a child to a scheduled appointment and one of the siblings needs to be seen as an urgent visit, we ask that **you call in advance** and schedule an appointment.
- **Appointment times.** It is important that you bring your child (ren) to their appointment at the time we have allotted for your child (ren). Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we will work you in between the scheduled patients or reschedule your child (ren's) visit.
- **Late arrivals.** In the case that you will not be able to make your appointment we ask that you call the office and make us aware of your situation. The office allows a 15 minute grace period and after that time the appointment will need to be rescheduled to the next available appointment.
- **Missed appointments.** If you are not able to make an appointment it is critical that you call the office at least two (2) hours in advance. If it is after hours, call the office number and leave a message on the voicemail. Our staff will get the message and cancel the appointment. We ask that you call back during office hours to reschedule the missed appointment. **Please note:** Appointments that are missed without a phone call will be considered as a No Show appointment. If you have two (2) or more No Show appointments within 6 months you will receive a letter from our office. At the third (3rd) No Show appointment, you will receive a non-compliance/dismissal letter from our office **for the patient and all siblings.**
- **New patient appointments.** If you schedule an appointment for your child and it is their first visit, it is imperative that you call to cancel/reschedule that appointment if you are not able to make that visit. If this is not done we will **not** be able to reschedule you another appointment.
- **No show appointments deny other patients the opportunity to receive medical care when needed.**
- **Forms.** Please allow us 24 – 48 business hours to fill out any forms that are dropped off to be completed.
- **Turn off cell phones in the office and examination rooms.**

After –hours Call Service

- **Please limit after- hour calls to URGENT issues and EMERGENCIES.**
  - For refills, appointments, and non urgent matters, **call the office during normal business hours.**
- **When leaving a message**
  - Please listen to the prompt, speak clearly and slowly.
  - State the child's name and date of birth.
  - State the parent/guardian's name
  - Enter correct call back number as prompted by the system.
  - Disable your call block feature.
  - Follow the doctor's instructions.
  - If call has not been returned within twenty (20) minutes, please call again.

We are here to provide the best care we can to your child (ren) should the need arise. As always, we welcome the opportunity to care for your child (ren) and appreciate your trust in the services we provide.

X_____ Date: _____
Parent/Guardian's Signature

PLEASE LIST EACH CHILD THAT IS A PATIENT IN OUR OFFICE

X_____ DOB_____
Child's Name

X_____ DOB_____
Child's Name

X_____ DOB_____
Child's Name

X_____ DOB_____
Child's Name

DEMOGRAPHICS

PLEASE FILL OUT THE FOLLOWING INFORMATION

PATIENT'S NAME: _____ **D.O.B**_____

Please circle one

RACE: Black or African American Asian

White Hispanic

Native Hawaiian or other Pacific Island American Indian or Alaskan Native

Other

ETHNICITY: Not Hispanic or Latin America Hispanic or Latin America

PREFERRED LANGUAGE: English Spanish

Indian Russian

Other

ONLY FILL OUT ONE OF THE LINES BELOW FOR YOUR PREFERRED METHOD OF CONTACT FOR REMINDER CALLS, APPTS, RESULTS, ETC.

HOME NUMBER: _____

CELL NUMBER: _____

TEXT: _____

_____ _____

Parent's Signature Date

PRESTIGE PEDIATRICS

FINANCIAL POLICY

As a courtesy, Prestige Pediatrics, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Prestige Pediatrics that payment is due **at the time of service** unless other financial arrangements are made in advance. **We require that all patients pay their deductible, copay and/or coinsurance payment at the beginning of each visit.** The Office Coordinator will explain this information to you prior to your first visit. At the conclusion of your visits with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with pediatric benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier to make sure our office is in network and check into your coverage for pediatric benefits. Do not assume that you will not owe anything if you have more than one insurance policy.

Policy on Co-Pay Requirements When a Sick Visit Is Added To a Well Child Visit

Prestige Pediatrics is required under contract with your insurance carrier to collect co-pays at the time of medical service, most commonly sick visits. **You will be charged a co-pay if you either request, or approve, treatment for an acute or chronic illness during a Well Child Visit.** Such a request constitutes a Sick Visit, in addition to the Well Child Visit.

By signing below, you agree to the above financial policy. You also agree that you have provided Prestige Pediatrics ALL insurance plans in which your child is covered.

_____ _____

Signature of Parent/Legal Guardian Date

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Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier to make sure our office is in network and check into your coverage for pediatric benefits. Do not assume that you will not owe anything if you have more than one insurance policy.

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_____ _____

Signature of Parent/Legal Guardian Date

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Prestige Pediatrics, P.C. to view my child(ren) external prescription history via our electronic health record system, eClinicalWorks.

I understand that prescription history from multiple unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here and may include prescriptions from several years ago.

My signature certifies that I read and understood the scope of my consent and that I authorize access.

_____ _____
Patient Name DOB

_____ _____
Patient Name DOB

_____ _____
Patient Name DOB

_____ _____
Parent Signature **Date**

Please list commonly used Pharmacy Information:

_____
Pharmacy Name Address Phone #

_____
Pharmacy Name Address Phone #