BEHAVIORAL PEDIATRICS of Rural Georgia

IMPORTANT INSTRUCTIONS

- Please fill out ALL questions completely
- Please print clearly
- Send copy of front and back of insurance and copy of Driver's License

PATIENT INFORMATION

FULL NAME_____

PREFERRED NAME_____ DATE OF BIRTH_____ AGE_____

MALE_____ FEMALE_____ CHILD LIVES WITH _____

HOME ADDRESS_____

MAILING ADDRESS_____

COUNTY_____ PHONE NUMBER_____

PRIMARY CARE PHYSICIAN/CITY _____

PREFERRED PHARMACY AND CITY_____

PERSON RESPONSIBLE FOR PAYMENT / GUARDIAN #1 INFORMATION

FULL NAME_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT_____ PLACE OF EMPLOYMENT_____

HOME ADDRESS_____

MAILING ADDRESS_____

PHONE NUMBERS: MOBILE_____ OTHER_____

EMAIL ADDRESS_____

GUARDIAN #2 INFORMATION

FULL NAME_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT_____ PLACE OF EMPLOYMENT_____

HOME ADDRESS_____

MAILING ADDRESS_____

PHONE NUMBERS: MOBILE_____ OTHER_____

EMAIL ADDRESS_____

EMERGENCY CONTACT INFORMATION (Other than Guardian(s) listed above)

FULL NAME_____

PHONE NUMBER: MOBILE_____OTHER_____

RELATIONSHIP TO PATIENT_____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY_____MEMBER ID #_____

GROUP #_____EFFECTIVE DATE_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE? IF YES, PLEASE FILL OUT BELOW:

SECONDARY INSURANCE COMPANY_____MEMBER ID #_____

VERY IMPORTANT: PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD(S) AND DRIVERS LICENSE OF GUARDIAN(S)

VIRTUAL VISITS AND MESSAGES

WHICH MOBILE PHONE NUMBER OR EMAIL ADDRESS WOULD YOU LIKE US TO SEND THE VIRTUAL APPOINTMENT LINK? (LIST ONLY ONE)_____

MAY WE LEAVE A CONFIDENTIAL MESSAGE? CHECK ALL THAT APPLY

GUARDIAN #1 HOME ____ CELL ____ WORK _____

GUARDIAN #2 HOME ____ CELL ____ WORK _____

COMPLETE BELOW ONLY IF PATIENT IS A FOSTER CHILD

IS PATIENT A FOSTER CHILD?_____COUNTY PATIENT IS FROM_____

CASE MANAGER'S NAME_____

CASE MANAGER'S PHONE NUMBER_____

CASE MANAGER'S EMAIL ADDRESS_____

EMAIL COMPLETED FORMS TO taylor@doctorzeanah.com

OR

FAX COMPLETED FORMS TO 912-681-4379

REMEMBER TO INCLUDE COPIES OF INSURANCE CARD(S) AND DRIVER'S LICENSE(S)

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PEDIATRICS
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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that as part of my child's healthcare, 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 child's care and treatment
- A means of communication among the many health professionals who contribute to my child's care
- A source of information for applying my child's treatment information to my bill
- A means by which a third-party payer can verify that services billed were 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 have 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 acted in reliance thereon.

Printed name (Parent) _____ Signature _____ Date _____

Printed name (Patient) _____ Date of Birth _____

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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.
- Behavioral Pediatrics of Rural Georgia 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

- Behavioral Pediatrics of Rural Georgia is open 8:30am to 5pm Tuesday - Friday.
- This office is not a primary care office and is closed on Monday 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 business 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 mental health prescriptions should either be written by Dr. Zeanah or by my child's PCP but only one provider should write these prescriptions.

Initial _____

BEHAVIORAL PEDIATRICS of Rural Georgia

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.
- If you are covered under a state funded program (Amerigroup, Care Source, WellCare, or Medicaid) 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.

Initial _____

Financial Policy

- All amounts deemed patient responsibility are due at time of service. You should be prepared to pay these before your visit begins on the day services are rendered. These include but are not limited to copay, co-insurance, deductible, self-pay visits, 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.
- Time-consuming forms will only be completed as part of an office visit. Please provide us the form in advance if your visit so that we can assist you appropriately.

Initial _____

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.
- Being rude or threatening staff is grounds for dismissal from the practice.
- Be courteous. Please do not use your cell phone while interacting with staff.

Initial _____

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 non-emergency tasks or questions, especially refill requests.
- Our answering service is not able to refill medications.
- Phone calls with our providers much be scheduled and are considered an office visit.
- Staff will try at least three times to return your call. Staff will attempt to return all calls before leaving for the day.

Initial _____

Alternate Caregiver Policy

- In consideration of working parents, Behavioral Pediatrics of Rural Georgia 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 plan in advance and inform the alternate caregiver that payment will be collected at the time service.

Initial _____

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 Behavioral Pediatrics of Rural Georgia 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 Behavioral Pediatrics of Rural Georgia for services provided. I authorize the practice to release any information required to process my claims. I understand that it is my responsibility to pay all amounts due at the time of service and 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's Date of Birth: _____

Parent/Guardian: _____ Date: _____

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ACCESS TO HEALTHCARE INFORMATION

The name(s) listed below can access my child's healthcare information.

_____ _____ _____

The above listed individuals can:

- ☐ Speak with clinical staff over the phone
- ☐ Speak with non-clinical staff over the phone
- ☐ Bring my child to appointments
- ☐ Retrieve lab or testing results via phone or in person

Behavioral Pediatrics of Rural Georgia sometimes works directly with schools to assist patients.

Is this office permitted to share my child's healthcare information with your child's school?

- ☐ Yes
- ☐ No

School name/city:_____

The office can provide:

- ☐ Diagnosis List
- ☐ Treatment Plan
- ☐ Recommendations for accommodations at school
- ☐ Date of Next appointment

Please check who the physician or office staff can speak with:

- ☐ Teachers
- ☐ Guidance Counselors
- ☐ School Administrators
- ☐ Special Education Professionals
- ☐ School Psychologists

Patient Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name:_____ Relationship: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:_____

I request and authorize _____ to release healthcare and educational information of the patients named above to:

Michelle Zeanah, MD at Behavioral Pediatrics of Rural Georgia

EHR direct messaging: Zeanah.valantdirect.com

Via CD: 406 Savannah Ave., Statesboro, GA 30458

FAX: 912-681-4379

This request and authorization apply to:

- ☐ Healthcare information relating to the following treatment, condition or dates listed below.

  _____

- ☐ First mental health/behavioral/developmental office visit, growth chart (with BMI), psychological testing results, last 3 office visits and any recent lab results.
- ☐ All healthcare information
- ☐ Other

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

Parent/Guardian Signature: _____ Date: _____

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Telehealth Informed Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telehealth care provided by Behavioral Pediatrics of Rural Georgia.
2. NATURE OF TELEHEALTH CONSULT: During the telehealth care:
   a. Details of your medical history, examinations and test will be discussed with you or other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)
3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth care. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth care, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth care.
5. RIGHTS: You may withhold or withdraw consent to the telehealth care at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telehealth care will be resolved in Georgia, and that Georgia law shall apply to all disputes.
7. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth care. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation/care for the procedure(s) described above.
I understand that the patient must be in the State of Georgia during Telehealth Services.

Signature: _____

Today's Date: _____ Time: _____

Relationship to Patient: (mom, guardian, etc.) _____

Client Gmail address: _____

Witness Signature: _____ Date: _____