WELCOME TO THE INTERNATIONAL PEDIATRIC CLINICS

How did you hear about our clinic? ☐ ESTABLISHED PATIENT ☐ YELLOW PAGES ☐ OUTSIDE SIGN

☐ FRIEND ☐ FESTIVAL ☐ NEWSPAPER ☐ INSURANCE COMPANY ☐ OTHER (specify):

PATIENT INFORMATION

Patient's Name:	Sex: ☐ M ☐ F	Date of Birth	SSN#:
Address	City/State	Zip Code:	Home Telephone
Mother's Name:		Date of Birth	Cell Phone Number:
Mother's Employer	Work Address	City/State	Work Number:
Father's Employer:		Date of Birth	Cell Phone Number:
Father's Employer	Work Address	City/State	Work Number:
Name of Person to call in case of an emergency:		Telephone Number:	

INSURANCE INFORMATION

☐ Medicaid ☐ Peachcare	Insurance ID Number:	Telephone Number:	
☐ Other Insurance	Name of Insurance Company:	Insurance ID Number:	Group Number:
Name of Responsible Party:	Relationship to Patient: ☐ Mother ☐ Father ☐ Other		

Name of the Pharmacy that you use? City		Pharmacy Telephone Number?
Name of your child's previous pediatrician?	Telephone Number?	When was your child last seen there?

AUTHORIZATION

Please show your insurance card to the receptionist.
I authorize International Pediatric Clinics to share information with and to receive payments from the insurance company whom I have an active contract.
Please return this form to the receptionist.

My signature will confirm that all the information provided above is to my knowledge true and correct:

Sign: _____ Date: _____

High quality pediatrics with love and without boundaries

International Pediatric Clinics
3780 Holcomb Bridge Rd., Suite C
Norcross, GA 30092
Office 770.263.9101
Fax 770.263.9102

Suzana Mara Montaña, MD, FAAP
Dennis Selva, MD
Alexa Thompson, RN, CPNP

Newborns

- If you have a newborn baby and have applied for Medicaid, we will need verification from Georgia Health Partnership. If your Medicaid has not been approved yet, a payment of $ 100 will be collected for the first visit, $ 100 for a check up or sick visit, and $ 60 for a follow up visit.
- If you do not have insurance, you will be expected to pay in full at the time of service. We accept cash, or debit and credit cards. **We no longer accept checks.**
- If you have any question or concerns, feel free to call the office during regular business hours and a staff member can assist you.

La Clinica del Nino dba: International Pediatric Clinics

Please initial the following statements if you agree:

_____ I authorize International Pediatric Clinics to discuss my account and my child's Medicaid application with Georgia Health Partnership.

_____ I authorize the following person (s) to bring my child to International Pediatric Clinics for medical care.

Print name: _____ Print Relationship: _____

Print name: _____ Print Relationship: _____

By signing below you acknowledge that you have read and agree with International Pediatric Clinics office and financial policies.

_____

Sign name Date

International Pediatric Clinics

Welcome to International Pediatric Clinics. Our goal is to provide high quality pediatrics with love and without boundaries.

These are our office policies. We ask for you to please sign this form and return it to the front desk. A copy is available for you by request.

Office Hours

Our office hours are Monday - Friday from 8 am to 5 pm. We receive sick walk in patients from 8 am to 9 am.

Appointments

We ask that you call ahead to make an appointment. Same day appointments are almost always available, except for vaccines, well child check-ups and school physicals.

Please arrive at least 15 minutes prior to your schedule appointment time. Please be aware that if you do not have an appointment or you are late to your appointment you will be seen on a first come serve basis, or you will be asked to reschedule. Arriving on time to your appointment is necessary so our staff can continue to provide the highest quality of care.

Insurance

Please bring your insurance card with you to each appointment. Your child's eligibility and covered services will be verified with your insurance company before services are rendered.

If your insurance plan requires you to select a doctor, you must change the doctor to our clinic or you will not be seen.

The Doctors and Staff of La Clinica del Nino, PC Want You to Know How We Will Protect Your Private Health Information.

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and others healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable, with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all of our patients with the attached Notice of Privacy Practices at their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have given you the opportunity to review and ask questions regarding the HIPAA privacy practices. You are entitled to a personal copy of the Notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Practice Manager, Beverly Paladinetti.

Thank you for your cooperation.

I acknowledge that I have been given the opportunity to review or receive a copy of International Pediatric Clinic's Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient Name:_____

(Please Print)

Signature of Patient or Personal Representative:

_____ **Date:** _____

If Personal Representative, give relationship to patient:

_____

PERMISSION FOR TREATMENT

I do hereby voluntarily request medical care or services at International Pediatric Clinics, PC for my child/children as listed on my application for registration. I hereby authorize and grant my permission and consent for all providers employed by International Pediatric Clinics, PC, to use such diagnostic and treatment procedures as they deem necessary for proper medical management and treatment of my child/children. I fully understand that no guarantee or warranty of results that may be obtained has been given or implied by the physicians or other medial services employees of International Pediatric Clinics, PC, or is in any way intended hereby. I also acknowledge that I may, at anytime, refuse to accept medical care or services for my child/children and I accept full responsibility for said act or statement of refusal.

I further understand that on-site services are not provided by International Pediatric Clinics, PC on nights, weekends, and announced holidays, that, if treatment is needed, and International Pediatric Clinics, PC is unable to provide off-site services, I will seek such treatment at the hospital providing Emergency Service for that particular day or night.

I acknowledge the right of International Pediatric Clinics, PC and/or its agents, for due and proper cause, to refuse to initiate or continue medical care or services for my child/children.

I certify that I am legally entitled to sign this statement of permission for treatment.

REQUESTOR'S SIGNATURE _____ DATE_____
I understand the above

REQUESTOR'S NAME_____
Print Name

WITNESS_____ DATE_____

I, _____, authorize the following persons to bring
(Name of parent or legal guardian)

_____ to this office for treatment as provided
(Name of child/children)
for on this form. This treatment includes all immunizations including but not limited to: DTAP, IPV, TB by PPD, HIB, Tdap, MCV, MMR, Hep A, Hep B, PCV, Varicella, Rotavirus, Flu, HPV.

_____ Relationship to Child _____
_____ Relationship to Child _____
_____ Relationship to Child _____
_____ Relationship to Child _____

Signature of Parent or Legal Guardian_____ Date _____
Relationship to Child _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Practice:_____ **Phone:**_____
Fax:_____

Patient name:	**Date of Birth:**	**Phone:**
Address:		

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the above-named practice.

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s):

_____

☐ Other: _____

You may disclose this health information to:

La Clinica Del Niño, P.C., dba:
Clinica Internacional de Pediatria
International Pediatric Clinics
Phone: 770.263.9101 Fax: 770.263.9102

Reason(s) for this authorization (check all that apply):

☐ At my request	☐ Other (specify)
	_____

This authorization ends: ☐ on (date) _____

☐ when the following event occurs_____

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR**
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature — Date

_____ _____
Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative, etc.)