

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION  
JUST US KIDS PEDIATRICS  
2462 HIGHWAY 34 EAST NEWNAN, GA 30265  
PHONE: 770-683-5437

**MEDICAL RECORDS ARE NOT ACCEPTED VIA FAX, PLEASE MAIL TO ABOVE ADDRESS**

Patient Name: First \_\_\_\_\_ Last \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Email Address (for E-bills & other important updates): \_\_\_\_\_

1. I authorize representatives Just Us Kids Pediatrics to (release/request) my health information (to/from) the following (facility/person): \_\_\_\_\_ (Please list past pediatrician info below)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:  
 Complete medical records (including IMMUNIZATIONS)  Partial medical records  
 History & Physical  Consultations  Discharge Summary  Lab Results  Xray Reports

3. PURPOSE OF DISCLOSURE:  
 At my request  Other: \_\_\_\_\_

4. EXPIRATION OF AUTHORIZATION  
Unless I request in writing otherwise, I understand that this authorization will expire on \_\_\_\_\_ . If I do not specify an expiration date or event, this authorization will expire ninety(90) days from the date on which I signed this authorization.

5. RIGHT TO REVOKE AUTHORIZATION  
I understand that I have a right to revoke this authorization. I must do so in writing and present my written revocation to Medical Records at Just Us Kids Pediatrics. I understand that the revocation will not apply to and health information that has been released in response to this authorization.

6. RE-DISCLOSURE  
I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearing house subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

7. FEES  
I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees, if they do occur.

8. RELEASE & WAIVER  
If the health information that I have requested Just Us Kids Pediatrics to disclose contains any privileged psychiatric or psychological information related to the treatment of physical/ or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency Syndrome (AIDS), Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Just Us Kids Pediatrics and their officers, trustees, agents and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

\_\_\_\_\_  
Signature of Patient (or patient's representative) \_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent \_\_\_\_\_  
Relationship to Patient

Just Us Kids Pediatrics  
Appointment Policy

All patients with a scheduled sick or well appointment will need to call within 24 hours to cancel. If a 24 hour notice is not received, the patient will be charged a \$25.00 broken appointment fee. We understand that sometimes emergencies do occur, in which we will waive the \$25 fee.

As a courtesy, our office will attempt to contact you to confirm your child's appointment; however, we ask that you assume responsibility for your child's appointed time. Multiple broke appointments (3 or more) without prior cancellation notice, may be subject to dismissal from the practice.

We sincerely appreciate your cooperation with us.

Thank you.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **POLICY ON CO-PAY REQUIREMENTS WHEN A SICK VISIT IS ADDED TO A WELL CHILD VISIT**

At Just Us Kids Pediatrics, we believe that Well Child Check visits are very important in addressing potential health concerns, keeping children properly protected against diseases, and discussing normal and unusual development. Generally speaking there are no co-pay requirements for a Well Child Visit. (That rule does not necessarily apply to a self funded insurance plan.)

Acute or chronic (sick) care performed with a Well Child Visit will result in an additional office charge that most likely will result in a co-payment charge as required per your insurance policy. A "typical" Well Child Visit may include, but not be limited to:

- Check growth and development
- Physical assessment
- Immunizations
- Parental concerns about growth and development
- Age specific exams may include: hearing & vision screening, lead assessment and screening, M-CHAT questionnaire for autism, and other developmental screens/questionnaires are necessary.

Acute (sick) illnesses include but not limited to- Bronchiolitis, pink eye, croup, common cold, dehydration, ear infection, rashes, eczema, fever, gastrointestinal infections/diarrhea, flu, sinusitis, urinary tract infection, medication modifications (asthma, ADD/ADHD, etc.), and vomiting. Chronic illness includes but not limited to allergies, asthma, ADHD and diabetes.

Generally speaking, just a refill of medication with no adjustment for chronic illness will not result in an additional charge. Changes in chronic illness health care medication will result in additional office visit charges for which a co-payment may be required.

**Just Us Kids Pediatrics is required, under contract with your insurance carrier, to collect co-pays at the time of medical service, most commonly sick visits. You will be charged a co-pay if you either request, or approve, treatment for an acute or chronic illness during a Well Child Visit. Such a request constitutes a Sick Visit, in addition to the Well Child Visit.**

Your insurance policy determines the co-pay requirements. If you are unable to or refuse to pay your co-pay, you may be asked to reschedule your appointment. Contact your insurance carrier if you have any questions specific to your policy's co-pay requirements plus any individual co-insurance and deductible limitations.

**RECEIPT OF POLICY STATEMENT ON SICK VISIT CO-PAYS DURING A WELL  
CHILD CHECK**

I, \_\_\_\_\_ (parents name) acknowledge that I have received a copy of the Just Us Kids Pediatrics statement regarding co-pay requirements when a Sick Visit is added to the Well Child Visit. I acknowledge that failure to pay co-pay at the time of service may generate an additional \$25 patient responsible charge.

I am aware that a copy is also in the waiting areas of Just Us Kids Pediatrics and that I can request another printed copy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Relationship to Patient

# **JUST US KIDS PEDIATRICS**

## **Notice of Privacy Practice**

As part of my health care, Just Us Kids Pediatrics originates and maintains paper and/or electronic records describing patients health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning patient care and treatment
- A means of communication among the many health professionals who contribute to patient care
- A source of information for applying my diagnose and surgical/treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

## **Consent to Disclosure of Patients Protected Health Information**

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I understand and have been provided with the practice Note of Privacy Practice before signing this document.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand that by failing to sign or revoking this consent, the practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and accept the terms of this consent.

## **Guarantor Recognition of Fiscal Responsibility**

I understand that I am responsible at the time services are rendered. I also understand that even though the office, out of courtesy, may verify my benefits, this is not a guarantee of payment. All benefits and eligibility are subject to change without notice. The benefits we verify are only a general summarization and are not intended to be used as an authorization of services provided. In the event my insurance does not cover all charges, I agree to pay the balance due in a timely manner. I am also responsible to notify the office of insurance changes.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_  
(Patient, Parent, Legal Guardian)Date: \_\_\_\_\_

If signed by representative, state relationship to patient: \_\_\_\_\_

