KIDZCARE PEDIATRICS, INC.

3772 SATELLITE BLVD, STE 101, DULUTH, GA 30096. TEL 770 559 - 4315 FAX 770 559 – 4318

NEW PATIENT INFORMATION

Patients Name: Last _____ First _____MI _____
Date of Birth: _____ Sex: M / F SS # _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: ( ) _____ Home Phone: ( ) _____

Mother's Name: _____ DOB: _____ SS# _____
Employer: _____ Work # ( ) _____
Father's Name: _____ DOB: _____ SS# _____
Employer: _____ Work # ( ) _____

Guardian: ( ) State Assigned Foster Parent ( ) Adopted ( ) Temporary Custody
( ) Other _____

Emergency Contact Information:
Name of person other than parents or guardian to notify in case of emergency:
Name _____Relationship _____ Phone number ( ) _____
Address: _____

Whom may we thank for referring you? ( ) Insurance ( ) Friend ( ) Online ( ) other _____

Agreement for Payment of Services Rendered

Please Note: Kidzcare Pediatrics Inc, as a courtesy and a convenience to our patients, files claims on health insurance coverage, but only for certain carriers that we provide service for. Before medical service is rendered, you should verify that Kidzcare Pediatrics Inc and / or the provider is an approved provider under your plan. If we are not providers for your child's insurance, the fees for the services provided are to be paid in full at the time service is rendered. If we are out of network provider for your child's insurance, please refer to the out of network agreement for further information.

There will be a $30.00 charge on all returned checks.

I, the undersigned party, the parent or legal guardian of the patient, do hereby authorize Kidzcare Pediatrics Inc and/or any providers within the practice to file for health insurance benefits for covered services rendered to the patient. I authorize that payments from the insurance company to be made directly to Kidzcare Pediatrics Inc. The practice and/or the provider may use my healthcare information and may disclose such information to my insurance company for the purpose of obtaining payment for services rendered.

Parent or Legal Guardian's Name _____

Signature of Parent or Legal Guardian _____ Date _____

PATIENT HISTORY FORM

Patient's Name: _____ Date:_____

D.O.B: _____

Patient Past Medical History

Please circle any illnesses your child has had and list approximate dates and/or frequency:

Anemia	Heart Condition	Vision Problems
Allergies	Heart Murmur	Hearing Problems
Asthma	High Blood Pressure	Seizures
Autism	Pneumonia	Behavioral Problems
Diabetes	Kidney Problems	Other: _____

List any surgeries/hospitalizations: _____

List any known drug allergies: _____

List all medications taken on a regular basis: _____

Family History

Has a family member ever been diagnosed with any of the following?

Please circle and list the relationship. Only include you and the **child's** other parent, siblings, grandparents, aunts, uncles, and cousins.

Anemia	Allergies	Asthma	Bleeding disorder
Cancer	Crohn's disease	Diabetes	Eczema
Emotional problems	Epilepsy	Heart Attack	High blood pressure
High cholesterol	Kidney Disease	Lazy Eye	Psoriasis
Stroke	Thyroid disease	Tuberculosis	Ulcerative Colitis
Unexplained/Sudden Death	Urinary Reflux		

Other: _____

If you circled any of the above, please identify the relative: _____

_____

Is there anything more you would like us to know about your child? _____

_____

Person completing this form: _____

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to durable medical equipment companies who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to access the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required By Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, and organ donation agencies.
Serious Threat to Health Or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for worker's compensation or similar programs providing benefits for work related injuries or illness.

In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the number listed (under "Contact Person") to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and on our Web site. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the number listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the number listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact: Kabir Ahmed at 770-559-4315.

Effective date 9/1/2013

Notice of Privacy Practices Acknowledgement

I have read and understand Kidzcare Pediatrics, Inc. 's HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that Kidzcare Pediatrics, Inc. has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, Kidzcare Pediatrics, Inc. will post a new notice in the office. I may contact Kidzcare Pediatrics, Inc. at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I may also access a copy on its website.

General Consent for Examination and Treatment

I hereby consent and authorize Kidzcare Pediatrics, Inc to perform medical examinations and provide routine medical care which may include routine diagnostic and laboratory procedures and tests and medication administration.

Release of Information

I hereby consent and authorize Kidzcare Pediatrics to use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Record of Disclosures

HIPAA Privacy Rules gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I wish to be contacted in the following manner (Please check all that apply):

- ☐ Home Telephone
- ☐ Work Telephone
- ☐ Written Communication: mail to my home address

Patient Name: _____

Signature of Parent or legal guardian: _____ Date:_____