McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

Dear Parents:

Thank you for selecting McDonough Pediatrics as your child's healthcare home. We appreciate your confidence in us. This group of forms has been compiled to meet the insurance and government requirements for a patient/physician relationship as well as information that is important to our successful partnering for your child's health.

Please review and complete each form prior to your initial visit to our office. There are the following forms in this package:

Welcome to Patient Portal
McDonough Pediatrics Registration Form
Request for Transfer of Medical Records
Permission to Treat Child in Parent Absence
Policies and Procedures for Our Managed Care Patients
HIPAA Patient Consent Form
HIPAA Notice of Privacy Practices
Patient's Bill of Rights
Policies & Procedures for McDonough Pediatrics
Prescription Refill and call-in request Protocol
Vaccination Policy Acknowledgment

Please follow the directions on the Patient Portal Letter to log into our patient information site and complete the Personal Medical, Family & Social History Form.
You may also send us a message with a copy of the completed forms prior to your first visit through the Portal.

Sincerely,

McDonough Pediatrics

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

Policies and Procedures for Our Managed Care Patients

- Co-payment and Co-Insurance must be made at time of service.
- As per your insurance, NCQA requirements, and our office policy, previous records and immunization records are required.

REFERRAL PROCEDURES & RULES

- You have to be referred by a McDonough Pediatrics, PC doctor.
- Must follow instructions on Referral sheet and office **MUST** be notified of **DATE, TIME,** and **SPECIALIST** at least 1 week in advance.
    - o ****on urgent/same day/ next day appointments, please call ASAP so we can process your referral.****
- If you do not notify our office of your appointment with your specialist, this may cause you to have to reschedule your appointment.
- Cancellations and/or rescheduling of appointments made by you at the specialist's office are **YOUR RESPONSIBILITY.**
- Remember, the specialist's office has their own policies and procedures, and you may not be able to get another timely appointment as needed for your child.
- Our office works very closely with specialists and their offices, to ensure that we get appointments for our children on an ASAP or first available/ work-in basis. We do not want to jeopardize this relationship by referring those patients who do not follow their office rules and procedures.
- Please work closely with the specialist to make sure you have a valid referral for your visit. If your referral expires by the next visit, please notify our office of the next appointment date and time, so we can have a valid referral in the system.

*****Please sign stating that you understand and agree to the Terms & Conditions above*****

Signature: _____ Date: _____

Office: 770-957-8626 | Fax: 770-957-7200

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honorthat agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 **(HIPAA).**

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.

The Consent was signed by: _____

Printed Name Patient or Representative

Relationship to Patient: _____

Witness: _____

Printed Name Practice Representative

Office: 770-957-8626 | Fax: 770-957-7200

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT \'OU MA\' BE USED AND DISCLO AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFLILLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment. Payment or health care operation, (TPO) and for other purposes that arc permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you. Including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care an, related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has 1 necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For exa1 obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed your protected health information in order to support the business-: activities of your physician's practice. These activities include, but are not limited to. Quality assessment activities, employee r activities, training of medical students, licensing. And conducting or arranging for other business activities. For example, we m disclose your protected health information to medical school students that sec patients at our office. In addition, we may use a in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations, include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, an< Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Us and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of He and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.
Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

PATIENT'S BILL OF RIGHTS

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his/her physician complete, current information concerning diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to five such information to the patient, the information should be made available to an appropriate person on his behalf. A patient has the right to know by name the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician any information necessary to give informed consent prior to the start of any procedure and/ or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to **know** the name of the person responsible for the procedure and/ or treatment.
4. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of this action.
5. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
6. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
7. The patient has the right to expect that within its capacity an office must make reasonable response to the request of the patient for services. Medical facilities must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, the patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for and alternatives to a transfer.
8. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating them.
9. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available.

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

Policies & Procedures for McDonough Pediatrics, PC

APPOINTMENTS
Our office is by appointment only, except in cases of extreme emergency. This policy helps our office stay on time with our appointments and keeps our waiting to a minimum. It is our policy to provide care to all sick children that need to be seen. When making an appointment for your sick child, this allows us to decide if the patient needs to be seen in our office or referred to a specialist. This helps our office in prioritizing our appointments, saving you time and expense. It is our policy to schedule Well Check-Ups every 30 minutes. Please make sure that you are on time for these appointments. When you are late you are in the next appointments time slot, and you will be worked into our existing schedule. This may also require you to reschedule your appointment. Please remember when you are late, our schedule runs late for the rest of the day.

REMINDER PHONE CALLS
It is the policy of this office to place reminder phone calls of scheduled appointments 2 days in advance. Please make sure that you give the receptionist the correct daytime phone number when you make your appointment. It is the patient's responsibility to be at the appointment on the correct date and time.

OUR OFFICE IS NOT A WALK IN FACILITY
Our office and staff are proud to be able to offer you the best medical care with the least amount of waiting time. In order to offer this level of service t our patients, we cannot offer walk-in appointments to our patients. If you do not schedule an appointment and your child needs to be seen, one of our nurses will triage the patient and decide if he/she needs to be worked in. Please note if we do work you into our schedule, you may experience delayed wait times, but you WILL be seen.

CANCELLATIONS
If you cannot make your scheduled appointment time, please call and cancel at least 24 hours in advance. If you do not call to cancel your appointment, you will be listed as a No-Show appointment.

RECHECK APPOINTMENTS
It is the policy of our doctor to order rechecks for recurrent ear infections, strep infections, bronchitis, pneumonia, severe sinus infections, other severe infections, or diseases that might require monitoring. It is imperative that you keep these recheck appointments. This helps the doctor plan a method of treatment that is best for your child. In younger children who still have regular checkup appointments, we try our very best to incorporate this recheck in with your monthly checkups.

FINANCIAL POLICIES OF MCDONOUGH PEDIATRICS, PC
Payment is due at the time of service. This includes Co-payments, Co-Insurance, and Self Pay Policies. PPO, HMO, POS, AND EPO Insurance Plans: We have a contracted fee schedule with these insurance companies. You are responsible for your co- payment and any other amount that the insurance company states as being your responsibility or any non-covered services. These fees are non-negotiable as we have already negotiated these fees and contracted them with your insurance company. The fee schedule for our self-pay patients is separate and will be given when requested. Please save your receipts. You may need them for your secondary insurance or for tax purposes. Our computer system does not print duplicate receipts and line by line statements.

BALANCE BILLINGS
It is the policy of this office to mail statements each month. The balance is due within 10 days of the receipt of statement. If you cannot pay the balance in full, please call the billing office to make payment arrangements. Finance charges will accrue on any account past due by 30 days. If you set up payment arrangements, please make payments on arranged date and amount or collection proceedings will start. All of our collections are handled via the courthouse or by our collection agency. If your account becomes past due, and if there are special circumstance or legitimate reasons, please call us so that a mutually agreeable solution can be found. Please do not let this impact the healthcare of your children.

If our office makes every effort in helping you and your account is past due, appropriate collection actions will be taken within 90 days of the initial billing. Our office makes the best effort to make arrangements with you in the best interest of both parties, but please understand that this is a business, and it is run in the most cost effective and efficient manner possible. Many insurance companies are covering Well Exams at 100%. Due to this we do not collect your copay at the time of service. Please note during a Well Exam, if your child has anything additional that is discussed during that exam, including a chronic condition, acute illness, or any other problem that is occurring, there will be an additional sick visit charge and may be subject to a co-payment. If you have any questions regarding financial expectations, please call our billing office at 770-745-1070.

***** I have read and understand the POLICIES AND RULES OF MCDONOUGH PEDIATRICS, PC. I have been given the original for my files. *****

SIGNATURE:_____ **DATE:**_____

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

PERMISSION TO TREAT CHILD IN PARENTS ABSENCE

I, _____, give permission to the names listed below to bring my
(PARENT'S NAME)

child, _____, in for medical treatment. I understand the purpose for disclosing personal
(CHILD'S NAME) (DOB)
health information to the person noted below. I also understand that I can refuse to sign this consent form.

Mother's full name: _____

Father's full name: _____

Individuals Name: _____

Relation: _____

Phone Number: _____

Individuals Name: _____

Relation: _____

Phone Number: _____

Individuals Name: _____

Relation: _____

Phone Number: _____

Individuals Name: _____

Relation: _____

Phone Number: _____

Individuals Name: _____

Relation: _____

Phone Number: _____

Parent Signature: _____ **Date:** _____

Office: 770-957-8626 | Fax: 770-957-7200

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Sekhar Sankaran, MD
101 Regency Park DR #140
McDonough, GA 30253
Phone: 770-957-8626 Fax: 770-957-7200

I authorize my child's Previous Doctor: _____

Street Address: _____

City, ST, ZIP: _____

To release to McDonough Pediatrics, PC the medical records for:

Patient's Name: _____ Date of Birth: _____

*****PLEASE DO NOT FAX RECORDS IF OVER 15 PAGES*****

Information to be released: **Entire Record including Immunization Record**
By signing below, I understand that I:

- Am entitled to receive a copy of this authorization
- May inspect my records and that a fee of $25 may be charged for duplication and print out of records
- Am authorizing the disclosure of this health information voluntarily. I can refuse to sign this authorization.
- Have the right to revoke this authorization at any time, except to the extent that action has been taken based on this authorization.
- This authorization will expire, without my express revocation, 90 days from the request date specified below.

By Signing below, you are hereby authorizing McDonough Pediatrics to request/release the requested information.

Patient/Parent/Guardian Signature DATE

Signature of Witness DATE

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

Vaccination Policy Acknowledgment

It is now the policy of McDonough Pediatrics that all children who visit our practice for care receive **ALL** immunizations recommended by the American Academy of Pediatrics.(A.A.P.). These immunization schedules change from time to time as new vaccines become available

WE NOW ARE UNABLE TO PROVIDE CARE TO NEW FAMILIES TO OUR PRACTICE WHO DO NOT FOLLOW THESE GUIDELINES.

McDonough Pediatrics believes that immunizations are of vital importance in the health of children individually and the population as a whole. There are no exceptions to this policy.
If there are questions regarding this policy, please do not hesitate to let us know. You may also refer to the **AAP website** regarding immunization practices and recommendations.

My signature below indicates that I have been made aware of the policy and will follow the APA guidelines on immunization for my child(ren).

Parent Signature:_____ Date:_____

Print Name of Parent:_____

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA. 30253

Sekhar Sankaran, MD
101 Regency Park DR #140
McDonough, GA 30253
Phone: 770-957-8626 Fax: 770-957-7200

Prescription Requests

While we make every effort to respond to prescription refill requests in a timely manner, requests can take up to 2 business days to complete (no weekends or holidays). Refill requests received on Fridays will be processed the following week and will be completed by Tuesday.

For Chronic conditions, such as asthma, unless otherwise directed by your provider, maintenance medications will be approved if the patient has had an office visit within the last 3 months for that condition. If the patient has not been seen, it will be necessary to schedule an appointment and a 30 day supply of the Medication can be prescribed. A follow-up appointment must be made for us to process the refill request. Only 1 reschedule will be allowed. Please speak with your provider during the next visit to see if your maintenance medications can be prescribed for 6 months of refills. This is usually a factor of the stability of the condition and DEA regulations.

We are unable to prescribe medications without the patient seeing a provider for non-chronic conditions. This includes requests for antibiotics and narcotics. Please do not ask our schedulers and nurse assistants to send messages to our clinical staff for these kinds of requests.

All messages for clinical providers must include the child's name, date of birth and a description of the issue/need. Failure to provide such information will result in a lack of response.

Below are guidelines regarding refilling of medications:

- Unless otherwise directed by your provider, maintenance medications such as asthma will be approved if patient has had an office visit within the last 3 months.
- Narcotics, other controlled substances such as ADD/ADHD medication, and sleep aids will require a mandatory visit every 3 months unless otherwise directed by provider.
- An office visit is required for Antibiotics and most Rx medications & will not be prescribed without a visit.

McDonough Pediatrics, P.C.

PATIENT REGISTRATION FORM

Child's First Name _____ MI _____ Last Name _____

Date of Birth _____ Gender (Circle One) Male Female

Home Address_____
Street *City* *State* *Zip*

Primary Phone _____ Work Phone _____ Other/Cell Phone _____

Email Address: _____

2nd Child's First Name _____ MI _____ Last Name _____

Date of Birth _____ Gender (Circle One) Male Female

3rd Child's First Name _____ MI _____ Last Name _____

Date of Birth _____ Gender (Circle One) Male Female

PARENT/GUARDIAN INFORMATION:

First Name _____ MI _____ Last Name _____

Date of Birth _____ SSN: _____-_____-_____

MEDICAL INSURANCE INFORMATION

Name of Insurance _____

Member ID number _____ Group # _____

Name of Subscriber _____

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) _____
Street *City* *State* *Zip*

I hereby assign all medical and/or surgical benefits to which I am entitled to **McDonough Pediatrics**. This assignment remains in effect until revoked by me in writing. A copy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to the release of my information by **McDonough Pediatrics** and my health insurance and/or payer to **McDonough Pediatrics** and its employees or representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that **McDonough Pediatric**s will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and this insurance company. **McDonough Pediatrics** is not a part to said contract. I understand that I am responsible for legal and/or collections fees necessary to settle accounts, should it become delinquent.

SIGNATURE: _____ **Date:** _____