**Kids Start Pediatrics, P.C. 1515 Westfork Drive Suite C. Lithia Springs, GA 30122**

## OFFICE POLICY

**Welcome to our practice. Our office is open Monday, Wednesday, Thursday and Friday from 8:00am - 11:30am and re-open at 1:00pm - 4:30pm, Tuesday from 1:00pm - 4:30pm, and Saturday hours are 9:00am - 11:30am. We do same day appointment for sick children. We also accept walk-in sick visits from 9am - 10am and 2pm - 3pm with a longer wait time. Thank You.**

- **Verification of insurance and filing claims: When verifying benefits, it is never a guarantee of payment per your insurance company's disclaimer. It is the patient's responsibility to know what their insurance carrier considers a covered or non-covered service.**
- **ALL INSURANCE CLAIMS THAT ARE NOT PAID WITHIN 90 DAYS BECOME THE RESPONSIBILITY OF THE PATIENT FOR PAYMENT.**
- **It is the member's responsibility to have the correct doctor and personal information on the insurance card. Failure to have the correct information may result in having to reschedule your appoint.**
- **Payment Policy - As a rule, payment is expected at the time of your visit. All co-pays, co-insurance, and deductibles are due at the time of service. We accept cash, money orders, visa, mastercard, debit/credit cards. Due to insurance regulations we must collect co-pays for every visit. All past due accounts (more that 120 days) are subject to an extra $25. Fee and sent to collections.**

- **APPOINTMENT SCHEDULE**
  - **Physicals - are scheduled every 30 minutes, being on time is very important, you have up to 15 minutes from the appointment time to arrive and still be seen. If not you will be asked to re-schedule your appointment.**
  - **Sick Visits - are scheduled through out the day from 8:00am - 11:30am and from 1:00pm - 4:30pm.**
  - **No Show Appointments - due to the continued growth of this practice, it has become necessary to charge a $50 fee for a no-show appointment when scheduled for a physical without a 24-hour notice. Failure to keep an appointment "waste" a time slot that could be used for another patient. Appointments canceled more than 24-hour in advance will not be charged the above fee. This fee is not paid by insurance. After 5 no-shows you will be dismissed as a patient and asked to find another provider.**

**My signature below signifies that I fully understand and accept the terms of this practice.**

| _____ | _____ | _____ |
|---|---|---|
| **Signature of parent/legal guardian** | **relationship to patient** | **date** |

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Date_____

Patient's Name_____Dob_____
Last first mi

Address_____
Street city zip

Phone_____SS#_____ sex m / f

Mother's Name _____Dob_____
Last first mi

Cell phone_____work phone_____SS#_____

Father's Name_____Dob_____
Last first mi

Cell phone_____work phone_____SS#_____

Primary insurance
Name of Company_____
Responsible Party_____
Policy Number_____
Group Number_____

I agree that I am responsible for any amount not covered by my insurance. I also authorize the release of medical information to the insurance company of my children.

_____ _____
Parent Signature Date

PLEASE FILL OUT THE FOLLOWING INFORMATION:

MOTHER'S FULL NAME

_____

FIRST MAIDEN LAST

CHILD'S FULL NAME

_____

FIRST MIDDLE LAST

DATE OF BIRTH_____

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# FORM REQUEST FOR LIMITATIONS AND RESTICTIONS OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ SSN_____

Date of Birth_____

Address_____

_____

Please check the type of patient information below that you want to be restricted. You may check more than one line. This information will only be given to another doctor or hospital in an emergency situation. This information will NOT be given to anyone else.

| | |
|---|---|
| _____home address | _____date of birth |
| _____patient history | _____date of service |
| _____home phone | _____office address |
| _____occupation | _____office phone |
| _____name of employer | _____spouse's name |
| _____visit notes | _____ spouse's phone |
| _____prescription info | _____other |

Please list below the type of restriction you would like to make on the patient's history information.

_____

_____

I have read the brochure and filled out the above information.

_____ _____

Parent Signature Date