South Georgia Pediatric & Allergy Center, P.C.

3440 N. Valdosta Road
Valdosta, Georgia 31602
Phone: 229.247.2211 Fax: 229.249.9490

ADULT PATIENT REGISTRATION FORM

Patient Information

LEGAL LAST NAME_____LEGAL FIRST NAME_____MI_____

DOB_____ SEX: M OR F SOCIAL SECURITY#_____

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER_____

RACE:_____ ETHNICITY: HISPANIC NON-HISPANIC OTHER

MAILING ADDRESS: _____

PRIMARY PHONE:_____ SECONDARY PHONE:_____

EMPLOYER:_____ WORK PHONE: _____

EMPLOYER ADDRESS:_____CITY,ZIP_____

E-MAIL ADDRESS:_____

INSURANCE INFORMATION – (Provide a copy of your Insurance Card)

PRIMARY INSURANCE_____ ID#_____

SUBSCRIBER_____DOB:_____ SS#_____

SECONDARY INSURANCE _____ ID#_____

SUBSCRIBER_____DOB:_____ SS#_____

CONSENT FOR PAYMENT/ASSIGNMENT OF BENEFITS

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that should I not pay in full for any services they may be subject to collection fees, should my account be turned over. I have read all the information on this sheet and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature_____ Date_____

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NOTICE OF PRIVACY PRACTICES (HIPAA) & AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practice informs how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also defines your rights to access and control your protected health information.

Uses and Disclosures of PHI

Your PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to obtain payment for your health care bills, to support the operation of the physician's practice, and any other use as required by law. For proper treatment, your PHI may be disclosed to a third party including referred physicians and home health agencies. In supporting business operations, your PHI may be disclosed to Public Health, Public Safety, Communicable Diseases, Health Oversight, Food and Drug Administration, Abuse or Neglect, Law Enforcement, Legal Proceedings, Coroners, Funeral Directors, Organ or Tissue Donation Agencies, Research, Worker's Compensation, and other uses as required by law.

You have the ability to revoke the authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. You have the right to request a restriction of your PHI as well as the right to authorize disclosure of your PHI.

Therefore, I, _____, hereby authorize South Georgia Pediatric and Allergy Center, P.C. to communicate with and disclose my PHI to the following person(s):

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

OR

I request that my PHI to only be disclosed to me._____

(Signature)

***Please note: if you are requesting that a child's biological parent NOT have access to their medical records you must provide court documentation supporting this request.*

Patient Name:_____DOB:_____

Patient Signature:_____Date:_____

This disclosure will remain in effect until I give written notification otherwise.

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OFFICE POLICES, FORMS & FEES

PATIENT'S NAME:_____

Please initial for acknowledgement of each policy.

_____ All patients must be accompanied by a parent/guardian of at least 18 years of age. If you are fifteen (15) minutes or more late for an appointment, you may be asked to reschedule or be given the option of being seen as a walk-in patient. After **three (3) or more missed appointments** in a **twelve (12) month period**, patients **may be subject for dismissal from the practice**.

_____All Allergy/Immunology/Asthma patients must give at least twenty-four (24) hours notice for rescheduling. All missed allergy/immunology/asthma appointments may be subject to a **$25 no-show fee** and must be paid in full before patient can be seen in the office. After **two (2) missed appointments**, patients **may be subject to dismissal.**

_____All copays, deductibles and balances are due at the time of service(s) rendered. If you have a balance due and have not made arrangements or honored your agreement your appointment may be rescheduled.

_____Please allow up to five (5) business days for all school/ college forms, PCS forms, family medical leave forms, and letters to be completed.

_____I have read and understand all office polices of SGPAC and am able to receive a copy if requested.

_____ _____

Patient Signature Date

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Alan J. Alvarado, M.D.
Board Certified Pediatrics
Board Certified Allergy and Immunology

Robert J. Criscuola, M.D.
Board Certified Pediatrics

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____
PRINT PATIENT'S NAME PATIENT'S DATE OF BIRTH

_____ _____
PRINT NAME OF PARENT/LEGAL GUARDIAN PHONE NUMBER

Name and Address of Office/Hospital from whom you are seeking Medical Records:

_____

_____

Phone:_____ Fax: _____

Check One:

I am the _____Patient (if 18 or older)
_____Parent
_____Legal Guardian with custody

Records to be Released:

_____All records including immunization records
_____:Other: _____

Purpose of Release of Protected Health Information is:

_____Transferring Physicians
_____Continued Medical Care
_____Legal Action/Review
_____Other:_____

This Authorization expires in 6 months (12 months for school requests) unless otherwise disclosed:_____

Mail or Fax Records to:

South Georgia Pediatric and Allergy Center, P.C.
3440 North Valdosta Road
Valdosta, Georgia 31602
Fax: 229.249.9490

- I place no limitations on history of illness (including HIV and/or AIDS, genetic, drug dependency psychiatric information) or diagnostic and therapeutic information (including treatment for alcohol/drug abuse or psychiatric disorders).
- I authorize the inspection of the above information by the above named agency.
- I understand that unless otherwise limited by state or federal regulations, I may withdraw this consent at any time by submitting my withdrawal request in writing.
- I hereby acknowledge that I have read or have had read to me the above statements, and I fully understand and do expressly and voluntarily authorize the disclosure of medial information to the agency listed above.

Authorizing Party: _____ Date:_____
Witness: _____ Date:_____