

PEDIATRIC ASSOCIATES OF FRANKLIN, P.A.

Frederick A. Berger, M.D., FAAP
S. Douglas Egge, M.D., FAAP
Shana F. Egge, M.D., FAAP

278 Riverview Street
Franklin, NC 28734
Telephone: (828) 369-4444
Fax: (828) 369-4241

PARENT/GUARDIAN INFORMATION

FATHERS NAME/GUARDIAN: _____ HOME #: (____) _____ - _____

STREET ADDRESS: _____ WORK #: (____) _____ - _____

CITY: _____ CELL #: (____) _____ - _____

STATE: _____ ZIP: _____ EMAIL ADDRESS: _____

SS#: _____ - _____ - _____ BIRTHDATE: _____ EMPLOYER: _____

MOTHERS NAME/GUARDIAN: _____ HOME #: (____) _____ - _____

STREET ADDRESS: _____ WORK #: (____) _____ - _____

CITY: _____ CELL #: (____) _____ - _____

STATE: _____ ZIP: _____ EMAIL ADDRESS: _____

SS#: _____ - _____ - _____ BIRTHDATE: _____ EMPLOYER: _____

INSURANCE INFORMATION

(Check one below)

____ NC MEDICAID ____ GA MEDICAID ____ NC HEALTH CHOICE ____ OTHER (Please list name below)

INSURANCE CO.: _____ ID #: _____ GROUP #: _____

INSURED'S NAME: _____ DOB: _____ EMPLOYER: _____

MEDICAID#: _____ SECONDARY INS.: _____ ID #: _____

YOU WILL BE ASKED TO SHOW PROOF OF INSURANCE CARD AT EVERY VISIT.

PATIENT INFORMATION

• PATIENTS NAME: _____ DATE OF BIRTH: _____

NICKNAME: _____ SS#: _____ - _____ - _____ AGE: _____ SEX: _____

• PATIENTS NAME: _____ DATE OF BIRTH: _____

NICKNAME: _____ SS#: _____ - _____ - _____ AGE: _____ SEX: _____

• PATIENTS NAME: _____ DATE OF BIRTH: _____

NICKNAME: _____ SS#: _____ - _____ - _____ AGE: _____ SEX: _____



Developing healthy lifestyles through preventive pediatrics

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MEDICAL HISTORY

Is your child allergic to any medications? Yes ___ No ___ If yes, please list the medications: _____

Is your child presently under the care of another physician for any illness? Yes ___ No ___ If yes, please provide the physician's name: _____

MISCELLANEOUS

For our information, please indicate below how you heard of us:

___ Yellow Pages ___ Newspaper ___ Friend/Relative ___ Employee (Name: _____) ___ Other: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Frederick A. Berger, Dr. Shana F. Egge or Dr. S. Douglas Egge for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Frederick A. Berger, Dr. Shana F. Egge or Dr. S. Douglas Egge, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

FAILED APPOINTMENTS CAUSE A WASTE OF VALUABLE TIME AND DEPRIVE OTHERS OF TREATMENT. IF YOU CANNOT KEEP AN APPOINTMENT, PLEASE CALL OUR OFFICE IN ADVANCE. FAILURE TO FOLLOW THIS POLICY MAY RESULT IN A CHANGE OF YOUR APPOINTMENT PRIVILEGES!

PATIENT: (please print) _____ DATE: _____

PARENT/GUARDIAN (please print): _____

SIGNATURE: _____ DATE: _____

PAYMENT REQUIRED AT TIME OF SERVICE- UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.



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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name: _____ Parent/Guardian Signature _____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.



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FINANCIAL AND OFFICE POLICY

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Thank you for choosing Pediatric Associates of Franklin, P.A. As your health care provider, we are committed to providing the highest quality care for your children. While we are doing everything possible to hold down the cost of medical care, you can help a great deal by eliminating the need for us to bill you.

The following is a summary of our payment policy:

**** FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE ****

**** WE ACCEPT CASH, CHECK, VISA AND MASTERCARD ****

Payment is required at the time services are rendered (including co-payments) unless other arrangements have been made in advance. We file all insurances; any payment received by insurance company will be refunded within one week of receiving EOB. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your personal account.

Patients with an outstanding balance of 120 days overdue must make arrangements for payment prior to scheduling appointments. Since we realize people may have financial difficulties at times, we are willing to make arrangements for monthly payments.

The adult accompanying a minor (or guardians of the minor) are responsible for full payment at the time of service.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy, and I understand and agree to this financial policy.

X _____ DATE: _____
Signature of responsible party



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