Michelle Zeanah MD FAAP
Helping children reach their potential

OFFICE POLICIES

Services Provided

- Care is only provided for behavioral and developmental pediatric problems.
- This office does not provide well child check-ups, vaccines, sports physicals, etc.
- We do not diagnose or treat contagious illnesses or infectious diseases. If your child has a fever, please call to see if your child should be rescheduled.
- Your child needs to have a medical home for primary care.
- Michelle Zeanah MD PC is happy to work with your existing medical home.
- If you or your child has special needs, please notify us so that we can try to accommodate your family.

Office Hours

- Michelle Zeanah MD PC is normally open from 9am to 5pm Wednesdays, Thursdays and Fridays.
- This office is not a primary care office and is closed several days each week to allow its physician and staff opportunities to serve in our community.

Appointment Policy

- All appointments are scheduled.
- Please be on time. If you are late, you may be considered a "no show" or your child's appointment will be shortened.
- Please provide at least 1 business day if you cannot keep your child's appointment.
- Two "no-shows" within 12 months (per family) or a new patient "no show" is grounds for dismissal from the practice.
- Patients receiving a new Schedule II prescription will be scheduled for follow up in 30 days or less.
- Patients receiving Schedule II medications must be seen every 90 days even if they are stable.

Initial _____

Prescriptions

- All prescriptions will be sent electronically to your pharmacy with the help of a pharmacy benefits manager. If your current pharmacy does not fully participate in electronic prescribing, you will need to choose a different pharmacy.
- Prescriptions will be ready 2 office days after we receive your request. We will only notify you if there is a problem with your request. We strongly encourage all patients to utilize our patient portal for all refill requests. This reduces errors and speeds up the process.
- Any patient who receives a refill of medication being managed by Dr. Zeanah from another office may be discharged from this practice. Doctor shopping will not be tolerated.
- I understand that all ADHD prescriptions should either be written by Dr. Zeanah or by my child's PCP but only one provider should write these prescriptions.

Initial _____

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Insurance Policy

- Please remember that your insurance coverage is a contract between you and your insurance company, not between you and this practice. We make every effort to work with you and your insurance company, however, if there is a dispute over what your insurance company paid and what they said is your responsibility, please contact your insurance company before calling us.
- Your insurance contract requires us to collect specific amounts. It is a contract violation for us to waive copayments, coinsurance, deductibles etc.
- Due to administrative expense, we do not file secondary insurance unless the patient has Medicaid, Amerigroup, Wellcare or Peach State. We will provide you with a detailed statement so that you can file secondary insurance yourself.
- If you are covered under a state funded program (Amerigroup, Wellcare, Medicaid or Peach State) you are required to report if you have additional primary insurance. Failure to do so is insurance fraud. These state funded programs can require the patient to pay back money for the paid claims in error. Please let us know if you have primary commercial insurance at check in.

Financial Policy

- All amounts deemed patient responsibility are due at time of service. You should come prepared to pay these at check in or check out on the day services are rendered. These include but are not limited to copay, co-insurance, deductible, self-pay visits, forms fees, balances, etc.
- Nonpayment will result in your account being turned over to an outside collection agency. You will incur an additional collection fee of 25% added to your bill.
- For patients whose accounts have been turned over to outside collections-we will be happy to see your child as soon as the account balance is paid in full.
- Any account with a returned check will incur a $35 NSF fee from our practice and you will no longer be able to use a check as a form of payment in our office.
- Forms take up to 1 week to complete. There is a $15 charge to complete time-consuming forms outside of an office visit. Please notify staff in advance if your visit may require extra time to complete forms so that we can schedule you appropriately.

Expectations for Behavior of Patients and Families

- You are responsible for your child's behavior in this office. You are also responsible for the behavior of any guests you bring here.
- Children should not be left unattended in the waiting room, exam room or parking lot.
- You are responsible for cleaning up any mess made by your child or guest. This includes food, drink, etc. Please ask for a dust pan and broom to clean up any dropped cheerios or other food crumbs.
- Being rude to or threatening staff is grounds for dismissal from the practice.
- Be courteous. Please do not use your cell phone while interacting with staff.

Professionalism Policy

- Our staff strives to be courteous at all times. If you feel you have received poor customer service, please notify us.
- If you have a suggestion of how we can improve, please tell us.

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Phone Call Policy

- Please use our patient portal for any nonemergency task or question, especially refill requests.
- Our answering service is not able to refill medications.
- Please do not call us regarding forms, billing, etc. outside of office hours.
- Phone calls that provide care for a new problem or a flare up of an old problem and help you avoid an office or ER visit may incur a charge. Some private insurance plans may require a co-pay.
- Staff will try at least three times to return your call. Staff will attempt to return all calls before leaving for the day.

Alternate Caregiver Policy

- In consideration of working parents, Michelle Zeanah MD PC allows alternate caregivers to bring established patients to follow up appointments. For example, an aunt could bring a patient while a mother is at work.
- Alternate caregivers will be responsible for any balance due such as co-pays, co-insurance and deductible, if applicable, if they bring the patient. Parents/guardians should make arrangements in advance and inform the alternate caregiver that payment will be collected at the time service.

I give permission to the following individuals to bring my child and make medical decisions on my behalf and/or in my absence.

Alternate caregiver _____ Relationship to patient _____

Alternate caregiver _____ Relationship to patient _____

I have read the office policies of Michelle Zeanah MD PC and agree to follow them.
I authorize the physicians of this practice and/or their assistants to provide medical care for my child. I authorize payment of medical benefits directly to the providers of Michelle Zeanah MD PC for services provided. I authorize the practice to release any information required to process my claims. I understand that it's my responsibility to pay all amounts due at the time of service & that I am financially responsible for all charges whether or not paid by said insurance.

I understand that they may be updated from time to time and that a current version is available at www.DoctorZeanah.com and on the patient portal at https://Valantmed.com/portal/MichelleZeanah.

Patient Name _____ Patient Birthday _____

Parent/Guardian _____ Date _____

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Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, this medical practice originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality of care.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice of privacy practices and prior to implementation will email a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

_____	_____	_____
Printed name (Parent)	Signature	Date

_____	_____
Printed name (Patient)	Date of Birth

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PLEASE FILL OUT FORM OR COMPLETE THE DEMOGRAPHICS SECTION IN THE PATIENT PORTAL

DATE /____/____

PATIENT INFORMATION:

Last Name: First: Middle:	Child lives with:
Preferred Name:	Sex (check one): ☐ Male ☐ Female
Date of Birth: Age:	Parents are (check one): ☐ Married ☐ Divorced ☐ Other
Address: City: State: Zip:	
Race: ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Other:	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Preferred Pharmacy with **city**:	Preferred Language:

GUARANTOR/PARENT INFORMATION (MOTHER):

Name:	DOB: / / SSN:
Employer:	Drivers Lic # and state:
Home Phone: ( )- - Cell Phone: ( )- - Work Phone: ( )- -	Email:

GUARANTOR/PARENT INFORMATION (FATHER):

Name:	DOB: / / SSN:
Employer:	Drivers Lic # and state:
Home Phone: ( )- - Cell Phone: ( )- - Work Phone: ( )- -	Email:

EMERGENCY CONTACT (OTHER THAN PARENT):

Name Phone #: Relationship to patient:	**At which number(s) may we leave a confidential message? (check all that apply)** Mom home: ( ) - Dad home: ( ) - Mom cell: ( ) - Dad cell: ( ) - Mom work: ( ) - Dad work: ( ) - Emergency Contact: ( ) -

CHILD'S PRIMARY INSURANCE:

Is this patient covered by additional insurance? ☐ Yes ☐ No **Check one:** ☐ Medicaid ☐ Amerigroup ☐ Wellcare ☐ Peach State **Member ID #:**_____ ****Currently we ONLY file with Medicaid, Amerigroup, Wellcare and Peach State as secondary insurance.****	Insurance Company Policy/Member ID: Group #: Policy Holders Name: _____ DOB:_____

THE INFORMATION ON THIS SHEET IS TRUE & CORRECT

I authorize the physicians of this practice and/or their assistants to provide medical care for my child. I authorize payment of medical benefits directly to the providers of Michelle Zeanah MD PC for services provided. I authorize the practice to release any information required to process my claims. I understand that it's my responsibility to pay all amounts due at the time of service & that I am financially responsible for all charges whether or not paid by said insurance.

⇨ SIGNATURE:_____ PRINTED NAME:_____ DATE:_____

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Access to Healthcare Information

Who can access my child's healthcare information? _____

_____

The above listed individuals can:

☐ Speak with the clinical staff over the phone

☐ Speak with nonclinical staff over the phone

☐ Bring my child to appointments

☐ Retrieve lab or testing results via phone or in person

Michelle Zeanah MD PC sometimes works directly with schools to assist patients. Is the office is permitted to share my child's healthcare information with my child's school? ☐ Yes ☐ No

Please check what the office can provide: ☐ A Diagnosis list ☐ A Treatment plan

☐ Recommendations for accommodations at school ☐ Date of next appointment

Please check who the Physician or her assistant can speak to: ☐ Teachers ☐ Guidance counsellor

☐ Parent liaison for the school system ☐ School administrators

Patient name _____ DOB_____

Parent/Guardian Signature _____ Date _____

Name _____ Relationship _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

I request and authorize

_____

_____

_____

to release healthcare information of the patients named above to:

Michelle Zeanah MD PC

EHR direct messaging: Zeanah.valantdirect.com ***preferred***

Via CD to 406 Savannah Ave. Statesboro, GA 30458

Fax to 912-681-4379

This request and authorization applies to:

◉ Healthcare information relating to the following treatment, condition, or dates

First mental health/behavioral/developmental office visit, growth chart (with BMI), psychological testing results, last 3 office visits and _____

○ All healthcare information ○ Other

_____

Please send before patient's appointment on _____. Thank you!

Parent/Guardian Signature: _____ Date : _____