AUGUSTA PEDIATRIC ASSOCIATES, P.C. EST. 1980

1245 Augusta West Parkway
Augusta, Georgia 30909
(706) 868-0389
FAX (706) 651-0729
www.augustapediatrics.com

Patient's Full Name _____ Birthdate _____ Age ____

Has this patient ever been known by any other name? (List) _____

Which doctor would you like to see? _____ Miller _____Moore _____Newton _____Hanna
_____ Drake _____Massey _____Threadgill _____Leverett

Address _____ Best Phone to Reach You: _____

City: _____ State: _____Zip _____ Child's SS# _____

Patient Lives with: _____ Both Parents _____ Mother _____ Father _____ Other

Please Specify if Other _____

Please list any brothers or sisters that we have seen in this office: _____
****

Best E-mail Address:_____

Father's Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Ph. _____

Employed By _____ Work Ph. _____ Cell Ph. _____

Mother's Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Ph. _____

Employed By _____ Work Ph. _____ Cell Ph. _____
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Medicaid/Peachcare Number _____ Effective Date _____

Name of Primary Insurance Company _____

Policy Number _____ Group Number _____ Effective Date _____

Policyholder's Name _____

Does your insurance policy pay for immunizations/vaccines? _____ Yes _____ No _____ Not Sure Please initial ___

We do not submit to secondary insurance plans. We will be happy to provide you with a receipt to submit for reimbursement. You will receive a response directly from your secondary insurance plan once you have filed your claim. PLEASE BE SURE YOU ASK FOR THIS RECEIPT AT EACH VISIT. WE ARE UNABLE TO GENERATE THIS RECEIPT AFTER THE CLOSE OF EACH BUSINESS DAY!!!!

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Nearest Relative that does not live at the above address (other than relative already listed on this form):

Name _____ Relationship to Patient _____

Address _____ Home Ph. _____

City _____ State _____ Zip _____ Work/Other Ph. _____

How were you referred to our practice? _____

Religious Preference _____

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By signing below, I authorize Augusta Pedicatric Associates to release immunization information to a daycare or school that I may designate at a later time upon my verbal request.

_____ _____

Parent or Patient's Guardian Signature Date

PLEASE READ AND SIGN THE FOLLOWING CONCERNING OUR OFFICE POLICIES AND ASSIGNMENT OF INSURANCE BENEFITS:

Payment is expected at time of visit unless prior arrangements have been made.
All copays,coinsurance and deductibles must be paid at time of service.

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I further expressly agree and acknowledge that my signature on this document authorizes any physician of Augusta Pediatric Associates, P.C. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Name of insurance company)

to pay and hereby assign directly to Augusta Pediatric Associates, P.C. all benefits, if any, otherwise payable to me for services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits when received by and paid to Augusta Pediatric Associates, P.C. will be credited to my account in accordance with the above assignment.

_____ _____

(Authorized signature of insured) (Date)

I hereby give my consent for the examination and treatment of the above named patient including immunizations and injections when indicated and properly authorized. I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment. I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). I understand that if at any time a collection agency is employed to collect fees that I am responsible for the fees incurred up to 50% of the balance due. **I am aware of the APA financial policy. A copy is available for my review in each exam room or online at augustapediatrics.com.**

_____ _____ _____

(Signature required for treatment) (Date) (Relationship to Patient)

I acknowledge by signing below that the Notice of Privacy Practices, Notice of Individual Rights are available to me and are posted for my review in the waiting room.

_____ _____

Patient or Patient's Guardian Signature Date