NOMBRE DEL PACIENTE: ____

FECHA DE NACIMIENTO DEL PACIENTE: ____

NOMBRE DE LA MADRE: ____

FECHA DE NACIMIENTO DE LA MADRE: ____________________________________

NOMBRE DEL PADRE: ____

PADRES FECHA DE NACIMIENTO: ____________________________________

DIRECCIÓN: ____

____

NÚMERO DE TELÉFONO DE CASA: ____

NÚMERO CELULAR: ____

NOMBRE DE CONTACTO DE EMERGENCIA Y NÚMERO DE TELÉFONO:

____

COVINGTON PEDIATRICS , LLC

4181 HOSPITAL DRIVE SUITE 202
COVINGTON, GA 30014

Office Consent Form

Juliana Nahas, MD, Patricia Hellam, CPNP, April Colley, CPNP (DBA Covington Pediatrics, LLC) – consent is hereby given for staff and physicians to provide diagnostic procedures and to provide such treatment and care as in the opinion of treating provider may be necessary or appropriate. I understand that medicine is not an exact science, and no guarantee has been made as to the results of the treatment or care rendered.

By signing this form, I am consenting for Juliana Nahas, MD PC (dba: Covington Pediatrics) use and disclosures of any medical information deemed necessary without restrictions.

I authorize direct payment of medical benefits to Covington Pediatrics, Juliana Nahas, MD, Patricia Hellam, CPNP, April Colley, CPNP for services rendered.

PLEASE READ CAREFULLY:

- I understand that I am financially responsible for any balance not covered by insurance, including if services are rendered by a provider at Juliana Nahas, MD PC (dba Covington Pediatrics) who your carrier states is not a 'covered physician'.
- All accounts over 90 days past due will be reviewed for collections. In addition, if my Insurance, Medicaid, Peachstate, Amerigroup, Wellcare or Peachcare for Kids coverage is terminated during the time of my date of service, Covington Pediatrics, LLC will bill me and I will be financially responsible for this bill.
- Failure to pay may result in my appointments being cancelled or rescheduled until payment is made in full.
- If my account is turned over to a collection agency, I understand that all accounts and fees will be added to this account balance.

To the best of my knowledge, the questions on this form have been accurately answered.

I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES.

______________________________	______________________________
Please Print Patient Last/First Name	Please Print Guardian/Parent Last/First Name

______________________________	______________________________
Signature	Date

Acknowledgement of Notice of Privacy (HIPAA) and Consent to Use/Disclose Health Information

I acknowledge that I have received a copy of **Covington Pediatrics LLC** Notice of Privacy Practices. I understand that as part of my healthcare, **Covington Pediatrics LLC** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

APPOINTMENT MESSAGES		MEDICAL MESSAGES	
☐ Home	☐ Person	☐ Home	☐ Person
☐ Office	☐ Mail	☐ Office	☐ Mail
☐ Cell	☐ E-mail	☐ Cell	☐ E-mail

Before signing this form, you should understand the following:

- By signing this form, I authorize the use and/or disclosure of my protected health information
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected
- I authorize the release of any medical or other information necessary to process the insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below.
- I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and / or disclose my protected health information have acted in reliance upon this authorization.
- I understand that I do have the right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.524).

Patient name and Date Of Birth: ______________________________

Signature: ______________________________ Date: ______________

BILLING AND INSURANCE

We appreciate your selecting Covington Pediatrics to serve your child(rens') needs. We will do all we can to provide your child/children with the very best care possible. Our purpose is to provide our patients with expert, comprehensive and continuous medical care from birth through adolescence in the setting of a group practice.

Our fees are based on our cost of delivering quality care. All charges are to be paid at the time services are rendered. We accept cash, Mastercard, Visa and Discover.

If you are insured by one of the health plans in which we participate, we will gladly follow the contractual arrangements in the plan agreement. You must show your plan card at the time of each visit and be prepared to pay your co-pay, deductible or any non-covered service at the time of your visit. Please become familiar with your health benefits as many plans have restriction on certain services such as well childcare and immunizations. Also, please remember that your insurance contract is between you and your insurance carrier. If you have questions regarding your coverage, payment determination: or other details relating to your contract you should contact the insurance carrier directly.

***Please note we also reserve the right to charge for No- Show's. We ask that you kindly give us 24 hours of advanced notice if you need to cancel or reschedule an appointment. Also, if there are three (3) no shows for appointments, I understand that my child(ren) could be dismissed from the practice.

AUTHORIZATION TO RELEASE INFORMATION/PAY INSURANCE BENEFITS

I hereby authorize the physicians of Covington Pediatrics to release (PHI) required information to process claims. I hereby authorize payment to be made directly to Covington Pediatrics for all covered benefits under my insurance policy and I also understand that I am responsible for any unpaid portion not covered by my insurance.

Signature of Parent or Legal Guardian Date

INSURANCE STATEMENT/FINANCIAL RESPONSIBILTY

I understand that Covington Pediatrics will bill insurance companies for which they are providers, and verify the insurance information on those insurance plans which they are contracted, prior to services as allowed. My child(rens') insurance ID cards must be presented each and every visit. I am responsible for all balances my insurance carrier does not pay within 90 days. I am also aware that if my account becomes delinquent past 90 days it will be referred to a third party agency for collections effort. Our billing specialist will assist you if you have any billing or insurance questions. You can reach the business office at 770-787-7444 during the hours of 8:15am 5:00pm. If a check is returned on my account, I am aware that my account will be charged an additional $35.00 fee.

Signature of Parent or Legal Guardian Date