Sandy Springs Pediatrics
and Adolescent Medicine, PC

6100 Lake Forrest Dr. Ste 100
Sandy Springs, GA 30328

Patient Name ______________________ **Preferred/Nickname** ______________

Date of Birth ____________ **Sex** ☐ Male ☐ Female

Race: ☐ America Indian/Alaska native ☐ Nat Hawaiian/Pacific Islander ☐ Asian

☐ Black/African American ☐ White ☐ Declined

Ethnicity - ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Home Address ______________________________

City ______________ **State** ____ **Zip** ________ **Home #** ______________

Father's Name ______________ **Date of Birth** ________ **Work #** ______________

Mother's Name ______________ **Date of Birth** ________ **Work #** ______________

Preferred Email Address ______________ **Preferred Cell#** ______________

Preferred Communications - ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Mail ☐ Patient Portal

Child's Primary Physician ☐ Steven Shore, MD ☐ Estonna Wells-Jarrett, MD ☐ Vanna Jackson, MD

☐ Sarah Aldridge, MD ☐ Elizabeth Theriot, MD ☐ Emily Andriessen, MD

Emergency Contact ______________________ Phone ______________

Address ______________________ Relationship ______________

Preferred Pharmacy

Name ______________ Street Address ______________

City ______________ Zip ________ Phone ______________

Primary Insurance

Name ______________

Address ______________

City,State,Zip ______________

Insured Name ______________

Relation to Patient ______________

Policy Number ______________

Group Number ______________

Secondary Insurance

Name ______________

Address ______________

City,State,Zip ______________

Insured Name ______________

Relation to Patient ______________

Policy Number ______________

Group Number ______________

Other Children

Name ______________ M / F Name ______________ M / F

Name ______________ M / F Name ______________ M / F

Consent for Medical Care and Assignment of Benefits – I authorize Sandy Springs Pediatrics to provide medical care for my child/children. I authorize payment of medical benefits directly to Sandys Springs Pediatrics for service provided. I authorize physician to release any information required to process my claims.

Signature ______________________ Date ______________

Sandy Springs Pediatrics & Adolescent Medicine, PC
Pediatric Infectious Disease Associates, LLC

FORMULARY BENEFITS CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescriptions drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance.

In summary, we ask your permission to obtain formulary information and information about other prescripts by other providers using RxHub.

By signing below I give permission for **SSP/PIDA** to access my pharmacy benefits data electronically through RxHub. This consent will enable **SSP/PIDA** to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

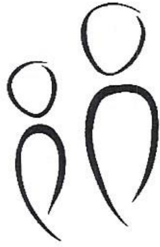
______________________________ ______________________________
Patient Name (Printed) Date of Birth

______________________________ ______________________________
Signature (Patient/Guardian) Date

Preferred Pharmacy (local) Name ______________________________

Address ______________________________ Phone # ____________________

Mail Order – Name ______________________________ Phone ____________________



Sandy Springs Pediatrics
and Adolescent Medicine, PC

Office and Financial Policies

Thank you for choosing Sandy Springs Pediatrics as your health care provider! Everyone at our practice is committed to providing our patient families with the highest quality care in a positive, respectful and caring environment.

The following is a statement of our financial and office policies. We ask that you read through it and sign where indicated.

We expect all patient families to respect the rights of others, including staff and any visitors at our office. We believe that aggressive or belligerent behavior whether physical or verbal is inappropriate and inconsistent with our practice mission and goals. Therefore, any guest who demonstrates this behavior, whether it be directed at a provider, employee, or visitor to our practice will be asked to leave our office immediately and may be dismissed from our practice.

Insurance and Payments

We encourage all patient families to become familiar with their insurance plan benefits, requirements, and exclusions. We encourage them to reach out to their company's Benefits Administrator (if applicable) if they require clarification of their benefits.

We will do all we can to work with our patient families to ensure the payment of claims for services rendered. In order to best help our patient families and due to frequent changes in health coverage we require proof of insurance at each visit. If you do not have proof of insurance or are unable to provide proof of coverage at your visit you will be required to pay in full for the service(s) rendered at that visit.

Co-payments, co-insurance, deductibles, and any other cost-sharing requirements set forth by your plan are due in full at the time of service. By law these fees cannot be waived.

If we are participating providers in your health plan we will file a claim on your behalf for reimbursement. If there is a dispute regarding your coverage, we will assert your rights for coverage for you with your insurance carrier for you if we have a signed copy of our Advanced Beneficiary Notice, which gives us permission to do so.

Referrals/Forms/Medical Records

Referrals:

Should your insurance plan require a referral before seeking treatment from a specialist or using a hospital service, we require no less than one business day (Monday-Friday) to complete the referral. We're not able to issue a referral for a visit after the fact. Please be sure to familiarize yourself with your plan's requirements and exclusions as failure to adhere to their policy may cause a denial of your claim for payment for services rendered.

Missed Appointments (No-Shows) or Late Cancellations

Missed appointments and late cancellations are very disruptive to our office and deny another child the opportunity to be given an appointment for care at that time. A late cancellation is a cancellation received

less than 24 hours prior to the scheduled visit. There is a charge of $50.00 per child for any visit missed or cancelled in less than 24 hours.

Patients under the age of 18 must be accompanied by a parent or guardian. We will not treat a patient under the age of 18 who is either unaccompanied, or accompanied by someone who is not a parent or legal guardian.

Returned Checks:

A 25.00 returned check fee will be charged for any check returned to us for insufficient funds or incorrect bank information. Multiple returned checks will result in your being responsible for payment in cash at the time of service or your release from the practice.

Past Due accounts may be referred to a collection agency if reasonable payment arrangements are not made upon receipt of the first invoice from our practice. Any family whose account is forwarded to a collection agency may be dismissed from our practice. In that event, and if your insurance plan requires you to be assigned to a new PCP, a letter will be sent to your insurance carrier as well so they may assign you a new provider

Forms

We're happy to help you complete any forms required by your child's school, camp, or other entity. To cover the cost of review and completion of a form, a $10.00 form fee will be charged for each form we review, complete and/or sign.

Medical Records

Medical Records are the property of Sandy Springs Pediatrics and Adolescent Medicine, P.C. A copy of those records may be furnished upon written request in a timely manner, and no later than 30 days of the receipt of that written request. The request must include the following:

Patient(s) Name and Date(s) of Birth

Party to whom the records are to be sent including full street address

Your street address and phone number(s)

Signature of parent or guardian, if the patient is under 21 years of age. Patients must make their own request for records at age 21.

"I have read and understand the Office and Financial Policies of Sandy Springs Pediatrics and Adolescent Medicine as described above. I agree to the terms and conditions outlined in this document."

Name of Patient ______________________ Date of Birth__________

Name of Patient ______________________ Date of Birth__________

Name of Patient ______________________ Date of Birth__________

Name of Patient ______________________ Date of Birth__________

Printed Name of Parent/Guardian ______________________

Signature of Parent/Guardian ______________________

Date ______________

Sandy Springs Pediatrics and Adolescent Medicine, P.C.

Advanced Beneficiary Notice and Assignment of Benefits

"I ______________________________ The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my authorized representative, Sandy Springs Pediatrics and Adolescent Medicine, P.C.., the right to pursue payment for benefits, and take any and all necessary steps, including pursing administrative appeals and remedies, filing suit and all causes of action wholly in my stand for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider under the Plan, regardless of the Provider's managed care network participation status. The Patient hereby appoints the provider, Sandy Springs Pediatrics and Adolescent Medicine, P.C., /or its appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes Sandy Springs Pediatrics and Adolescent Medicine, P.C. to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize Sandy Springs Pediatrics and Adolescent Medicine, P.C. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator). I also hereby instruct my benefit plan (or its administrator) to pay Sandy Springs Pediatrics and Adolescent Medicine, P.C. directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and Sandy Springs Pediatrics and Adolescent Medicine, P.C. upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to Sandy Springs Pediatrics and Adolescent Medicine, P.C. I understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles. I understand, agree and hereby certify that I am obligated to pay, as charged and billed for global service charges, irrespective of whether the above services are covered under my health insurance or plan. I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by Sandy Springs Pediatrics and Adolescent Medicine, P.C. in the event that I can't afford to pay 100% of my deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount, once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigence discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to Sandy Springs Pediatrics and Adolescent Medicine, P.C., as full payment, as my authorized representative, and an ERISA or ACA claimant, to claim or legally pursue proper payment of benefits from my health insurance or plan.

I hereby irrevocably designate, authorize and appoint the Provider, Sandy Springs Pediatrics and Adolescent Medicine, P.C. its attorneys or other designated business associates as my true and lawful attorney-in-fact to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This power of attorney is hereby provided for the limited purpose of receiving all payments, rights and remedies due under my governing Health and Welfare Plan or policy to include all benefits entitled for all services rendered and/or ordered by my treating physician. This power of attorney will remain in effect until all benefits are paid in full compliance of applicable federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. This order will remain in effect until revoked by me in writing. I authorize Sandy Springs Pediatrics and Adolescent Medicine, P.C., its attorneys, or designated business associates to make any request, file and obtain appeals information, receive any notice in connection with my healthcare services, benefits, appeal, take legal action or other rights, wholly in my stead. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Sandy Springs Pediatrics and Adolescent Medicine, P.C., or its designated business associates any and all relevant Plan and claim documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from Sandy

Springs Pediatrics and Adolescent Medicine, P.C., its attorneys or designated business associates, in order to secure and claim such medical benefits. I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process.

I authorize my designated authorized representative to make any request; to present or to produce evidence; to file and obtain any claim, appeal or external review information; to receive any notice in connection with my claim, appeal or external review; wholly in my stead. I understand that I will be held financially responsible for all fees accumulated for collection agency fees, administrative fees, attorney fees and court costs incurred by Sandy Springs Pediatrics and Adolescent Medicine, P.C. for any delinquent account requiring outside collection assistance, to the fullest extent of the law. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it was the original. I understand that, by signing this form, I am confirming my appointment of my authorized representative, the scope of my authorized representative's authority, and the option of revoking of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT."

Patient's Name: ______________________________ Date of Birth ________________

Patient's Name: ______________________________ Date of Birth ________________

Patient's Name: ______________________________ Date of Birth ________________

Patient's Name: ______________________________ Date of Birth ________________

Printed Name of Patient/Guardian/Insured ____

Relationship to Patient(s) ____

Signature of Parent/Guardian/Insured ____

________________________ ____

Date Name of Insurance Carrier/ Employer Group