11050 Crabapple Road
Suite 120
Roswell, GA 30075
(770) 518-9277
(770) 518-8718 fax

1111 Alderman Drive
Suite 250
Alpharetta, GA 30005
(678) 527-1555
(678) 527-1559 fax

Pediatric Physicians, PC

18+ Registration

PPPC Account #_________________________

Your full name: ________________________________ Male: __________ Female: _________

Birth Date: ________________ Name you like to be called: ________________________

Address: ____

City: ____________________ State:______________ Zip Code: ______________

Home phone number:________________ Cell phone number:________________ Are you a student? ________________

Do you live with your parents? ______________ If not, who?________________ Relationship ________________

Father's full name: ________________ DOB ________________ Phone # ________________

Mother's full name: ________________ DOB ________________ Phone # ________________

Emergency contact: ________________ Phone number: ________________ Relationship: ________________

Billing Information:

Who is responsible for your medical bills? Self _____Mother ______Father ________ other: ________________ (List Full Name)

Insurance Information: Who is the policy holder for the insurance? ________________ Date of birth:________________

Please provide address of person responsible for medical bills if different from your address:

Address: ____

City: ____________________ State:______________ Zip Code: ______________

Access to my Protected Health Information (PHI):

As a patient 18 years or older, I have been made aware of my rights to privacy and I authorize the following to have access to my medical information:

____

(Name must be written completely. Writing “mom” or “dad” is not sufficient.)

PIN : _____________ Please choose a PIN, usually four digits or letters long. We will only discuss protected health information with individuals who have your PIN code. If patient allows parents access to health information, they may continue to use the same PIN code. Otherwise, patients past their 18th birthday must choose their own PIN code.

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
- IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.
- If this account is assigned for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
- I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **Pediatric Physicians, PC.**
- This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
- I have been given the opportunity to review the Notice of Privacy Practices for **Pediatric Physicians, PC**.

SIGNED ____ DATE ________________________

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