Email: info@covingtonPediatrics.com
Fax: 770-787-5050

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

Patient Information:

Patient Name: _____DOB: ____/_____/_____ Gender: Male/Female

Home Address:_____

City, State and Zip Code: _____

Ethnicity (Please circle): Hispanic / Non- Hispanic / Unknown

Race (Please Circle) : Asian / Black / Hawaiian / White

Phone Number for Appointment Reminders: _____

Email Address: _____

Primary Insurance Policy: Policy Holder's Name: _____DOB____/____/_____

Insurance Carrier: _____ ID and Group #: _____

Secondary Insurance Policy: Policy Holder's Name: _____DOB____/____/_____

Insurance Carrier: _____ ID and Group #: _____

Contact 1:

Name: _____ Relationship to patient: _____

Lives with patient? Please Circle: Yes / No DOB: ____/_____/_____ SS#:_____

Work Phone: _____ Cell Phone: _____

Work Email: _____ Home Email: _____

Employer: _____Occupation: _____

Contact 2:

Name: _____ Relationship to patient: _____

Lives with patient? Please Circle: Yes / No DOB: ____/_____/_____ SS#:_____

Work Phone: _____ Cell Phone: _____

Work Email: _____ Home Email: _____

Employer: _____Occupation: _____

If this contact will need to be notified in addition to Contact #1 for medical issues, Appointments, Reminders, Recall Notices, Billing Statement, General Practice Notices and Patient Portal Notifications list their preferences here: (work, cell, home email, or work email)

Please note our policy at Covington Pediatrics is after 3 no shows your family is dismissed form the practice. We ask that you give us the courtesy of calling to cancel with at least a 24 hours' notice. Thank you.

Covington Pediatrics
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Emergency Contacts, Other than parents:

Contact 1:

Name: _____ Relationship to patient: _____

Phone Number: _____

Contact 2:

Name: _____ Relationship to patient: _____

Phone Number: _____

Who should receive billing statements? _____

May all contacts have access to the patients records electronically? (please circle) Yes / No

If no, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

_____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please provide documentation.

List any Hospitalizations (also age): _____

Child's Health History: _____

List any non-prescription drugs your child is on: _____

Prescription Drugs child is currently taking: _____

List any drugs that your child is allergic to: _____

HAVE ANY OF YOUR CHILD'S RELATIVES EVER HAD ANY OF THE FOLLOWING?

[ ] Anemia
[ ] Arthritis
[ ] Birth Defects
[ ] Bleeding tendency
[ ] Cancer
[ ] Deafness
[ ] Drinking or Drugs
[ ] Eczema
[ ] Epilepsy/ Seizures
[ ] Glaucoma
[ ] Heart Attack or Heart Disease
[ ] Mental or emotional issues
[ ] Nerve or muscle disease
[ ] Obesity
[ ] Stroke
[ ] Suicide or Attempted Suicide
[ ] Tuberculosis
Other: _____

DO YOU OR YOUR FAMILY HAVE ANY CONCERNS WITH THE FOLLOWING?

[ ] Other family members
[ ] Friends
[ ] Housing or living arrangements
[ ] Finances
[ ] Education
[ ] Job/ Employment
[ ] Legal
[ ] Transportation
[ ] Family Violence or abuse
[ ] Recent loss of a job or retirement
[ ] Mental or emotional difficulties
[ ] Serious illness or disability
[ ] Recent break-up, separation, or divorce
[ ] Recent death of spouse, friend, or family member
[ ] Neighborhood violence
[ ] Other: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMEBERS (WHERE POSSIBLE)

NAME(S):	MALE/FEMALE:	DOB/AGE:	MARITAL STATUS:	LIVING AT HOME?

PLEASE LIST ANY ADDITIONAL CONCERNS, OR INFORMATION ABOUT YOUR CHILD, YOU, OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW: _____

Signature (parent/guardian): _____ **Date:** _____

Juliana Nahas MD

Covington Pediatrics

FUNCTIONAL AND INTEGRATIVE MEDICINE

5211 Highway 278 NE
Covington, GA 30014
Phone: 770-787-7444 Fax: 770-787-5050

Patient Name: _____ Patients Date of Birth: _____

_____ _____

_____ _____

_____ _____

PLEASE INITIAL ALL REQUESTED INFORMATION BELOW:

____ General Medical Info ____Lab Reports ____X-ray/ Radiology Reports

___Mental Health (from _____ to _____) ____Alcohol/Drug (from_____ to _____)

____ HIV (from _____ to _____) _____ STD's (from_____ to _____)

_____ Other: _____

Please provide us with **FORMER PROVIDER'S** information below:

Physicians Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

If the request is to **RELEASE TO ANOTHER PROVIDER** please provide the information below:

Physicians Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

This authorization expires _____ or in 6 months, whichever is shorter. Authorization is subject to revocation at any time. Once HIPPA information is disclosed to another entity the information may be subjected to future use and disclosure without protection offered by HIPPA.

Check one: I am the _____ Patient (must be 18 or older) _____ Parent or _____ legal guardian with custody (Please state relationship) _____

Signature: _____ Date: _____

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Patients Full Name: _____ DOB: _____
Mothers Maiden Name: _____
Hospital Child Was Born In: _____
C-Section or Vaginal Birth: _____ Childs Birth Weight: _____
Child's Grade in School (If applicable): _____

INSTRUCTIONS: Put an (X) in the appropriate box for each question:

[ ] Never Married [ ] Living with partner [ ] Married Now
[ ] Separated [ ] Divorced [ ] Widowed

CHECK THE APPRORIATE BOX FOR YOUR CHILD:

[ ] Multi Racial [ ] American Indian [ ] Hispanic [ ] Black; not of Hispanic origin
[ ] White; Not of Hispanic origin [ ] Asian or Pacific

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Arthritis	[ ]	[ ]	German Measles	[ ]	[ ]	Mumps
[ ]	[ ]	Asthma	[ ]	[ ]	Allergies/Hayfever	[ ]	[ ]	Rheumatic Fever
[ ]	[ ]	Bronchitis/Pneumonia	[ ]	[ ]	Hearing Problems	[ ]	[ ]	Tonsillitis or Strep
[ ]	[ ]	Cancer	[ ]	[ ]	Heart Disease	[ ]	[ ]	Vision Problems
[ ]	[ ]	Dental Problems	[ ]	[ ]	Learning Difficulties	[ ]	[ ]	Depression/Anxiety
[ ]	[ ]	Diabetes Mellitus	[ ]	[ ]	Measles	[ ]	[ ]	ADHD
[ ]	[ ]	Ear Infection	[ ]	[ ]	Mental or Emotional Problems			
[ ]	[ ]	Eczema	[ ]	[ ]	Other: _____			

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILDS HISTORY:

- Were there any complications during the pregnancy? Yes/ No
- Were there any complications during birth or delivery? Yes/ No
- Was the pregnancy full-term (9 months or 40 weeks)? Yes/ No
- Did the child go home with Mom after birth? Yes/ No
- Did the child have any problems with jaundice? Yes/ No
- Does the child have birth defects? Yes/ No
- Has the child's growth and development been normal? Yes/ No
- Are the child's immunizations up to date? (Please have immunization records available) Yes/ No
- Does anyone in the child's house smoke? Yes/ No
- Is your child exposed to sources of lead that you are aware of? Yes/ No

List Any Injuries: _____

List Any Operations: _____

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

BILLING AND INSURANCE

We appreciate your choosing Covington Pediatrics to serve your child(rens') needs. We will do all we can to provide your child's/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 arrangement 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 restrictions 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 appointments. We ask that you kindly give us 24 hours' 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) would 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 RESPONSIBILITY

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 allowed. My child(rens') insurance ID cards must be presented at each 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 if you have any billing or insurance questions. You can reach the business office at 770-787-7444 during business 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 of Legal Guardian Date

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

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 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.

Where would you like for us to leave messages concerning the following:

Appointment Messages:

___ Home ___ Person

___ Office ___ Mail

___ Cell ___ E-mail

Medical Messages:

___ Home ___ Person

___ Office ___ 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 by 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 the 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:_____

Covington Pediatrics
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PATIENTS WHO ARE NOT ACCOMPANIED BY A PARENT OR GUARDIAN

A parent or guardian must accompany all children/ teens under the age of 18. The parent or guardian can designate another person to seek medical care for their minor by completing the information below.

I, _____, give the following person(s) permission to make medical decisions in my absence. They have permission to sign any appropriate documents related to my child: _____Date of Birth:_____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

The person(s) named above are allowed to:

_____ pick up prescriptions

_____ pick up forms

_____ pick up medical records

_____ speak to nurse for medical advice

<u>Please list all siblings this may apply to:</u>

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Guardian Signature: _____ **Relationship:** _____

Print Name: _____ **Date:** _____

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

Office Consent Form

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 for, 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

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 appointment being cancelled or rescheduled until payment is made in full.
- If my account is turned over to a collections agency, I understand that all accounts and fees will be added to this account balance and need to be paid and all balances cleared before the patient is seen again.

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

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

Consent for Appeal

Name: Covington Pediatrics
Address: 5211 US HWY 278, NE
City, State, Zip: Covington, GA 30014
Phone: 770- 787- 7444 Fax: 770- 787- 5050

Patient:
Date of Birth:
Date(s) of Service:
Provider:
Reference Inquiry:
Regarding:

Reason for appeal:

I give consent for the provider listed above to file an appeal on my behalf with my insurance carrier _____. This will be an appeal of the denial of health care services that are described above. I have read this consent or have had it read to me and it has been explained to my satisfaction.

I have the right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
This authorization will expire upon resolution of this appeal.

Thank you,

Member Signature: _____

Consent from a representative: The member listed above is unable to sign this consent form because of the reason(s) listed below, and I consent for this member: _____

If signed by anyone other than the member's parent, you must provide a copy of the power of attorney or court ordered document showing authority to act on the member's behalf, if you have not already done so.

Covington Pediatrics
FUNCTIONAL AND INTEGRATIVE MEDICINE

Vaccine Policy

Patient Name: _____ **Date of Birth:** _____

We at Covington Pediatrics firmly believe that immunizations are one of the most important medical breakthroughs in history. Vaccines are important for all children and have saved countless lives and avoided untold suffering.

WE ARE A PRO-VACCINE PRACTICE. WE EXPECT PARENTS TO IMMUNIZE THEIR CHILDREN ACCORDING TO THE SCHEDULE RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS (AAP) AND THE CENTERS FOR DISEASE CONTROL (CDC). WE DO NOT OFFER NON-STANDARD OR "ALTERNATIVE" SCHEDULES.

The AAP and CDC both recommend administering multiple immunizations at each visit. Multiple shots and combination vaccines are utilized for three main reasons:

1. To provide broad immunological protection to children when they are young and most vulnerable.
2. To minimize the total number of shots needed.
3. To minimize the number of office visits and thus the cost to the healthcare system.

Administration of simultaneous vaccines has been extensively studied, determined to be safe and effective, and has NO negative effect on a child's immune system. In fact, the number of antigens in vaccines are tiny compared to the millions of germs that an average child is exposed to each day.

There is NO credible scientific evidence that vaccines cause autism. Numerous scientific studies have conclusively shown that vaccines DO NOT CAUSE AUTISM.

We realize that immunizations may be a worrisome subject for many parents and we will be happy to provide you with literature and web-sites on the subject. We will be happy to answer any questions you may have. **However, parents who refuse to vaccinate their children are not a good fit for our practice and will be referred elsewhere.**

_____ _____

Parents Name Parents Signature Date