1527 Vernon Road
LaGrange, GA 30240

LAGRANGE PEDIATRICS

Suzie Schuessler, M.D., FAAP
www.lagrangepediatrics.net

Tel: (706) 883-6363
Fax: (706) 884-5588

DATE: _____

PATIENT'S INFORMATION

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET CITY STATE ZIP

SOC.SEC. NO: _____ **MALE** ☐ **FEMALE** ☐ **RACE:** _____

PHONE#: _____ **DATE OF BIRTH:** _____

RESPONSIBLE PARTY'S INFORMATION

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET CITY STATE ZIP

SOC.SEC. NO: _____ **DATE OF BIRTH:** _____

HOME PHONE #: _____ **WORK PHONE #:** _____

EMPLOYER: _____ **EMPLOYER ADDRESS** _____

MOTHER'S INFORMATION

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET CITY STATE ZIP

SOC.SEC. NO: _____ **PHONE HOME #:** _____ **PHONE WORK #** _____

DATE OF BIRTH: _____

FATHER'S INFORMATION

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET CITY STATE ZIP

SOC.SEC. NO: _____ **PHONE HOME #:** _____ **PHONE WORK #** _____

DATE OF BIRTH: _____

EMERGENCY CONTACT'S INFORMATION

NAME: _____
FIRST MIDDLE LAST

ADDRESS: _____
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT: _____ **PHONE HOME #:** _____ **PHONE WORK #** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **GROUP NO:** _____

POLICY HOLDER NAME: _____ **CONTRACT #:** _____

SOC SEC NO: _____ **PLAN NO:** _____

SECONDARY INSURANCE: _____ **GROUP NO:** _____

POLICY HOLDER NAME: _____ **CONTRACT #:** _____

SOC SEC NO: _____ **PLAN NO:** _____

PHARMACY: _____

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PLEASE READ THE FOLLOWING

The patient or the patient's "responsible party" is herby responsible for all charges regardless of insurance coverage. If for any reason the insurance company denies the claim or makes only a partial payment, then the patient or the patient's "responsible party" is responsible for any remaining balance. The patient or patient's "responsible party" is also responsible for any co-payments or deductibles at the time of service unless other arrangements have been made. If there is a remaining balance after 90 days from the date of service, the unpaid balance(s) becomes the responsibility of the patient or the patient's "responsible party". It will no longer be the sole responsibility of the office of LaGrange Pediatrics to communicate with your insurance after the 90 day period to collect a remaining balance.

The patient or the patient's "responsible party" understands that if a check written to this office is returned for any reason, the name on the account will be charged a $36.00 (subject to change) returned check fee. If the check is not picked up within a reasonable time, possible legal action will be taken. The patient or "responsible party" is also responsible for any other bank charges (i.e. stop payment fees, etc.).

I hereby authorize the office of LaGrange Pediatrics to file claims with Medicaid or my insurance company for services rendered. I request that payments be assigned to LaGrange Pediatrics/ Suzanne W. Schuessler, M.D.

I certify that the information I have reported is correct and further authorize the release of any necessary medical information to aid in the processing of any claims.

I permit a copy of this authorization to be used in the place of the original and I understand that the position of this authorization regarding medical records release may be revoked by at any time in writing.

I hereby certify that I have read and understood this form and that it has been answered to the best of my knowledge.

_____
SIGNATURE OF PATIENT OF RESPONSIBLE PARTY

_____
DATE

_____ _____
PATIENT'S NAME PATIENT'S DATE OF BIRTH

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, LaGrange Pediatrics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LaGrange Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. LaGrange Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: LaGrange Pediatrics
Patsy Johnson, Privacy Officer
1527 Vernon Road
LaGrange, Ga 30240.

With my consent, LaGrange Pediatrics may call my home or other designated location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, LaGrange Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With my consent, LaGrange Pediatrics may e-mail to me appointment reminder cards and patient statements. I have the right to request that LaGrange Pediatrics restrict how it uses or discloses m PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. My desired restrictions are listed as such:

_____

_____

By signing this form, I am consenting LaGrange Pediatrics use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, LaGrange Pediatrics my decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to LaGrange Pediatrics for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Parent or Legal Guardian Date

_____
Printed Name of Parent or Legal Guardian

_____
Printed Patient's Name

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Patient Acknowledgement of Notice of Privacy Practices

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I had access to a copy of the Notice of Privacy Practices of **LAGRANGE PEDIATRICS** on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of **LAGRANGE PEDIATRICS.**

I also understand that if I wish to receive a copy of this Notice of Privacy Practices in the future or if I have any questions in regard to this Notice of Privacy Practices, I may contact:

Patsy Johnson
Privacy Officer
1527 Vernon Road
LaGrange, Ga 30240
Tel: (706) 883-6363
Fax: (706) 884-5588

_____

Signature of Patient of Legal Guardian

_____

PLEASE PRINT NAME

_____

DATE

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION (PHI)

PLEASE NOTE: THE PRACTICE NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

PATIENT NAME:		
GUARDIAN'S NAME:		
ADDRESS:		
PHONES HOME:	**CELL:**	**WORK:**
PATIENT DATE OF BIRTH:		
PHYSICIAN NAME: SUZANNE W. SCHUESSLER, M.D.		

State below any special requests you have with regard to how this practice communicates with you in writing. Give names of people that may receive patient's PHI:

State below any special requests you have with regard to how this practice communicates with you by telephone. Give names of people that may receive patient's PHI:

State below any people who **MAY NOT** receive patient's PHI:

Signature of Patient or Personal Representative Date

If you are signing as the patient's Personal Representative, please state your authority to do so:

SPACE TO USED BY PRACTICE ONLY **DATE RECEIVED:**

REQUEST ACCEPTED OR DENIED:

NOTIFICATION / ADDITIONAL DOCUMENTATION REQUIRED:

NAME OF PERSON REVIEWING REQUEST:

DATE:

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I, _____, currently do not have insurance coverage for my child _____. However, I have applied for PeachCare / Medicaid for the above named patient. If I do not present an applicable PeachCare / Medicaid card or letter from the Department of Medical Assistance supplying a recipient client number within 30 days of the date of this agreement, then I shall be held solely responsible for any charges incurred during the time frame that my child was without insurance coverage.

_____ _____

Responsible Party Signature Account Number

_____

Responsible Party Written Name

_____

Relation of Patient Date

_____

Witness Date

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To Our Valued Patients Receiving Medicaid Assistance:

If you receive services in our office for which Medicaid will be billed, you must sign this acknowledgment stating that you have no additional insurance coverage above and beyond Medicaid. Pursuant to the laws that authorize Medicaid, if you have private health insurance, this claim must be submitted to your private insurance first then Medicaid. If your claim is submitted to Medicaid and you have private health insurance, you are committing fraud.

By signing this document, you, as the undersigned, swear or affirm under penalty of law that you have no private health insurance coverage.

I, _____, so hereby swear or affirm that I have no private health insurance coverage, and that based upon my signature to this document, this office will be submitting the bills for my medical services to Medicaid. If I fail to provide any private insurance information I may be reported to the State of Georgia for further investigation.

_____ _____

Date Signature

_____

Patient Name

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HISTORY NO.:_____

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the previous healthcare provider, _____, to release the following medical information, including and treatment related to drug or alcohol abuse, psychological, psychiatric conditions or AIDS/HIV condition from the medical record of

_____ _____
Printed Patient Name Date of Birth

_____ _____
Address Soc. Sec. No.

Dates of Treatment: _____
_____

Office Notes
Lab
X-Ray
Other

Information to be released to : **Dr. Suzanne W. Schuessler, M.D.**
1527 Vernon Road
Lagrange, Ga 30240

Purpose for release of information: _____
_____

I understand this consent, except for action already taken, can be withdrawn at any time in writing.

This authorization will remain in effect for 90 days after I sign and date this form below. Other conditions upon which this consent expires, if any:

_____ .

The facility, its employees and physicians are released from legal responsibility or liability for the release of the above medical records to the extent indicated and authorized herein.

_____ _____
Signature of Patient or legal guardian Date

_____ _____
Relationship to patient Phone Number

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PRESENTATION/ MEDS AUTHORIZATION

I hereby authorize the following person(s) to present my child(ren) for treatment and/or to pick up medications or prescriptions as designated below. If someone not on the list either presents my child(ren) for treatment and/or to pick up medications or prescriptions, I understand that they must have a signed and dated note from me to that effect. The practice would then call and verify the authenticity of the note before services would be rendered or medications /prescriptions surrended. The note will be kept for our records. Upon your return to the practice we will require that this document be updated to reflect any changes, additions or deletions.

I also understand that I am still the financially responsible person for any charges and/or co-pays associated with the visit, etc.

Person's Name	Relationship to you	Present for Treatment	Pickup Med/Prescripton
		YES / NO	YES / NO
		YES / NO	YES / NO
		YES / NO	YES / NO
		YES / NO	YES / NO
		YES / NO	YES / NO
		YES / NO	YES / NO

_____ _____

Date Signature

_____ _____

Home or Cell # Work #

_____

Child(ren)'s Name(s)