The World of Pediatrics
Dr. Lyudmila Vayman | Dr. Rosalie Vayman
3005 Royal Blvd S., STE 110, Alpharetta, GA 30022
Tel: 770-442-5437 Fax: 770-674-3777

Medical Records/Health Information Release

(Please fill out and fax or send to your current practice or pediatrician)

Previous Physician's Office Information

Date: _____

To: _____

Phone: _____

Fax: _____

Please release a copy of medical records for the following patient(s):

1) Patient's Name: _____
   Patient's DOB: _____

2) Patient's Name: _____
   Patient's DOB: _____

3) Patient's Name: _____
   Patient's DOB: _____

4) Patient's Name: _____
   Patient's DOB: _____

5) Patient's Name: _____
   Patient's DOB: _____

Please send the records to the following address:

The World of Pediatrics
3005 Royal Blvd S, STE 110
Alpharetta, GA 30022
Tel: 770-442-5437
Fax: 770-674-3777

Printed Name _____

Relation to Patient _____

Signature _____

Date _____

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Patient Information

Date:_____

Patient's Name: _____
First Middle Last

Preferred Name: _____ **Date of Birth**:_____ **Age**: _____
Sex Assigned at Birth: ❑M ❑F

Patient's Street Address: _____
City, State, Zip Code: _____

Person Responsible for Bill (person under which insurance is carried):
_____ **Relationship to Patient**: _____
Date of Birth: _____ **Email**: _____
Same Address as Above? ❑
Address:_____
City: _____ **State**:_____ **Zip**:_____

Home Phone: (____)_____ **Cell Phone**: (____)_____

Marital Status of Parents: ❑ Married ❑ Divorced ❑ Separated ❑ Other:_____
If Not Married, Who Has Custodial Rights (Please Provide Legal Documents Supporting Selection):
❑ Mother Only ❑ Father Only ❑ Both Parents ❑ Other _____

Mother's Name: _____ **DOB**: _____ **Cell Phone**: (____)_____
Name of Employer: _____ **Work Phone**: (____)_____
Address of Employer: _____

Father's Name: _____ **DOB**: _____ **Cell Phone**: (____)_____
Name of Employer: _____ **Work Phone**: (____)_____
Address of Employer: _____

Emergency Contact (Not Parent):_____ **Phone**: (____)_____
Address: _____
Relationship:_____

Pharmacy Name: _____ **Tel**: _____ **Fax**: _____

Address:_____

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Insurance Information

Name of Insured:_____
Name of Insurance Company:_____ **Phone**: (____)_____
I.D. Number:_____ **Group Number**: _____

-- MEDICAID PATIENTS ONLY --

Medicaid Plan: ❑ Peach State ❑ Amerigroup ❑ CareSource ❑ Straight Medicaid
Medicaid Number: _____

I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid, Peach State, CareSource, or Amerigroup during the course of treatment. **Sign**_____

Release of Information

I authorize the release of any medical information necessary to process insurance claims.

Insured's or Authorized Person's Signature

I authorize and request payment of medical benefits to **The World of Pediatrics**.

I certify that I am the responsible party for the patient listed above and that I have the authority to agree to and sign on behalf of the patient for all services rendered. I also certify that I am the financially responsible party for the patient listed above and that I have the authority to agree to all practice policies and financial policies.

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Signature _____

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Patient Authorization for Use and Disclosure of Protected Health Information (PHI)

I authorize **The World of Pediatrics** to use and/or disclose certain protected health information (PHI) about me. Failure to authorize release of PHI may prevent the exchange of vital information associated with care and billing insurance.

This authorization permits **The World of Pediatrics** to use and/or disclose health information, including but not limited to the following:

- Office Notes
- Lab Results
- Radiology Reports
- Hospital Records
- Other Physicians Notes
- Immunization Records
- Medication Logs
- Problem Lists and Treatment as requested by Health Care Specialists that are caring for your child
- Diagnoses

The information will be used for the following purposes:

- To carry out treatment, receive payment, collaborate with other physicians or healthcare entities and/or to carry out health care operations.
- To comply with Federal, State, or Local laws, regulations, or requests.
- For insurance companies and third-party billing

I consent for **The World of Pediatrics** to call me, leave a message on voicemail, text, email, or mail communications in reference to any items that assist the practice. These messages may include, but are not limited to appointment reminders, insurance items, and any calls pertaining to clinical care, including lab and radiology results.

The purposes of disclosing PHI have been provided, so that you may make an informed decision. **The World of Pediatrics** will not receive payment from a third party in exchange for disclosing PHI.

I understand that I have a choice for whether to sign this release to receive treatment at **The World of Pediatrics**. I also understand that I have the right to revoke this authorization at any time by written request to **The World of Pediatrics**. However, please, remember that failure to authorize release of PHI may prevent the timely exchange of vital information associated with the care of a patient. By signing this document, you are accepting the disclosure of PHI described above.

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Signature _____

Date _____

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Practice Policies

Immunizations

It is **The World of Pediatrics** practice policy that we perform mandated immunizations per the CDC Immunization Schedules. No delayed vaccination schedules will be accommodated. We highly encourage and provide but do not require non-mandated vaccinations. We are happy to perform catch-up vaccinations for children with delayed vaccines. We **require mandated vaccinations** in order to keep our vulnerable population protected - a promise that we make and keep to all patients in our practice. We believe patients have a right to make a different choice and an informed choice; patients that choose a different route for vaccinations would best be served with a pediatrician more aligned with their philosophy.

We look forward to a relationship built on mutual trust and partnership with our families. Thank you for giving us the opportunity to keep our kids healthy and safe!

_____ ***Initial***

Appointments

Appointments can be made during our regular office hours from 9am-5pm Monday through Friday, excluding lunch from 1-2pm. Same-day appointments are encouraged for sick visits, and we will do our best to accommodate. Walk-ins are permitted but discouraged and will be worked around previously scheduled visits.

Cancellation or Missed Appointments

Much effort goes in to preparing for your visit. If you are unable to keep your appointment, please be considerate of other patients needing to be seen and contact us no later than two business days before your scheduled appointment to cancel.

If you have a well child appointment scheduled and your child becomes ill, then we will change the appointment to a sick visit and reschedule your well child appointment for another date. If you elect not to come in for the sick visit, this will be counted as a no-show and incur a fee.

All cancellations within two business days and no-show visits will be charged a $50 missed appointment fee. Two non-emergent missed appointments per family may result in discharge from the practice.

_____ ***Initial***

After Hours

A provider is on call at our office number after hours for urgent, non-emergent medical phone calls that are unrelated to scheduling, prescriptions, and billing. Calls are only intended for urgent illnesses. If your child is having an emergency, please call 911 instead.

After hours calls with a duration longer than ten minutes may be charged a telehealth visit.

Prescriptions/Refills

Please give us three business days to fill needed medication requests.

Prescription requests for Control II drugs (e.g., Adderall, Concerta, Ritalin, etc.) should be requested one week prior to need. These prescriptions must be picked up at our office during normal business hours.

We will not authorize refills during after hours or weekends. We will not refill another physician's prescription.

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Requests for new medications or antibiotics will not be filled without first making an appointment for your child to be seen.

Referrals

If your insurance requires a referral in order for your child to see a specialist, we require one week's notice to process the referral. Same day referral requests will be denied.

Cell Phones:

Cell Phones must be turned off while patients are with a provider. No recordings are allowed in the office due to HIPAA and privacy concerns. Disregard of this policy will result in discharge from the practice.

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Financial Policies

Full payment of amounts due and all outstanding balances must be paid at time of service prior to the next appointment. We accept cash, checks, Visa, MasterCard, or Discover.

Insurance:

Knowledge of insurance plan coverage is the responsibility of the patient. All outstanding balances not paid in full by insurance are the responsibility of the patient.

All Medicaid (Amerigroup, CareSource, Peach State, and Straight Medicaid) patients are required to have their **The World of Pediatrics** primary care physician updated on the card prior to any visit. Fees incurred due to not accomplishing this will be the responsibility of the patient. Should this be resolved during the time of the scheduled visit, patient will be treated as a walk-in or same-day no-show fee.

Some insurance policies do not cover in-house labs, labs sent out of house, or imaging. It is your responsibility to know the coverage of your plan prior to your visit. Any additional concerns addressed or labs obtained at the time of a well child exam may have an added cost to the exam. **All patients have the right to elect for us not to perform these services in our office.** By accepting this treatment during your exams, you accept financial responsibilities for all medical care provided and lab work completed that is not covered by your insurance.

_____ ***Initial***

Payment:

We will file insurance for patients as a courtesy. You must present a valid insurance card at each office visit. Any co-payments or deductibles are to be paid at the time of service. Self-pay patients are required to pay for visits in full at the time of their visit. The patient is ultimately responsible for all outstanding balances. All payments must be made to **The World of Pediatrics**. A service charge of $50 will be due for each bounced check.

Medicaid patients are responsible for all medical expenses in the event that the patient loses Medicaid coverage during the course of treatment.

Telehealth Consultations

Insurance policies typically do not cover telephone appointments or consults with physicians to discuss problems or medical issues. Conversations with a physician lasting longer than ten minutes are considered to be telehealth visits. Fees that are not covered for these services by insurance will be the patient's sole responsibility.

_____ ***Initial***

School & Camp Forms:

Forms needed for patient participation in activities and documentation (e.g., school, camp, sports programs, daycare, legal documents, insurance required forms, etc.) can require significant time from our nursing staff and medical providers. For this reason, charges ranging from $20-$50 will be charged; see Table below for typical charges for forms. We also request that all forms be dropped off at least 7-10 days in advance, so that we may have ample time to complete all forms. We aim to complete the forms as soon as possible, but it is unlikely they will be completed in less than 72 hours.

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Typical Form Charges

Type of form	Charge
5 pages or fewer at the time of visit	courtesy
More than 5 pages at the time of visit	$20
5 pages or fewer after the visit	$20
Over 5 pages, not to exceed 20 minutes of office staff time	Will be assessed based upon required time, not to exceed $50

Specialty forms will incur larger charges based upon level of difficulty, skill sets needed, providers and time required, etc.

Katie Beckett forms will need to be completed by Psychology or Developmental Pediatricians; **The World of Pediatrics** does not complete these.

Medical Records:

If requesting your child's medical records, please allow thirty days for our office staff to process your request. Georgia Fee Schedule is as follows:

Georgia Fee Schedule for Medical Records

Search, Retrieval and Other Direct Administrative Costs	$25.88	
Certification Fee (Mailing)	$9.70	
Copying Costs for Records in Paper Form	Per page for pages 1-20:	$0.97
	Per page for pages 21-100:	$0.83
	Over 100 pages	USB only
USB Drive (Electronic PDF)	$20	

Notary:

Notarization services are provided by **The World of Pediatrics** for a service charge of $10 per document.

Labs, Screenings, Diagnostic Procedures

Insurance policies may or may not cover labs and screenings drawn or performed in the office. Insurance may or may not cover particular labs, screenings, or diagnostic procedures. Fees not covered for these services will be the patient's sole responsibility. The most common of these are listed below, but this is not an all-encompassing list.

- Vision and Hearing Screening when done as part of a physical
- Urinalysis when done as part of a physical
- Hemoglobin when done as part of a physical
- Hemoccult
- Blood Stick Glucose

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Injections, Vaccines, and Fees for Administering Vaccines

Insurance policies may or may not cover some vaccines or injections that are administered to our patients. Charges not covered for these services and the vaccines or injections themselves will be the patient's sole responsibility. The most common of these are listed below, but this is not an all-encompassing list.

- Rocephin Injections
- Decadron Injections
- Penicillin Injections
- Hormone Injections
- Vaccines or Immunizations
- Influenza Shot or Intranasal Influenza Vaccine
- Administration Fee for each injection or intranasal application given

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Authorization for Treatment of a Minor without the Parent or Legal Guardian Present

Re: Patient's Name: _____
Patient's Date of Birth: _____

To whom it may concern:

I, _____, the legal guardian or parent of _____,

_____ Initial

Give authorization for the individuals listed below to make medical decisions in my absence for the health and well-being of the child listed above. These individuals may authorize and sign for all medical procedures and/or treatments performed at **The World of Pediatrics**.

_____

_____

_____

_____

_____ Initial

Give authorization for my minor, _____, to make medical decisions in my absence. The minor child listed above may authorize and sign for all medical procedures and/or treatments performed at **The World of Pediatrics**.
Note: Minors must be at least 16 years of Age. We prefer that a Parent or Legal Guardian attend all physicals or appointments where immunizations will be given.

These authorizations extend to urgent care centers, hospitals or other medical specialists and medical offices that may be needed to treat my child in my absence. I will be responsible for all financial obligations incurred for procedures performed.

This authorization will remain in effect indefinitely from the date listed below until receipt of written withdrawal of this authorization.

Printed Name _____

Relation to Patient _____

Signature _____

Date _____