Georgia Pediatric Cardiology
Clinic Visit Form For Initial Visit

Name_____________________________________ **DOB**_______________ **Age**________ **Today's Date**_____________

Reasons for seeing the doctor today: ____

Alergies: List drug allergies____ ☐ Patient has no drug allergies

Birth History: Birth Weight: ______ ☐ Full Term ☐ Premature ☐ Vaginal delivery ☐ C-Section

Social History: Mother/Age ______ Father/Age _______ Siblings: Brothers/Age ____________ Sisters/Age _________________

Medical History: List all medical problems:____

Hospitalizations: List all previous hospital admissions: *☐ Patient has had no hospital admissions.*

Reason for hospital admission	Name of hospital	Age at hospitalization	Date
_______________________	_____________	________________	______
_______________________	_____________	________________	______

Current Medications: *☐ Patient is taking no medications*

Name of Medication	Dosage	Frequency-

FAMILY HISTORY *(If any family members has any of these conditions, describe relationship to patient and age of onset):*

Condition	No	Yes	Relationship to patient	Age of onset
Heart disease	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Irregular heart beats	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Congenital defects	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Heart surgery	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Heart attack	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
High blood pressure	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Stroke	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Cholesterol problems	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Diabetes	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Sudden cardiac death	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Seizures	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Pacemaker treatment	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Sudden infant death syndrome	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Sudden or accidental death	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Enlarged heart	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Hypertrophic cardiomyopathy	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Dilated cardiomyopathy	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Long QT syndrome	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Short QT syndrome	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Brugada syndrome	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Marfan syndrome	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Arrhythmogenic right ventricular dysplasia (ARVD)	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Catecholamine ventricular tachycardia	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Deaf at birth	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Passing out	☐ No	☐ Yes	Relationship to patient______________________________________	Age of onset_________
Stillbirth	☐ No	☐ Yes	Relationship to patient____	

REVIEW OF SYSTEMS (Please check all that applies) *☐ Patient does not have any of the symptoms listed below*

☐ Recent weight gain	☐ Recent weight loss	☐ Fatigue easily	☐ Feeling down	☐ Rash
☐ Itching	☐ Excessive sweating	☐ Swelling	☐ Wheezing	☐ Cough
☐ Headaches	☐ Blurred or double vision	☐ Red eyes	☐ Eye drainage	☐ Nausea
☐ Nose bleeding	☐ Congestions	☐ Tooth pain	☐ Swallowing problems	☐ Falls
☐ Ear pain	☐ Ear drainage	☐ Neck pain	☐ Swollen neck glands	☐ Vomiting
☐ Abdominal pain	☐ Diarrhea	☐ Blood in stool	☐ Fever	☐ Gum bleeding
☐ Difficulty urinating	☐ Blood in Urine	☐ Cloudy Urine	☐ Frequent urination	☐ Chills
☐ Seizures	☐ Weakness	☐ Muscle cramps	☐ Night sweat	☐ Sore Throats
☐ Numbness	☐ Feeling tired	☐ Easy bleeding	☐ Easy bruising	☐ Passing out
☐ Swollen lymph glands	☐ Feeding difficulties	☐ Poor weight gain	☐ Poor exercise tolerance	☐ Dizziness
☐ Shortness of breath	☐ Rapid heart beats	☐ Irregular heart beats	☐ Lightheadedness	☐ Chest pain

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VITAL SIGNS (To be filled by medical professionals)

Weight: ______kg ______lbs (______% for age) Height: _______cm _______inches (____% for age) BMI:________(______%)

Heart rate________Resp Rate______ BP: ☐ RA ☐ LA ☐ RL ☐ LL (BP 95% for pt.____/____) Pulse ox:_____%

Orthostatic Vitals: Supine: BP_______ HR_______ **Sitting:** BP_______ HR_______ **Standing:** BP_______ HR______

PATIENT DEMOGRAPHIC FORM

Patient Name ____ Male/Female
Last First Middle Initial

Date of Birth ______________________________ Social Security # ______________________

Address ____
Street City State Zip

Mothers' Name ______________________	Fathers' Name ______________________
Social Security # ______________________	Social Security# ______________________
Birth Date ______________________	Birth Date ______________________
Address ______________________	Address ______________________
______________________	______________________
Home Phone ______________________	Home Phone ______________________
Cell Phone ______________________	Cell Phone ______________________
Employment ______________________	Employment ______________________
Work Phone ______________________	Work Phone ______________________

Marital Status of Parents: Single Married Widowed Divorced

IN CASE OF EMERGENCY CONTACT: ______________________________________
NAME PHONE

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS IN-PATIENT HOSPITAL SERVICES

I hereby authorize the above physician to obtain records from other sources as may be needed in the treatment of this patient.
I herby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of t
I authorize the release of information to the insurance company as needed to pay for charges incurred by this patient.
I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital.
I understand that I am responsible for any amount not covered by the insurance company.

A copy of this information shall be as valid as the original.

______________________________________ ______________________________
Signature of Responsible Party Date

Pediatrician ____
Address ______________________________ **Phone** ______________________________
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____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Georgia Pediatric Cardiology may use and disclose protected health information (PHI) about me to carryout treatment, payment and healthcare operations (TPO). Please refer to Georgia Pediatric Cardiology's 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.

Georgia Pediatric Cardiology 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 Georgia Pediatric Cardiology, Privacy Officer at 1045 Southcrest Drive, Suite 220, Stockbridge, Georgia 30281.

With my consent, Georgia Pediatric Cardiology my call my home or other designated location 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 results among others.

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

With my consent, Georgia Pediatric Cardiology may email my appointment reminder cards and patient statements. I have the right to request that Georgia Pediatric Cardiology 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 Georgia Pediatric Cardiology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already make disclosures in reliance upon my prior consent. If I do not sign this consent, Georgia Pediatric Cardiology may decline to provide treatment to me.

______________________________________	____
Signature of Patient or Legal Guardian	Date
______________________________________	________________________________
Patient's Name	Print Name of Patient or Legal Guardian)

GEORGIA PEDIATRIC CARDIOLOGY
FINANCIAL POLICY

If you have medical insurance, we are please to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- Co-payments for office services are required at the time of service.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been made prior to services being rendered.
- Returned checks are subject to a handling fee of $25.00.
- Patient balances over 30 days must be turned over to a collection agency.
- You will be billed and are responsible for, all fees involved in that process.
- A no-show fee of $65.00, which is not billable to insurance, will be charged for any appointment not cancelled with 24 hours notice.

YOU MUST REALIZE:

1. You must provide your insurance coverage at the time of service. If you have two commercial policies, please provide both policies at the time of service. If you have a commercial policy and Medicaid, you must provide both at the time of service. **FAILURE TO PROVIDE THE APPROPRIATE COVERAGE INFORMATION WILL RESULT IN THE CHARGES BEING DUE FROM YOU. WE ALSO REPORT FRAUD AND ABUSE OF INSURANCE AND MEDICAID.**

2. Your insurance is a contract between you and your employer and/or insurance company. While we may be a provider of service, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services; however, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

PLEASE READ THE ABOVE CAREFULLY <u>BEFORE</u> SIGNING

Signature ____

Date ____

GEORGIA PEDIATRIC CARDIOLOGY
PRESCRIPTION REFILL POLICY / CONTROLLED SUBSTANCES

1. I agree to allow 48 hours for prescription refills.

2. I understand that prescription refill requests after 4:30pm will not be received until the next business day (Friday and Holiday calls will not be handled until the next business day).

3. I understand that a follow-up visit may be required in order to obtain any refill.

4. I agree to take (give) any medications exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking medications without first speaking to my (child's) physician or his assistant.

5. Controlled substance medications CAN NOT be called or faxed in. An original prescription must be carried to the pharmacy.

6. I will not give away, trade or sell medications.

7. Georgia Pediatric Cardiology will NOT refill prescriptions for controlled substances that have been lost, stolen, misplaced or destroyed within a 30 day fill period.

8. Altering or forgery of a prescription written by a provider of this practice is a felony and will be reported. Forgery is grounds for immediate dismissal from this practice.

9. Patients can be reported to the Department of Children's and Family Services for misuse of or noncompliance of medications prescribed by this practice.

10. I must keep all appointments as recommended.

I have read, understand and agree to the policies above. I understand that if I do not sign this document my physician may refuse to prescribe medications for my child.

Patient Name:____
(Please Print)

Parent/Guardian Signature:____

Date:_________________