Henry County Pediatrics, LLC

Patient Information Form

Patient Full name: _____

Birth Date: _____

Male_____ Female_____

Address_____

_____

_____

Home Phone: _____ Alternate Phone: _____

Mother's Name: _____ Birth Date: _____

**If address is different from patient then enter here:

Mother's Social Security Number: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Employer: _____ Work Number: _____

Father's Name: _____ Birth Date: _____

**If address is different from patient then enter here:

Father's Social Security Number: _____ Email: _____

Home Phone: _____ Alternate Phone: _____

Employer: _____ Work Number: _____

Insurance Information

Insurance Company Name: _____

Phone#_____

ID#_____ Group #_____

Thank you for choosing us as your child's pediatrician!!!!

How did you hear about us or who may we thank for referring you? _____

Patient Consent for Use and Discloser of Protected Health Information

With my consent Henry County Pediatrics, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

Please refer to Henry County Pediatrics, LLC Notice of Privacy Practices for a more complete description of such uses and discloser. Henry county Pediatrics, LLC reserves the right to revise its Notice of Private practices at anytime. If you have any questions regarding this notice or our health information privacy policies and would like to receive a revised notice, please contact the privacy officer by forwarding a written request to Henry County Pediatrics, LLC 125 Eagles Pointe Parkway, Suite 120 Stockbridge, GA 30281.

With my consent, Henry County Pediatrics, LLC may call my home, office, cell phone or other designated number(s) and leave a message on 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 and pathology results, among others.

With my consent, Henry Count Pediatrics, LLC 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.

I have the right to request that Henry County Pediatrics, LLC restrict how it uses or discloses my 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.

By signing this form, I am consenting to Henry County Pediatrics, LLC use and disclosure of my PHI to conduct treatment, payment, and healthcare operations (TPO).

I understand that I am responsible for payment of professional services at the time they are rendered, unless alternative arrangements have been made in advance. This includes all co-payments and deductibles.

I certify that I am the patient or the parent/legal guardian of the patient, and I consent to treatment necessary for the patient indicated on this form. I hereby authorize Henry County Pediatrics, LLC to release any medical or incidental information that may be necessary for medical care or 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, Henry County Pediatrics, LLC may decline to provide treatment to me.

I hereby acknowledge that I receive/reviewed the Notice of Privacy Practices for Henry County Pediatrics, LLC.

Signature_____ **Date**_____