PEDIATRIC CENTER FOR WELLNESS, P.C.

CRYSTAL B. HOOD, M.D.

1506 KLONDIKE RD SW SUITE 205

CONYERS, GA 30094

678-750-4000 TELEPHONE

678-750-4005 FAX

www.pcfwellness.com

Dear Family,

We are excited to welcome you into our PCW family. It is a privilege for us to have the opportunity to care for your child/children. We look forward to providing quality, evidence-based, preventive healthcare. It is also our mission to arm you with knowledge as parents/caregivers to successfully maintain the health of your children. It is our belief that children are gifts and that they are our greatest, most important assets. Therefore, we will journey together to ensure that they reach their full potential--physically, emotionally, mentally, and spiritually.

So that we can best serve you, please contact your previous physician's office to have your child/children's medical records mailed or faxed to our office. If you already have them, please bring or fax them to the office prior to your first visit. By doing so, the paperwork processing time can be greatly reduced during your first visit. You may contact our office manager for any concerns or questions that you may have. In addition, our nursing staff is available to assist you with any medical questions.

In order to minimize the spread of infection, we offer a sick waiting area for all patients with illnesses (fevers, colds, rashes, etc.). There is a well waiting area for well visits and all babies 4 months old and younger. We offer same day sick call in appointments. However, please be advised that same day appointments may experience a slightly longer wait than usual.

Again, thank you for choosing Pediatric Center for Wellness. We look forward to developing a lasting and rewarding relationship with your family.

Sincerely,

Pediatric Center for Wellness Staff

PEDIATRIC CENTER FOR WELLNESS
1506 KLONDIKE RD SW STE 205
CONYERS, GA 30094
678-750-4000 TELEPHONE
678-750-4005 FAX

PATIENT NAME _____ **SEX** ____ **DOB** _____
(FIRST) (LAST) (MM/DD/YYYY)

MOTHER'S NAME _____ **DOB** _____
(FIRST) (LAST) (MM/DD/YYYY)

SS# _____ **EMPLOYER** _____ **PHONE#** _____

HOME ADDRESS _____ **HOME#** _____

CITY _____ **STATE** _____ **ZIP** _____

CELL# _____ **WORK #** _____

EMERGENCY#/NAME/RELATIONSHIP TO PATIENT _____

_____

E-MAIL ADDRESS _____

FATHER'S NAME _____ **DOB** _____
(FIRST) (LAST) (MM/DD/YYYY)

SS#_____ **EMPLOYER** _____ **PHONE#**_____

HOME ADDRESS _____ **HOME#** _____

CITY _____ **STATE** ____ **ZIP** _____

CELL# _____ **WORK #** _____

E-MAIL ADDRESS _____

Pharmacy Name _____ **Location** _____

INSURANCE INFORMATION

1) **INSURANCE COMPANY** _____ **ID#**_____
GROUP# _____ **INSURED'S NAME** _____ **DOB**_____
(FIRST) (LAST) (MM/DD/YYYY)

2) **INSURANCE COMPANY** _____ **ID#** _____
GROUP#_____ **INSURED'S NAME** _____ **DOB** _____
(FIRST) (LAST) (MM/DD/YYYY)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC CENTER FOR WELLNESS (PCW) OF ALL SURGICAL AND/OR MEDICAL BENEFITS FOR SERVICES PROVIDED FOR MY CHILD WHICH YOUR OFFICE MAY FILE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION. I UNDERSTAND THAT IF A BALANCE ON THIS ACCOUNT IS UNPAID AFTER THIRTY (30) DAYS ON OFFICE VISITS AND SIXTY (60) DAYS ON HOSPITAL CHARGES, I AM RESPONSIBLE FOR ALL COLLECTION FEES INCURRED IN ORDER TO COLLECT THE BALANCE. ALL OFFICE VISITS AND SERVICES ARE DUE AND PAYABLE AT TIME OF SERVICES, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO MY VISIT. I UNDERSTAND THAT ALL CONTRACTED INSURANCE CLAIMS WILL BE FILED, BUT I, THE GUARANTOR, AM RESPONSIBLE FOR ALL FEES INCURRED. I HEREBY AUTHORIZE RELEASE OF ANY RECORDS/INFO FROM PREVIOUS AND HOSPITAL PROVIDERS TO PCW THAT IS NECESSARY FOR MEDICAL TREATMENT OR TO PROCESS ANY CLAIMS FILED ON MY CHILD'S BEHALF.

SIGNATURE _____ **DATE** _____
PARENT OR LEGAL GUARDIAN/GUARANTOR

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT
AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PHI

PEDIATRIC CENTER FOR WELLNESS

1506 KLONDIKE RD SW STE 205 CONYERS, GA 30094

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from a third-party payer
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the use and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

With my consent, Pediatric Center for Wellness may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out daily operations such as appointment reminders, insurance items and any calls pertaining to my child's clinical care including laboratory results among others.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Parent or Legal Guardian Name Patient Name

_____

Printed Name Signature Date

OFFICE USE ONLY

I attempted to obtain the parent or legal guardian's signature in acknowlegdement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____

Date Initials Reason

Newborn to Adolescent Medical History Form

Patient Name:_____ **Birth Date:** _____ **Sex M F Today's Date:** _____

Form Completed By: _____ **Relationship to Patient:** _____

Child's Primary Caretaker(s): _____ **Legal Guardian(s):** _____

_____ _____

Immediate Family Information:

Name	Relationship	Age	Lives in same house?	Marital status	Race	Occupation
	Mother		**Yes/No**			
	Father		**Yes/No**			
			Yes/No			
			Yes/No			
			Yes/No			

Birth History:

Birth weight _____ Type of delivery (circle one)? Vaginal Cesarean Why? _____

Length of pregnancy in weeks _____ Any health problems in mother during pregnancy? _____

Complications during pregnancy (circle one)? Yes No If yes explain: _____

During pregnancy did mother smoke (circle one)? Yes No Drink alcohol (circle one)? Yes No

Use illicit drugs (circle one)? Yes No If yes what and when: _____

Use any medications (circle one)? Yes No If yes what and when: _____

Did baby have any problems after birth (circle one)? Yes No If yes explain: _____

Newborn feeding (circle one): Breast Formula Hepatitis B vaccine given to baby in hospital (circle one)? Yes No

Past Medical History:

Does your child take any medications or over the counter supplements regularly?
Please list all below with doses:

Medication/Supplement Name	Dose	How often	Reason for use

Allergies to medications and reactions if known:

_____

_____

Surgeries your child has had with date:

Surgery	Date	Surgeon	Hospital

Immunization History (you may skip this section if full immunization records are availbable today):

Is your child up to date with all immunizations (circle one)? Yes No Unsure

Has your child had the chickenpox vaccine? (circle one)? Yes, once Yes, twice No Unsure

Has your child had the meningitis vaccine (usually as teenagers) (circle one)? Yes No Unsure

Patient Name: _____

Has your child had the HPV vaccine (three times, girls only—usually 9-26 years old) (circle one)? Yes No Unsure
Has your child ever had the flu vaccine (recommended age 6-59 months) (circle one)? Yes No Unsure
Has your child ever had the Hepatitis A vaccine (recommended from 1-2 years old, encouraged 2-18 (circle one)?
Yes No Unsure

Medical & Family History:

	Patient	**Family member** (list relationship)	**Additional information**
Asthma			
Allergies			
Heart Disease before 50 years of age			
Diabetes			
High Blood pressure before 50 years of age			
High Cholesterol			
Development/Behavior Problems			
Anemia			
Bleeding Disorder			
Liver Disease			
Kidney Disease			
Seizures			
Bedwetting (after 10)			
Alcohol or drug abuse			
Mental illness			
Mental retardation			
Deafness			
Arthritis			
Cancer and type			
Birth defects			
Early childhood death			
Immune problems or HIV or AIDS			
Tuberculosis			
Other			

Tobacco use in home? (circle one)? Yes No Outside use only

Lead Risk: Age of Home _____ Zip Code _____

PEDIATRIC CENTER FOR WELLNESS

1506 Klondike Road SW

Suite 205

Conyers, GA 30094

678-750-4000 Telephone
678-750-4005 Fax
pcfwellness.com

PLEASE BE ADVISED THAT IF ANYONE OTHER THAN THE PARENTS WILL BE BRINGING YOUR CHILD

_____ TO THE DOCTOR FOR
(Patient Name)

EXAMINATION, IMMUNIZATIONS OR LAB TESTS, THEIR NAME AND OTHER INFORMATION MUST BE LISTED BELOW.

Name	Relationship	Phone #
1)		
2)		
3)		
4)		

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may also contact you to provide apppointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Pediatric Center For Wellness Financial/Appointment Policy

We would like to thank you for choosing Pediatric Center for Wellness to care for your child/children. As one of our patients, we would like to keep you informed of our current office financial/appointment policy. We require a signature to document that you have read and understand these policies.

PAYMENT: Payment is expected at the time of service. This is an insurance company rule. This includes co-payments or coninsurance for participating insurance companies. Pediatric Center for Wellness accepts cash, personal checks, VISA and MasterCard. There is a service charge of $35 for returned checks.

INSURANCE: It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If your plan requires, you must name **Dr. Crystal Hood** as your primary care physician prior to your first appointment. If **Dr. Crystal Hood** is not named on your insurance card as your primary physician, your appointment will need to be rescheduled.

REFERRALS: You must receive your referral to specialists before your appointment.
No retroactive referrals will be given.

CANCELED APPOINTMENTS: If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $30 for appointments that are not canceled at least 24 hours in advance. If you have 3 or more no shows, you may be asked to find another physician.

PAST DUE ACCOUNTS: If we have to turn your account over to collections, you will be charged interest on the outstanding balance from the date your bill was due, and you will be responsible for all costs and expenses of collection including, but not limited to, our reasonable attorneys' fees.

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with the Office Manager. Satisfactory arrangements can almost always be made. Financial considerations should never prevent children from receiving the care they need at the time they need it. Again, thanks for choosing PCW. It is our honor to serve you.

_____

Printed Name **Signature** **Date**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth**:_____

Parent/Guardian Home #:_____ **Parent/Guardian Cell #:** _____

Parent/Guardian Work #: _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient or parent/guardian authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City/ State/Zip: _____

Dates and type of information to disclose:

☐ **Two years prior from last date seen**

☐ **Other dates:** _____

☐ **Specific Information Requested** _____

_____

The purpose of disclosure is:

☐ **Change of Insurance or Physician**

☐ **Continuation of Care (e.g. VA Med Ctr)**

☐ **Referral**

☐ **Other** _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Pediatric Center for Wellness

Address: 1506 Klondike RD Suite 205

City/ State/ Zip: Conyers, GA 30094 ☐ **Please mail records.**

Phone: 678-750-4000 **Fax:** 678-750-4005 ☒ **Please fax records.**

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**

If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

Date

_____ _____

Printed name of Authorized Representative

Relationship/Capacity to patient

_____

Address and telephone of authorized representative