Mountain View Pediatrics

James T. Bell, M.D. *James B. Gilbert, M.D.* *Christy Floyd, R.N., M.N., C.P.N.P.*

2049 Beverly Road
Gainesville, GA. 30501
(770) 287-1788

Nombre de Madre:_____ Número de Seguro Social _____-_____-_____
Fecha de Nacimineto:_____/_____/_____
Nombre del Padre:_____ Número de Seguro Social _____-_____-_____
Fecha de Nacimineto:_____/_____/_____

Dirección Postal:_____

Cuidad:_____Estado:_____Código Postal:_____

Teléfono de casa: ( )_____-_____Teléfono de Emergencia ( )_____-_____

#Trabajo de Mamá( )_____-_____ #Trabajo de Papá( )_____-_____

Tél. Celular de Mamá ( )_____-_____ Tél. Celular de Papá ( )_____-_____

Autorización para tartar al niño(a): _____
Firma
Relación: ____Mamá ____Papá ____Guardián ____Otro:_____

Quién es la persona responsible del recibo de pago?_____

<u>Por favor complete la lista de todos sus niños(as):</u>

1.Nombre del Paciente:_____
Sexo: Femenino Masculino
Fecha de nacimiento:_____/_____/_____
Seguro Social _____-_____-_____

2.Nombre del Paciente:_____
Sexo: Femenino Masculino
Fecha de nacimiento:_____/_____/_____
Seguro Social _____-_____-_____

3.Nombre del Paciente:_____
Sexo: Femenino Masculino
Fecha de nacimiento:_____/_____/_____
Seguro Social _____-_____-_____

4.Nombre del Paciente:_____
Sex: Femenino Masculino
Fecha de Nacimineto:_____/_____/_____
Seguro Social _____-_____-_____

5.Nombre del Paciente:_____
Sex: Femenino Masculino
Fecha de Nacimineto:_____/_____/_____
Seguro Social _____-_____-_____

6.Nombre del Paciente:_____
Sex: Femenino Masculino
Fecha de Nacimineto:_____/_____/_____
Seguro Social _____-_____-_____

MOUNTAIN VIEW PEDIATRICS
PRACTICAS DE COBROS Y PAGOS

INFORMACION DE ASEGURANZA: Por favor entregue su tarjeta a la recepcionista para que podamos hacer una copia para el expediente. La cuenta de los servicios proveídos serán cobrados al paciente o guardian. Los recibos se le proveerán para obtener el nreembolso de su aseguranza. El paciente o su guardián es responsible de todos los costos sin importar su cubierta.

Aceptamos pagos con tarjeta de crédito(VISA,MASTERCARD,DISCOVER&AMERICAN EXPRESS), cheque o efectivo. Le pedimos que cualquier co-pago o deducible sea pagado en el momento de servicio. Esto nos ayudará a mantener nuestros precios bajos. En casos especiales, haga arreglos con la gerente de la oficina antes de su visita.

INFORMACION DEL SEGURO MEDICO:

Nombre del Seguro Médico Primario:_____ Nombre del Asegurado:_____
Grupo #:_____ # de Identificación:_____

Nombre de Seguro Médico Secundario:_____ Nombre del asegurado:_____

Grupo #:_____ # de Identificaión:_____

NUESTRA OFICINA ACCEPTA PACIENTES Y SOMETE RECLAMOS A LOS SIGUENTES PLANES MEDICOS:

Affordable / Health Care Compare	Blue Cross/Blue Shield of Ga.	First Health
America's Health Plan	United Payors	United Providers
Multiplan	Community Care Networks	Focus Healthcare Management
Galaxy Health Network	National Hospital Network	Northeast Ga. Health Partners Plus
Preferred Health Network	Preferred Plan of Ga.	Multi-Plan
BCE Emergis	Principal Healthcare (PHCS)	Southcare – PPO
USA Managed Care	Coventry	United Healthcare
Medicaid	Peachcare for Kids	Tricare

***** IMPORTANTE *****

Esta lista cambia con frequencia. Hable con la recepcionista si suplan no está incluido.

I hereby authorize ***MOUNTAIN VIEW PEDIATRICS*** to furnish all information to insurance carriers concerning my child(s) illness and treatment and I hereby assign to the physician all payments for medical services rendered to my dependents.

I understand that I am responsible for any amount not covered by insurance.

Date:_____/_____/2014 Responsible Party Signature:_____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.
We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:__________________________________ Signature_____________________________ Date____/_____/ 2014

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphas on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

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INFORMACION DE PACIENTES NUEVOS

Nombre del niño(a): _____Fecha de Nacimiento:____/____/_____ Fecha :___/____/2014

Raza:_____ Sexo:_____ Idioma preferido:_____

Doctor previo y su dirección:_____

Allergias o reacción a vacunas:_____

Medicinas:_____

HISTORIA DEL NACIMIENTO:

¿Algún problema con su embarazo? □ Sí □ No ¿Alguna enfermedad durante su embarazo? □ Sí □ No
¿Nació su babe a tiempo? □ Sí □ No Parto: □ Vaginal □Cesárea Peso al nacer:_____
¿Tuvo su bebé problemas en el hospital luego de nacer? □ Sí □ No _____

HISTORIAL MEDICO:

Hospitalización: □Sí □ No ¿Cuándo/Porqué?:_____
Cirugías: □Sí □No ¿Cuándo/Porqué?:_____
¿Algún golpe o trauma serio?:_____
¿Tiene su niño(a) alguna de las siguientes condiciones? (Marque todas las que aplique)
□Asthma □Eczema □Alergias nasals □Problemas de atención □Croup □Anemia
□ Problemas par air al baño □Pulmonia □RSV □Varicela □Infeciones de oído frecuentes □Infección de orina
□ Silbido del pecho (wheezing)
Immunización: □ Al día □Atrasado □ No sé

HISTORIAL FAMILIAR: (Marque cualquier problema que las papás, abuelos, hermanos, hermanas, tíos o tías han tenido)
□Anemia □Asthma □Allergias □Diabetes □Tuberculosis □Problemas del corazón □Presión alta
□Enfermedad mental □Problemas de drogas □Problemas con alcohol □Problemas heredados □Cancer
□HIV/AIDS □ Convulsiones □Problemas de sangrado fácil □Problemas de la tiriodes
Otros problemas:_____

SOCIAL HISTORY:

¿Quién vive en casa? (Si es necesario, use el otro lado del papel)

NOMBRE	EDAD	RELACION	SALUD EN GENERAL

Escuela/Centro de cuido:_____ Días a la semana/Grado:_____
Seguridad en el hogar: □Cinturón de seguridad/asiento protector de niños □Casco de bicicleta □Detectores de humo
□ Revólver □Fumadores □Marcotas □ Piscina

DESSAROLLO:

A qué edad su niño(a):

¿Caminó solo? _____ ¿Dijo su primera palabra? _____
¿Sentó sólo? _____ ¿Tuvo su primer diente? _____

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AUTHORIZATION TO TREAT

It has come to our attention that at times as a parent, you may not be able to bring your child to the Doctor or call to get information about your child. According to the HIPPA REGULATIONS, only the person having legal custody can obtain information about that child or seek medical attention. If the parent or guardian or person having legal custody, gives permission for information to be given out, IT HAS TO BE IN WRITING.

Please list below any person(s) who will have your permission to bring the child in for office visits or call and get information on the child, such as lab results, x-ray, appointment times or to set-up appointments. The people you put on this list will also be able to sign for, but not limited to, immunizations, lab work and breathing treatments.

For security purposes, please provide name, date of birth, address and relationship to child of person you are giving permission to obtain information or seeking care for your child.

1. Name:_____ **Relationship:**_____ **Date of Birth:**_____

Address:_____

2. Name:_____ **Relationship:**_____ **Date of Birth:**_____

Address:_____

3. Name:_____ **Relationship:**_____ **Date of Birth:**_____

Address:_____

4. Name:_____ **Relationship:**_____ **Date of Birth:**_____

Address:_____

_____ _____/_____/_____

Signature of Parent / Legal Guardian **Date**

You may change or update your list in person at the office or in writing at any time