BEHAVIORAL PEDIATRICS of Rural Georgia

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IMPORTANT INSTRUCTIONS

- Please fill out **ALL** questions completely
- Please print clearly.
- Send copy of front and back of insurance

PATIENT INFORMATION

FULL NAME_____

PREFERRED NAME_____ DATE OF BIRTH_____ AGE_____

M_____ F_____ Other_____ CHILD LIVES WITH _____

RACE_____ ETHNICITY_____

HOME ADDRESS_____

MAILING ADDRESS_____

COUNTY_____ PHONE NUMBER_____

PRIMARY CARE PHYSICIAN _____ SPECIALIST_____

PREFERRED PHARMACY AND CITY_____

GUARDIAN #1 INFORMATION

FULL NAME_____ M_____ F_____ Other_____

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_____ M_____ F_____ Other_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT_____ PLACE OF EMPLOYMENT_____

HOME ADDRESS_____

MAILING ADDRESS_____

PHONE NUMBERS: MOBILE_____ OTHER_____

EMAIL ADDRESS_____

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

FULL NAME_____

PHONE NUMBER: MOBILE_____OTHER_____

RELATIONSHIP TO PATIENT_____

PATIENT'S INSURANCE INFORMATION

IF THE PATIENT HAS PRIMARY INSURANCE AND SECONDARY INSURANCE, PLEASE PUT BOTH INSURANCES.

IF YOU ONLY PROVIDE PRIMARY INSURANCE, YOU WILL BE RESPONSIBLE FOR ANY REMAINING BALANCE.

PRIMARY INSURANCE COMPANY_____MEMBER ID #_____

GROUP #_____EFFECTIVE DATE_____

SECONDARY INSURANCE COMPNAY_____MEMBER ID#_____

GROUP#_____

MANDATORY: PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD(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 IF PATIENT IS A FOSTER CHILD

IS PATIENT A FOSTER CHILD? _____WHAT COUNTY IS CHILD FROM_____

CASE MANAGER'S NAME_____

CASE MANAGER'S PHONE NUMBER_____

CASE MANAGER'S EMAIL ADDRESS_____

EMAIL COMPLETED FORMS TO Intake@doctorzeanah.com

OR FAX COMPLETED FORMS TO 912-681-4379

REMEMBER TO INCLUDE COPIES OF THE INSURANCE CARD's AND GUARDIAN'S LICENSE.

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Privacy Practices/HIPAA Disclosure

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition.
- Provide disaster relief.
- Provide mental health care.

Our Uses and Disclosures

We may use and share your information as we:

- Treat you.
- Run our organization.
- Bill for your services
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Address law enforcement and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information.

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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Acknowledgement of Receipt of HIPPA Disclosure

I, _____ have read Behavioral Pediatrics of Rural Georgia's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

*You may refuse to sign this acknowledgement.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ Other (Please specify)

_____

_____

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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 Monday - Friday.

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 24 hours' notice 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.
- Doctor shopping will not be tolerated. Any patient receiving prescriptions at Behavioral Pediatrics of Rural Georgia, is managed by our team. Medications being received from other physician offices will be discharged from this practice.
- I understand that all mental health prescriptions should either be written by Behavioral Pediatrics of Rural Georgia or by my child's PCP but only one office 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 office. 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, 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 co-pay, 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 with the form in advance for 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 too always be courteous. 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 must be scheduled and are considered an office visit.
- Staff will try at least two 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 and inform the alternate caregiver that payment will be collected at the time of 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 healthcare providers of this practice and/or their designees 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 not covered by insurance.

I understand that office policies may be updated from time to time and that a current version is available at www.DoctorZeanah.com or on the Athena Patient portal https://27415.portal.athenahealth.com/.

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 Counselor
- ☐ School Administrators
- ☐ Special Education Professionals
- ☐ School Psychologists
- ☐ School Nurses

Patient Name: _____ Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

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RELEASE OF MEDICAL RECORDS

Date: _____

This Authorization expires: _____
(If no date is inserted, it expires one year after signed)

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone number: _____

I hereby authorize Behavioral Pediatrics of Rural Georgia to

Obtain records from:

_____

Name of physician or organization

_____

City State

_____

Phone

Release records to:

_____

Name of physician or organization

_____

City State

_____

Phone

Please check one of the following:

- ☐ Healthcare information relating to the following treatment, condition or dates is listed below.
- ☐ First mental health/behavioral/developmental office visit, psychological testing results, last 3 office visits and any recent lab results.
- ☐ All healthcare information
- ☐ Other; please specify_____

- I authorize the use/ and or release of my child's protected health information as described above.
- I understand that there may be medical records from another doctor or facility in my chart.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, expect to the extent that action has been taken in reliance on this authorization.
- I understand that if the person or the entity that receives the information is not covered by the federal privacy regulations, the information described above may no longer be protected by those regulations.

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 using 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 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.
8. REQUEST: If you need to request a trial of how videochat works, please contact our front office several days prior to your scheduled appointment.
9. IMPORTANT: The patient cannot be in a moving vehicle during videochat.

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 email address: _____

Witness Signature: _____ Date: _____

MCHAT

Child's Name: _____ Date of Birth: _____

Name of Person Completing Form: _____ Relationship to Child: _____

Date Form Completed: _____

Please fill out the following about your child's usual behavior. Answer every question by choosing YES or NO. If the behavior is rare (you've only seen it once or twice), please answer as if your child does not do it.

1	Does your child enjoy being swung, bounced on your knee, ect.?	YES	NO
2	Does your child take an interest in other children?	YES	NO
3	Does your child like climbing on things, such as stairs?	YES	NO
4	Does your child enjoy playing peek-a-boo or hide-and-seek?	YES	NO
5	Does your child ever pretend, for example, to talk on the phone or take care of doll or pretend other things?	YES	NO
6	Does your child ever use his/her index finger to point, to ask for something?	YES	NO
7	Does your child ever use his/her index finger to point, to indicate interest in something?	YES	NO
8	Can your child play properly with small toys (e.g., cars or blocks) without just mouthing, fiddling, or dropping them?	YES	NO
9	Does your child ever bring objects over to you (parent/guardian) to show you something?	YES	NO
10	Does your child look you in the eye for more than a second or two?	YES	NO
11	Does your child ever seem oversensitive to noise? (e.g. plugging ears)	YES	NO
12	Does your child smile in response to your face or your smile?	YES	NO
13	Does your child imitate you? (e.g., you make a face – will your child imitate you?)	YES	NO
14	Does your child respond to his/her name when you call?	YES	NO
15	If your point at a toy across the room, does your child look at it?	YES	NO
16	Does your child walk?	YES	NO
17	Does your child look at things you are looking at?	YES	NO
18	Does your child make unusual finger movements near his/her face?	YES	NO
19	Does your child try to attract your attention to his/her own activity?	YES	NO
20	Have you ever wondered if your child is deaf?	YES	NO
21	Does your child understand what people say?	YES	NO
22	Does your child sometimes stare at nothing or wander with no purpose?	YES	NO
23	Does your child look at your face to check your reaction when faced with something familiar?	YES	NO