WELCOME TO INTERNATIONAL PEDIATRIC CLINIC

How did you hear about our clinic? ☐ ESTABILISHED PATIENT ☐ YELLOW PAGES ☐ OUTSIDE SIGN
☐ FRIEND ☐ FESTIVAL ☐ NEWSPAPER ☐ INSURANCE COMPANY ☐ OTHER

PATIENT INFORMATION

Patient's Name:		Sex: ☐M ☐F	Date of Birth:	SSN#:
Address:				Home Telephone:
Mother's Name:	Mother's Date of Birth:			Cell Phone Number:
Mother's Employer:	Work Address:			Work Number:
Father's Name	Father's Date of Birth:			Cell Phone Number:
Father's Employer:	Work Address:			Work Number:
Emergency Contact:				Telephone Number:

INSURANCE INFORAMTION

☐ Medicaid ☐ other ☐ Peachcare	Insurance Name:	Insurance ID Number:	Group Number:	Insurance Telephone Number:
Name of Responsible Party:		Relationship to Patient: ☐ Mother ☐ Father ☐ Other:		

PHARMACY INFORMATION

Name of Pharmacy you use?	City:	Telephone Number:
Name of your child's previous pediatrician?	Telephone number	When was you last seen there?

Email Address:

Authorization

Please show your insurance card to the receptionist.

I authorize International Pediatric Clinic to share information with and to receive payments from the insurance company with whom I have an active contract. Please return this form to the receptionist.

My signature will confirm that all the information provided above is to my knowledge true and correct.

Signature:______________________________ Date:______________________________

International Pediatric Clinic
3780 Holcomb Bridge Rd. Suite C
Peachtree Corners, GA 30092
Office: 770-263-9101
Fax: 770-263-9102

Suzana Mara Montana, MD, FAAP
Johelin De Freitas Hernandez, MD
Lauren Oberg, FCNP
Claire Wan, PAC

High quality pediatrics with love and without boundaries

The doctors and staff of La Clinica del Nino, PC want you to know how we will protect your private health information. When you visit our office, it is very important that you feel safe in telling your doctor your personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assure that our practice has always had strict policies and procedures to protect the confidentiality of the information that you gave entrusted to us. However, on April 14, 2003 new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

- Give patients more control over their health information;
- Set boundaries for the use and release of health records;
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information;
- Hold violators accountable with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that our practice provide all to our patients with the attached Notice of Privacy practice at their first visit. The notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to your access to this information.

Please sign below that we have given you the opportunity to review and ask questions regarding the HIPAA privacy practices. You are entitled to a personal copy of the notice at any time to review and keep for your records. If you have any questions about our Privacy Practices, please feel free to contact our Business Administrator Iman Mohamed @ 770-263-9101.

Thank you for your cooperation.

I acknowledge that I have been given the opportunity to review or receive a copy of La Clinica del Nino, P.C.'s Notice of Privacy Practices and have been given an opportunity to ask questions.

Patient's name: ______________________________Patient's signature or Personal Representative: _____________________

If personal Representative, give relationship to patient: ________________________ Date: ___________________________

Permission for treatment

I do hereby voluntarily request medical care or services at La Clinica del Nino, PC for my child/children as listed on my application for registration. I hereby authorize and grant my permission and consent for all providers employed by La Clinica del Nino, PC, to use such diagnostic and treatment procedures as they deem necessary for proper medical management and treatment of my child/children. I fully understand that no guarantee or warranty of results that may be obtained has been given or implied by the physicians or other medical services employees of La Clinica del Nino, PC, or is in any way intended hereby. I also acknowledge that I may, at anytime, refuse to accept medical care or services for my child/children and I accept full responsibility for said act or statement of refusal. I further understand that on-site services are not provided by La Clinica del Nino, PC on nights, weekends, and announced holidays, that if treatment is needed, and La Clinica del Nino, PC is unable to provide off-site services, I will seek such treatment at the hospital providing Emergency Services for that particular day or night. I acknowledge the right of La Clinica del Nino, PC and/or its agents, for due and proper cause, to refuse to initiate or continue medical care or services for my child/children. I certify that I am legally entitled to sign this statement of permission for treatment.

I, __________________________ (patient/guarantor), understand the above statement and authorize the following persons to bring my child to the office for evaluation and/or treatment:

1.____________________________________Relationship to child______________________________

2.____________________________________Relationship to child______________________________

For patients age 18 years and older ONLY:

I hereby authorize for all of my medical records to be discussed with the following persons:

1.____________________________________ Phone #: ______________________________

2.____________________________________ Phone #: ______________________________

Please initial the following statements if you agree:

_________ I authorize La Clinica del Nino (dba: International Pediatric Clinics) to discuss my account and my child's Medicaid application with DXC Technology.

By signing below, you acknowledge that you have read and agree with La Clinica del Nino (dba: International Pediatric Clinics) "Permission for Treatment" & "Office and Financial" policies.

Signature: _________________________________ Print Name: __________________________ Date: ________________