REQUEST FOR RELEASE OF MEDICAL RECORDS

PLEASE PRINT

PATIENT'S FULL NAME: _____

PATIENT'S DATE OF BIRTH: _____

I HEREBY AUTHORIZE (Prior Pediatrician's Name): _____

FACILITY ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____ (REQUIRED. Records cannot be released without fax #)

TO RELEASE ALL MEDICAL RECORDS (including lab & imaging results) TO:

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
719 W LANIER AVE, STE. A
FAYETTEVILLE, GA 30214
TEL: 470-278-2300
FAX: 770-731-2385

_____ _____

PARENT/GUARDIAN'S SIGNATURE DATE

_____

DAYTIME PHONE #

REASON FOR RELEASE:

- CHANGE OF INSURANCE
- **MOVED**
- **DENTAL SURGERY CLEARANCE**
- REFERRING DOCTOR
- COURT ORDERED
- OTHER (PLEASE SPECIFY) _____

TRINITY PREDIATRIC MEDICINE OF FAYETTEVILLE

DR. BRITTANY WILSON
719 WEST LANIER AVENUE, FAYETTEVILLE, GA 30214

DATE: _____

CHILD'S FULL NAME:
FIRST **MIDDLE** **LAST**

_____ **SEX:** M F **AGE:** _____

DATE OF BIRTH: _____ **RACE (circle one):** WHITE/CAUC BLACK/AFR-AMER HISPANIC/LAT OTHER

ADDRESS: _____
NO. & STREET APT CITY COUNTY ZIP CODE

HOME PHONE #: _____

PARENT'S INFORMATION:

FATHER'S NAME: _____ **S.S. #** _____

FATHER'S DATE OF BIRTH: _____ **OCCUPATION:** _____

EMPLOYER: _____ **WORK PHONE:** _____

CELL PHONE #: _____

MOTHER'S NAME: _____ **S.S. #** _____

MOTHER'S DATE OF BIRTH: _____ **OCCUPATION:** _____

EMPLOYER: _____ **WORK PHONE:** _____

CELL PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ **POLICY #:** _____

SUBSCRIBER NAME: _____ **SUBSCRIBER D.O.B:** _____

SECONDARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER D.O.B: _____

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN PARENTS):

NAME: _____ **PHONE:** _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

I hereby authorize Trinity Pediatric Medicine of Fayetteville to give my child total Pediatric Care, also to release medical information when and if requested by insurance company.

SIGNED: _____ **RELATIONSHIP:** _____

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
BRITTANY WILSON, MD
719 WEST LANIER AVENUE
FAYETTEVILLE, GA 30214
PHONE: 470-278-2300
FAX: 770-731-2385

PAYMENT AGREEMENT

I have read and understand the Patient Information form provided to me by Trinity Pediatric Medicine of Fayetteville and do hereby confirm that all of the information I have submitted in the completion of this form is true and correct, to the best of my knowledge.

I also agree to notify Trinity Pediatric Medicine of Fayetteville of any changes in the information I have provided, either health status or general patient information, on a timely basis or upon my next scheduled appointment with Trinity Pediatric Medicine of Fayetteville.

I hereby acknowledge that I am ultimately responsible for the full payment of any and all fees or charges for services provided to me by Trinity Pediatric Medicine of Fayetteville and that the filling of insurance claims with my health care insurance coverage I may hold is a courtesy to me and does not in any way relieve me of financial responsibility for any balance remaining after insurance payments, including any amount that exceeds my insurance company's usual, reasonable, and customary rate.

PLEASE NOTE: If we are a participating provider with your insurance company, we will follow the contractual obligations.

I understand that if this visit has not been authorized by my Primary Care Physician and I have no referral number, the service(s) I receive may not be covered by my health care benefits plan and I will be responsible for payment to full for services rendered. (NOTE: This paragraph includes patients who require a referral number from their PCP.)

I also understand that certain procedures may not be covered by my insurance plan and that if I request a non-covered service, I will be financially responsible for those services and agree to pay any and all non-covered fees and charges. (NOTE: This paragraph includes patients with Medicaid.)

I am aware that my co-pay, co-insurance and/or deductible are due at the time services are rendered.

I understand that if my account should ever be turned over to a "collection agency", I will be responsible for any and all collection costs, including attorney fees and any court costs.

_____ _____
Patient's Name Date of Birth

_____ _____
Guardian/Insured Signature Date

_____ _____
Witness Date

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
BRITTANY WILSON, MD
719 WEST LANIER AVENUE
FAYETTEVILLE, GA 30214
PHONE: 470-278-2300
FAX: 770-731-2385

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

NAME OF PATIENT: _____
DATE OF BIRTH: _____

I hereby acknowledge that I have the option to receive a copy or read the Notice of Privacy Practices from Trinity Pediatric Medicine of Fayetteville.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
BRITTANY WILSON, MD

PREFERRED METHOD OF CONTACT

For notification of **MEDICAL ISSUES**, I prefer to receive **(*pick ONE*)**

- ☐ A CALL on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A CALL on my WORK phone
- ☐ A TEXT to my CELL phone (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my HOME EMAIL
- ☐ An email to my WORK EMAIL

For **REMINDERS OF UPCOMING APPOINTMENTS**, I prefer to receive **(*pick ONE*)**

- ☐ A CALL on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A CALL on my WORK phone
- ☐ A TEXT on my CELL phone (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my HOME EMAIL (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my WORK EMAIL (**your patient portal account MUST be set up to receive this type*)

For **GENERAL NOTIFICATIONS/RECALLS**, I prefer to receive **(*pick ONE*)**

- ☐ A call on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A TEXT on my CELL phone (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my HOME EMAIL (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my WORK EMAIL (**your patient portal account MUST be set up to receive this type*)

For **BILLING STATEMENTS**, I prefer to be contacted via **(*pick ONE*)**

- ☐ A TEXT to my CELL phone (**your patient portal account MUST be set up to receive this type*)
- ☐ Mail to my HOME ADDRESS
- ☐ An email to my HOME EMAIL (**your patient portal account MUST be set up to receive this type*)
- ☐ An email to my WORK EMAIL (**your patient portal account MUST be set up to receive this type*)
- ☐ A FAX to _____ (*please include fax number*)

Child's Name: _____ **D.O.B.:** _____

Home Email: _____

Work email: _____

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
BRITTANY WILSON, MD
719 WEST LANIER AVENUE
FAYETTEVILLE, GA 30214
PHONE: 470-278-2300
FAX: 770-731-2385

LATE ARRIVAL POLICY

Our doctors and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 10 minutes late for an appointment, the appointment may need to be rescheduled. The 8:00 am, 11:00 -11:45 am, 1:00 pm, and 4:00 – 4:45 pm appointment slots do not have grace periods. Patients must be on time or early to be seen. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment on the same day if one is available. We ask that you contact the office via phone if you are running late for your appointment time, so that we can reschedule the appointment if needed. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our patients.

New patients are encouraged to print off new patient paperwork from the website and fill it out prior to coming in. Otherwise, new patients need to arrive at our office at least 15 minutes prior to the scheduled appointment to complete the paperwork.

Date: _____

Child's Name: _____

Child's D.O.B.: _____

Parent/Guardian's Name: _____

Parent/Guardian Signature: _____

TRINITY MEDICAL & DENTAL PEDIATRIC CENTER OF FAYETTEVILLE
BRITTANY WILSON, MD

WHO HAS PERMISSION TO BRING MY CHILD TO THE DOCTOR (Proxy Form)

Photo ID from the individuals listed below must be provided at time of visit

Date: _____

Name of Child: _____ **Child's Date of Birth:** _____

Name of Person #1: _____

Relationship to Child: _____

Contact Number: _____

Name of Person #2: _____

Relationship to Child: _____

Contact Number: _____

Name of Person #3: _____

Relationship to Child: _____

Contact Number: _____

I give permission for the above listed individual(s) to transport my child to and from the doctor's office, to provide medical information about my child, to receive medical advice/instructions pertaining to my child, and to make medical decisions pertaining to my child at the time of the visit.

Parent/Guardian's Signature: _____ **Date:** _____

TRINITY PEDIATRIC MEDICINE OF FAYETTEVILLE
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FAYETTEVILLE, GA 30214
PHONE: 470-278-2300
FAX: 770-731-2385

OFFICE POLICY ON PAYMENT, MANAGED CARE, INSURANCE & APPOINTMENTS

PLEASE READ CAREFULLY! YOUR SIGNUATURE INDICATES AGREEMENT.

In order to accommodate the needs and requests of our patients, Trinity Pediatric Medicine of Fayetteville have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, but it is impossible for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often, where and by whom medical services may be rendered. Even within the same insurance company, the plans differ with the type of contract you or your employer has negotiated. Please make sure you are familiar with the benefits and requirements of your plan.

Providing quality medical care for our patients is our primary concern. In some cases, we may recommend or render medical services that are not covered by your insurance plan. For example, if your insurance carrier requires you to use a specific lab or other outside facility, it is your responsibility to inform the nurse. Failure to do so may result in charges that your insurance company does not cover.

You are required to pay for office visits or co-pay by cash, check or credit card. Please be prepared to pay at the time of the appointment. If you have any past-due outstanding balances, these will be collected before you are seen by the doctor, as well as any co-payments that may apply. A copy of your insurance card is required to be on file. It is our office policy to bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire balance now. Once the carrier is billed, we will set aside the portion of the balance estimated to be paid by your insurance carrier for 30 days. If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you. Also, as a courtesy to you we would file your secondary insurance for any outstanding copays, coinsurance, and deductibles that were not covered by your primary insurance. However, if we do not receive payment within 30 days or if for some reason your secondary claim is denied, it would be your responsibility to pay the outstanding balance promptly.

If any payment is made by your insurance carrier after you have paid the balance, we will promptly refund the credit amount to you.

**We require a minimum 24-hour notice when cancelling a well check-up appointment. Failure to do so will result in a $40.00 missed appointment charge. Repeated violations may result in dismissal from the practice.

PATIENT COPY