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

Mother's Name:_____ Mother's Social Security:_____-_____-_____
Mother's Date of Birth:_____/_____/_____

Father's Name:_____ Father's Social Security _____-_____-_____
Father's Date of Birth:_____/_____/_____

Mailing Address:_____

City:_____State:_____Zip Code:_____

Home Phone # ( )_____-_____Emergency # ( )_____-_____

Mother Work # ( )_____-_____Father Work # ( )_____-_____

Mother Cell # ( )_____-_____ Father Cell # ( )_____-_____

Authorization to Treat Minor Child: _____
SIGNATURE
Relationship: ____Mother ____Father ____Guardian ____Other:_____

Who is financially responsible for this bill?_____

PLEASE LIST ALL CHILDREN- FULL NAME- (Including the one(s) we are seeing today):

1.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

2.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

3.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

4.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

5.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

6.Patient Name:_____
Sex: Male Female
Date of Birth:_____/_____/_____
Social Security # _____-_____-_____

MOUNTAIN VIEW PEDIATRICS - PAYMENT POLICY

INSURANCE INFORMATION: *Please give your card(s) to the receptionist so that we may keep a copy on file. All professional services rendered are charged to the patient / guardian. Receipts will be provided for insurance reimbursement.* ***HOWEVER****, the patient /guardian is responsible for all fees regardless of insurance coverage.*

We accept payment by cash, check or credit card (VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS). We do ask that any co-pay or deductible be paid at time services are rendered. This will help us to keep our costs down. For special cases, please make arrangements with our office manager prior to your appointment.

INSURANCE INFORMATION:

Primary Insurance Name:_____ Name of Insured:_____

Date of Birth of Policy Holder:_____/_____/_____

Group #:_____ ID #:_____

Secondary Insurance Name:_____ Name of Insured:_____

Date of Birth of Policy Holder:_____/_____/_____

Group #:_____ ID #:_____

WE DO FILE & ACCEPT ASSIGNMENT ON THE FOLLOWING PLANS:

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

***** PLEASE NOTE *****
This list is updated frequently. Please ask if your plan is not listed.

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 costing 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 emphasis 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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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

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NEW PATIENT QUESTIONAIRE

Child's Name:_____ **Date of Birth:**_____/_____/_____ **Date:**____/_____/**2014**

Race:_____ **Gender:**_____ **Ethnicity:**_____ **Preferred Language:**_____

Child's Previous Doctor & Address:_____

Allergies/Reactions to Medicines or Vaccines:_____

Current Medications:_____

PREGNANCY AND BIRTH:

Any problems with the pregnancy? □ Y □ N Any illness during pregnancy? □ Y □ N
Was the baby born on time? □ Y □ N Delivered: □ Vaginal □Cesarean Birth Weight:_____
Did the baby have any problems is the hospital? □ Y □ N _____

PAST MEDICAL HISTORY:

Hospitalizations □ Y □ N When/Why?:_____
Surgeries □ Y □ N When/Why?:_____
Any serious injuries:_____
Does your child have any of the following conditions? (Check all that apply)
□Asthma □Eczema □Hay Fever □Attention Problems □Croup □Anemia □ Problems Going Potty
□Frequent Ear Infections □Pneumonia □RSV □Chicken Pox □Urine Infection □Wheezing

Immunizations: □ Up to Date □Behind □ I Don't Know

FAMILY HISTORY: (Check any problems that this child's parents, brothers, sisters, aunts or uncles ever had)
□Anemia □Asthma □Allergies □Diabetes □Tuberculosis □Heart Trouble □High Blood Pressure
□Mental Illness □Drug Problems □Alcohol Problems □Inherited Problems □Cancer □HIV/AIDS
□ Bleeding Problems □Seizures □Thyroid Problems Other:_____

SOCIAL HISTORY:

Who lives at home? (Use back of page if needed)

NAME	AGE	RELATIONSHIP	GENERAL HEALTH

School/Daycare:_____ Days per week/Grade:_____
Home Safety: □Seat belt/Car seat □Bike helmet □Smoke detectors □Guns □Smokers □Pets □Swimming pool

DEVELOPMENT:

At what age did your child:

Walk Alone? _____ Said First Word? _____
Sit Alone? _____ Had First Tooth? _____