CHILDRENS CLINIC, LLC
DR. JAMIKA TRAWICK, DR. MALCOLM COLE, JR, SHANNON BOLES, PNP

DEAR PARENT/GUARDIAN,

THANK YOU FOR SCHEDULING AN APPOINTMENT WITH OUR OFFICE. IT IS OUR PLEASURE TO WELCOME YOU TO CHILDRENS CLINIC IN ADVANCE OF YOUR FIRST VISIT.

FOLLOWING IS SOME INFORMATION THAT WILL HELP FAMILIARIZE YOU WITH OUR PRACTICE:

CHILDRENS CLINIC, LLC
931 LOWER FAYETTEVILLE ROAD, SUITE I
PHONE: 770-253-0170
www.ChildrensClinicGA.com

PRACTICING PROVIDERS
Dr. Jamika W. Trawick
Dr. Malcolm H. Cole, Jr.
Shannon L. Boles, PNP

BUSINESS HOURS
Monday - Thursday 8:30am-5:00pm
Friday 8:30-Noon

OFFICE CONTACT
Patti Ferguson, manager

If you have any questions regarding the enclosed information, we will be happy to answer them for you prior to your visit by telephone at 770-253-0170. Also enclosed are a patient registration form and a privacy form to be completed prior to your scheduled visit. These forms may be faxed to 770-253-0206, emailed to patti.f@ccgakids.com, or you may bring them to your appointment.

Please bring the following information to your visit, if you have not already provided it to us prior to your scheduled visit:
Insurance card(s)
Photo identification
Medical history

We appreciate you selecting Childrens Clinic for your child's medical care and we will work hard to serve your needs.

Sincerely,

Childrens Clinic Staff

PAYMENT POLICIES

(Please initial all fields)

____Payments:
It is our payment policy to collect the appropriate payment due from the patient at the time service is rendered. This may only be your copayment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit. We accept Visa, MasterCard, and Discover.

____No-Shows: A no-show is defined as missing a scheduled appointment without calling us in advance to cancel or reschedule the appointment. The first incident you will not be charged. However, any subsequent incidence will result in a fee of $50. Please be mindful, after a consecutive no-show status, Childrens Clinic has the right to terminate your child from the practice.

____Claims: We submit all claims/charges to your insurance company and strive to assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be mindful that all charges are ultimately your responsibility regardless if they are covered by your insurance or not.

____Well Visits: Well visits are typically covered 100% by most insurance companies. However, all services recommended by the American Academy of Pediatrics may not be covered for your child's well visit. This includes but is not limited to hearing screens, vision screens, and routine labs. Please note if your insurance doesn't cover these services, you will be required to make payment within 30 days of receiving your bill. Additionally, if concerns are addressed outside of your child's Well visit, you may incur a copay, depending on your insurance plan.

____Sick and Other Visits: Insurance companies typically only classify visits as preventative (well) or office (sick/other/follow-up). These are the only 2 types of basic visits in our office. Please note that follow-ups are deemed as office visits. Your physician may recommend a follow-up based on your child's medical condition, including after an asthma attack, weight checks, lab follow-ups, etc. All copays and other requirements for an office visit, per your contract with your insurance company, will apply.

____Newborn Period: The Bright Futures guidelines, which have been endorsed by the American Academy of Pediatrics, recommends that newborns have 2 well visits within the 1st month of life. This occurs within 2-3 days of discharge from the hospital and within 2-3 weeks of the initial visit. However,

you may be required to return to the office for weight checks and follow-ups on any concerns. These visits will be deemed office visits (non-well visits) or sick/other visits on our schedule. Please be mindful these visits will require any copay or associated fees with an office visit, per your contract with your insurance company. You must pay these fees in full at the time of your visit. Additionally, it is very important that you call your insurance company to have your newborn placed on your insurance ASAP. Please call the office with the updated insurance information as soon as it is received.

____Self-Pay: All self-pay patients are expected to pay in full at the time services are rendered. We will be happy to provide an estimate of cost. However, please keep in mind this is only an estimate and may change depending on services rendered.

____After Hours: Please contact the nurse line with your insurance company. The phone number can be found on the back of your insurance card. If this is not available, you may contact our answering service at 678-633-6207. We also recommend Kidstime Pediatrics after hours clinic, 678-477-6904.

(Terminology)
Copayment/Copay: This is the cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company that is your responsibility to pay at each visit. Common copays are $10 - $40 per visit, but please be aware that these rates vary with each insurance company.
Deductible: This is the amount of cost sharing that you must pay for medical services, often before your health insurance company starts to pay.
Co-insurance: The part of your bill, in addition to your copay, that you must pay. Co-insurance is usually a percentage of the total medical bill, for example 20%.

We greatly appreciate your adherence to these payment policies. We will work hard to serve your needs.

Thank You!

Childrens Clinic Staff

Patient Name:_____

Parent/Guardian's Name:_____

Parent/Guardian's Signature:_____Date_____

PATIENT REGISTRATION

PATIENT LAST NAME_____
PATIENT FIRST NAME_____
PATIENT MIDDLE_____

PATIENT DATE OF BIRTH: _____/_____/_____ SEX: _____
ETHNICITY: HISPANIC/NON-HISPANIC/UNKNOWN RACE: ASIAN/BLACK/HAWAIIAN/WHITE

MAILING ADDRESS:
STREET/PO BOX: _____
CITY: _____
STATE & ZIP: _____

HOME PHONE: (_____)-_____-_____
CELL PHONE: (_____)-_____-_____

WHO LIVES AT THIS HOUSEHOLD? _____

<u>INSURANCE</u>
PRIMARY POLICY:
POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH _____/_____/_____
POLICY HOLDER'S SEX: MALE / FEMALE
INSURANCE CARRIER: _____
ID# _____GROUP #_____

SECONDARY POLICY:
POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH _____/_____/_____
POLICY HOLDER'S SEX: MALE / FEMALE
INSURANCE CARRIER: _____
ID# _____GROUP #_____

MOTHER'S MAIDEN NAME: _____

CONTACT (PRIMARY)

NAME: _____

RELATION TO PATIENT: _____
LIVES WITH PATIENT: YES / NO CONTACT'S DATE OF BIRTH: _____/_____/_____
WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____
EMAIL: _____
EMPLOYER: _____OCCUPATION: _____

CONTACT #2

NAME: _____

RELATION TO PATIENT: _____
LIVES WITH PATIENT: YES / NO CONTACT'S DATE OF BIRTH: _____/_____/_____
WORK PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____
EMAIL: _____
EMPLOYER: _____OCCUPATION: _____

PLEASE LIST ANY RESTRICTIONS IN WHO CAN OBTAIN PATIENT INFORMATION:

_____

_____

_____

PATIENT MEDICAL HISTORY (please complete a separate form for each child):

PATIENT'S NAME: _____

MEDICATIONS: List all medications and strengths your child is currently taking:

_____
_____
_____
_____

ALLERGIES:
Drug Allergies: List all allergies and reactions

_____

MEDICAL PROBLEMS/HISTORY (check and list date of diagnosis)
Allergic Rhinitis_____ Asthma_____ Urticaria_____
Food Intolerance_____ Chronic dry skin_____ Eczema_____
Other: _____

NEWBORN PERIOD:
Vaginal delivery_____ C-section_____ Difficult Delivery_____
Term_____ Premature_____ Birth weight_____
Heart or lung problems_____ Phototherapy_____ Jaundice_____
Feeding problems_____ Delayed discharge from nursery_____
Other: _____

FEEDING AND DIGESTION:
Breast fed_____ Bottle fed_____ Appetite Poor_____
Chronic vomiting_____ Chronic loose stools_____ Constipation issues_____
Other: _____

PATIENT MEDICAL HISTORY, CONTINUED:

INFECTIONS, DEVELOPMENT, MISCELLANEOUOS PROBLEMS:

Dental problems_____ Developmental delays_____ Eye problems_____
Frequent sore throats_____ Frequent ear infections_____ Hearing loss_____
Heart problems_____ Elevated blood pressure_____ Seizures_____
Pneumonia_____ Pica(eating dirt,plants,etc.)_____ Orthopedic problems_____
Kidney/bladder infections_____ Bed wetting_____
Other: _____

SURGICAL PROCEDURES AND HOSPITALIZATIONS:

Tonsillectomy_____ Adenoidectomy_____ Ear tubes_____
Other surgical procedures _____
Serious injuries (concussions, broken bones, etc.) _____
Hospitalizations: _____

PSYCHOLOGICAL PROBLEMS:

Antisocial behavior_____ ADHD issues_____ Drug use/abuse_____
Discipline problems_____ Breath holding_____ School adjustment problems_____
Peer relationship problems_____ Tics/nervous habits_____ Learning Disability_____
Mental retardation_____ Nightmares_____ Temper tantrums_____
Speech problems_____ Anxiety_____ Poor school performance_____
Other: _____

FAMILY HISTORY:

PATENT'S NAME _____

Please indicate if the following illnesses have occurred in the patient's <u>mother, father, siblings, or grandparents</u>. Please indicate age at diagnosis (if known) and relation to patient.

CARDIOVASCULAR	**Relation/Age**	**PULMONARY**	**Relation/Age**	**HEMATOLOGY/ ONCOLOGY**	**Relation/Age**
Angina		Asthma		Anemia	
Heart Attack(age)		Chronic Bronchitis		Leukemia	
High Blood Pressure		Tuberculosis		Bleeding Disorder	
Congenital Heart Disease		Cystic Fibrosis		Cancer	
Irregular Heart Beat		COPD			
GASTROENTEROLOGY		**NEUROLOGICAL**		**BEHAVIORAL**	
Ulcers		Seizures		Autism	
Irritable bowel syndrome		CVA (stroke)		Developmental Delay	
Crohn's Disease		Chronic Headaches		Intellectual Disability	
Enuresis		Migraines		Learning Disability	
Kidney Failure					
Kidney Stones					
PSYCHIATRIC		**DERMATOLOGY**		**ENDOCRINE/ IMMUNOLOGY**	
Depression		Skin cancer		Diabetes	
Schizophrenia		Eczema		Thyroid Disorder	
Substance Abuse/Addiction		Psoriasis		Lupus	
		Severe Acne		Rheumatoid Arthritis	
		Seborrheic Derm		Immune Deficiency	
AUDITORY/VISUAL		**OTHER:**		**OTHER:**	
DEAFNESS					
BLINDNESS					

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(MEDICAL RECORDS ARE NOT ACCEPTED BY FAX. PLEASE MAIL TO ADDRESS LISTED BELOW)

PREVIOUS PEDIATRICIAN:

NAME _____

ADDRESS _____

_____

PHONE/FAX NUMBER (_____)_____-_____

RELEASE TO: CHILDRENS CLINIC, LLC
931 LOWER FAYETTEVILLE ROAD, SUITE J
NEWNAN, GA. 30263

PATIENT NAME: _____
DATE OF BIRTH: _____/_____/_____

PARENT/GUARIDAN NAME: _____
PARENT/GUARDIAN SIGNATURE:_____
DATE: _____

INFORMATON TO BE RELEASED: (CHECK ALL APPLICABLE)
___ALL INFORMATION ___ALL PROGRESS NOTES ___LAB REPORTS ___X-RAY REPORTS
___EKG ___ALLERGY RECORDS ___IMMUNIZATION RECORDS ___OTHER

SPECIAL AUTHORIZATION: (CHECK ALL THAT ARE APPLICABLE AND SIGN BELOW)
BY SIGNING BELOW, YOU ARE AUTHORIZING THE OFFICE TO RELEASE ANY AND ALL INFORMATION REGARDING:
___ ALCOHOL ___DRUGS ___MENTAL HEALTH ___ HIV ___AIDS
___SEXUALLY TRANSMITTED DISEASES
SIGNATURE: _____DATE_____

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. The requestor may be provided with a copy of this authorization.

CONSENT FOR TREATMENT OF MINOR CHILD

PATIENT FOR WHOM CONSENT IS GIVEN:

_____

PATIENT'S FULL LEGAL NAME **PATIENT'S DATE OF BIRTH**

As the parent of the minor child listed above, I hereby consent to any radiology or lab testing, medical or surgical treatment, or other medical service rendered to my minor child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Childrens Clinic, LLC.

My consent is given in advance of a specific medical diagnosis or treatment that may be required, and is given to encourage each physician as well as any assistant, designee, or employee of Childrens Clinic, LLC to exercise his/her best judgment in ordering tests or treatment appropriate to the child's medical needs.

This consent is effective on the date below and will be updated if the medical history or information of the child or parent change.

EMERGENCY CONTACTS, other than parents: Name & Relationship
1: _____phone (_____)_____-_____

2: _____phone (_____)_____-_____

PERSONS AGE 18 OR OVER AUTHORIZED TO BRING YOUR CHILD TO PHYSICIAN:
1: _____RELATIONSHIP TO PATIENT_____
PHONE (_____)_____-_____

2: _____RELATONSHIP TO PATIENT_____
PHONE (_____)_____-_____

_____ _____
SIGNATURE OF PARENT DATE

PHARMACY INFORMATON

_____ _____
PHARMACY PHARMACY PHONE NUMBER/LOCATION