Coker Pediatrics, LLC

Patient Information Update

Patient Information

Child's Name _____ □ Male □ Female
(First) (Middle) (Last)

Name preferred _____ Child's DOB _____

Child's Street Address _____

Child's Mailing Address_____

City _____ State _____ Zip _____ Home # _____

Ethnic group (please select one): □ Hispanic/Latino □ Non Hispanic/Latino

Race (please select one or more of the following racial categories):

□ American Indian or Alaska Native □ Asian □ African American

□ Native Hawaiian or Pacific Islander □ Caucasian □ Other

Preferred Language: _____

With whom does child live with? □ Mom and Dad □Mom □Dad □Other
Who has legal custody? □ Mom and Dad □Mom □Dad □Other
Who is responsible party? □ Mom and Dad □Mom □Dad □Other

List all household members and their relationship to patient:

_____

_____

Emergency Contact & Relationship (Someone Not in Home)

1. Name _____ Phone # _____

2. Name _____ Phone # _____

Pharmacy Information

Our office prefers to fax medications to the pharmacy. Please list your preferred pharmacy. If you prefer the prescription to be hand written so that you can take it to the pharmacy of your choice, please inform our staff.

Preferred Pharmacy _____

Mother/Guardian Information

Name _____ Maiden Name _____

Address (if different than patient's) _____

Phone # _____ ____ Cell # _____ Work #_____

Employer _____ Employer Address _____

DOB _____ SS # _____ **Email** _____

Relationship to patient _____

Father/Guardian Information

Name _____

Address (if different than patient's) _____

Phone # _____ ____ Cell # _____ Work #_____

Employer _____ Employer Address _____

DOB _____ SS # _____

Relationship to patient _____

Child's previous pediatrician

Name _____ Phone # _____

Insurance Information (Please give card to receptionist)

Insurance Company name _____ Co-pay amount $ _____
Policy/ID _____ Group # _____
Policy holder's full name _____ DOB_____
Policy holder's relationship to patient: _____ Effective date _____

I understand that payment of all medical care is ***due at the time of service***. In case of divorced parents, responsibility and payment shall be ***that of the guardian bringing the child in for treatment***. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that I am responsible for any costs incurred in the collection of patients account in case of default, including reasonable attorney fees and court costs.

I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my Insurance authorizes and to inform the staff of Coker Pediatrics, LLC as to which laboratory my insurance covers.

I hereby grant permission to Coker Pediatrics LLC to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Coker Pediatrics LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Permission for Telephone Messages

Patient confidentiality is a top priority at Coker Pediatrics LLC. Therefore, it is important that parents or patients over 18 years of age provide us with the following information to ensure there is no violation of your or your child's privacy.

Please name all persons and places where we may leave health information including return phone messages, lab and test results, and scheduling:

Name: (Mother) _____
Email address: _____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Name: _____
Email Address: _____
Home Phone #: _____
Cell Phone#: _____
Work Phone#: _____

Name: (Father) _____
Email Address: _____
Home phone #:_____
Cell phone #:_____
Work phone #:_____

Name: _____
Email Address: _____
Home Phone#: _____
Cell Phone#: _____
Work Phone#: _____

I understand that if the status of any of above information changes, it will be my responsibility to inform the staff of Coker Pediatrics LLC.

Parent signature: _____ Date: _____

Treatment Authorization

I (We) _____authorize Coker Pediatrics and its personnel to deliver
Print Name of Legal Guardian(s)

medical services to my child, _____.
Child's Name and Date of Birth

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Coker Pediatrics, LLC

14557 Highway 19, Suite A
Griffin, GA 30224-9582

NEW OFFICE POLICIES
EFFECTIVE MAY 1, 2011

No Show Appointment Policy- In consideration of other patients, we ask you to notify our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient, who needs to see the doctor. **THREE** consecutive missed appointments will result in dismissal from the practice.

Late Policy- When you are more than 30 minutes late for your child's appointment, our front office staff will ask your doctor to help determine when best to see your child. You may be worked into the schedule with a wait, or you may be asked to reschedule, especially if it is a well-child visit. We are always trying our best to balance your needs with the needs of our other patients.

Transfer Policy- When a parent/guardian (also known as guarantor) transfers one child to another practice, then all children associated to that parent/guardian are made inactive and in effect transferred. A letter will be sent to the parent/guardian confirming transfer of medical records and notice of all children being made inactive. Coker Pediatrics will release all medical records to the new provider once the signed release request (must have request on all children) has been received from the new provider. **Once the confirmation letter has been sent, we will see the child and associated children on an emergency basis for 30 days.**

Please remember we are always looking for ways to improve our practice and provide high-quality healthcare to your children.

I, _____, have read and understand the policies above.

Signature _____ Date _____

Coker Pediatrics, LLC

FINANCIAL AGREEMENT

Patient Name _____ DOB _____

As a member of _____ insurance plan, I am aware of the responsibility that certain services rendered to my child/children by my physician may be considered non-covered or deemed not necessary by my insurance plan.

If my insurance denies payment to Coker Pediatrics, LLC, because the services rendered to the patient are considered non-covered or deemed not medically necessary, I agree to be personally and fully responsible for payment of these services.

I understand that I am responsible for all co-pays, deductibles and coinsurance amounts that are made my responsibility by the insurance company. *I understand that if my co-pay is not paid at the time of service, that there will be a $25 processing fee due in addition to the visit co-pay.*

I understand that failure to pay any patient balance due from me will result in the account being turned to an outside collection agency and a fee of **35%** of the balance will be assessed on the account, in addition to the balance owed. I also understand that I will be responsible for all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on my account.

_____
Parent/Guardian Printed Name

_____
Parent/Guardian Signature Date