PEDIATRIC PATIENT REGISTRATION – GALEN MEDICAL GROUP, PC

Your Child:
Child's Full Name: _____ Name Your Child Goes By: _____
Gender: ❑ Male ❑ Female DOB: _____ Age: _____ SS#: _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Primary Physician: _____

❑ **Mother** ❑ **Stepmother** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

❑ **Father** ❑ **Stepfather** ❑ **Guardian**
Name: _____ DOB: _____
SS #: _____ Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Cell Phone(s): _____ E-Mail: _____

MAY WE LEAVE MESSAGES BY:	EMAIL	TEXT CELL	HOME PHONE	WORK PHONE	CELL PHONE
FOR TEST RESULTS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
FOR APPOINTMENT REMINDERS	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

PARENTAL MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PREFERRED LANGUAGE: ***Must complete.*** ❑ English ❑ Spanish ❑ Other: _____

PATIENT ETHNICITY: ***Select one.*** ❑ Hispanic or Latino ❑ Non-Hispanic or Non-Latino

PATIENT RACE: ***Select one or more.*** ❑ African American ❑ American Indian or Alaska Native ❑ Asian
❑ Caucasian/White ❑ Native Hawaiian or Other Pacific Islander ❑ Other

INSURANCE INFORMATION:

We require copies of ALL Insurance Cards pertaining to child in order to file your insurance claims.

PRIMARY INSURANCE: _____ INS ID#: _____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____
SECONDARY INSURANCE: _____ INS ID#: _____
RELATIONSHIP TO SUBSCRIBER: _____ SUBSCRIBER NAME: _____
SUBSCRIBER'S ADDRESS: _____
SS #: _____ DOB: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ HOME PHONE: _____ WORK PHONE: _____
RELATIONSHIP TO CHILD: _____

PLEASE COMPLETE THE ADDITIONAL INFORMATION ON THE BACK OF THIS SHEET **GMG 2017-P**

CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to have access to any and all of my child's medical information that pertains to his/her care from the physicians of this group. This includes, but is not limited to, appointment times, lab results, his/her physician's plans for health care, etc.

Signature: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CONSENT FOR MEDICAL TREATMENT:

I, _____, parent/legal guardian of _____, grant permission for the person(s) listed below to bring my child to Galen Medical Group, PC for medical treatment.

Signature: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AGREE TO NOTIFY GALEN MEDICAL GROUP, IN WRITING, IF THERE ARE ANY CHANGES IN THE PERSON(S) AUTHORIZED.

Please list any siblings who are also patients of ours. Give both first and last names:

_____ _____

_____ _____

_____ _____

_____ _____

ADVANCED DIRECTIVES & AUTHORIZATION:

I authorize Galen Medical Group, PC to release to my insurance company, managed care organization, state agency(ies), federal agency(ies), Health Care Financing Administration, Third Party Administrators, and/or Workers' Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services. I also authorize Galen Medical Group, PC to utilize a fax machine to transmit any or all of the above medical records pertaining to my medical care or insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records. I grant permission to Galen Medical Group, PC to release all or part of my medical record to any consulting entity that may be involved in my medical care. This includes, but is not limited to, testing facilities, consulting physicians, and outpatient facilities.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered under a contractual write-off agreement between Galen Medical Group, PC and my third party payer. My carrier's failure to pay does not release me from this responsibility. I also agree that should this account be turned to collection, I will be responsible for all costs associated with debt collection, including attorney fees and court costs.

_____ _____

Signature of Responsible Party / Insured ***Date***

THANK YOU!

NEWBORN HEALTH HISTORY

Dear Parents: Welcome to our practice! While the following form may take a few minutes to complete, please fill in as much as possible, even the parts that do not seem important. The information that you provide will help us take better care of your child now and in the future.

DATE:_____ NAME: _____

Age:_____ Date of Birth:_____ Sex: ❑ Male ❑ Female Race: (insurance purposes) _____

Parent/Guardian: _____

Physician in Hospital: ❑ Alcantara ❑ Harris ❑ Spraggins ❑ Tigar ❑ Other: _____

How did you learn about Galen Pediatrics? _____

What is the chief reason your child is being seen today? _____

_____

Are there other problems that you are concerned about? _____

_____

Did you see a physician throughout your pregnancy? ❑ Yes ❑ No If Yes, who? _____
Were you tested for group B Strep prior to delivery? ❑ Yes ❑ No ❑ Unknown. Results? ❑ Positive ❑ Negative ❑ Unknown
Were you tested for hepatitis B prior to delivery? ❑ Yes ❑ No ❑ Unknown. Results? ❑ Positive ❑ Negative ❑ Unknown

While pregnant with this child, did the mother of this child . . . ? **Circle** any that apply.

Receive IV fluids because of dehydration?	Receive IV antibiotics in the 2-3 days prior to delivery
Get admitted to the hospital for problems prior to delivery?	Receive blood transfusions?
Have toxemia?	Have high blood pressure?
Have seizures?	Smoke?
Take medications other than prenatal vitamins?	Drink Alcohol?

Where was your child born? _____
Birth Weight:_____ lbs. _____oz. Birth Length:_____
Was your child born via vaginal or caesarian section? _____
Was your child born headfirst? ❑ Yes ❑ No At how many weeks gestation was your child born? _____
Did your child go home from the hospital at the same time that you did? ❑ Yes ❑ No
Did your child pass a hearing screen prior to discharge from the hospital? ❑ Yes ❑ No ❑ Unknown
Did your child receive a hepatitis B vaccine prior to discharge from the hospital? ❑ Yes ❑ No ❑ Unknown

After delivery did your child ... ? **Circle** any that apply.

Go to the intensive care unit?	Receive oxygen for more than a few minutes?
Receive a blood transfusion?	Receive treatment for jaundice?
Require a ventilator or respirator?	Receive IV fluids or IV medications?

ANSWER THE NEXT TWO QUESTIONS ONLY IF YOUR CHILD WENT TO NICU AFTER DELIVERY:
If your child went to the neonatal intensive care unit after delivery, please explain briefly what problems your child was treated for?

_____

_____

If your child went to the **neonatal intensive care unit** after birth, did your child go home . . . ? **Circle** any that apply.

On any medications?	On an apnea and bradycardia monitor?
With instructions to see an other physicians?	With instructions to schedule a hearing screen?
With instructions to return to the NICU clinic?	With instructions to go to the Synagis clinic?

PATIENT NAME:_____ DOB: _____

FAMILY HEALTH: List the age and health of ***this child's*** parents, grandparents, brothers and sisters.

This child's relatives	Age	Health if living	Age at death	Cause of Death
Patient's father				
Patient's mother				
Patient's grandmother on *mother's* side				
Patient's grandfather on *mother's* side				
Patient's grandmother on *father's* side				
Patient's grandfather on *father's* side				
Brothers/Sisters of the PATIENT (not the parent)—include names				

FAMILY HISTORY: (***Circle*** all that apply).

Has any blood relative ever had...? (*Circle* all that apply)	
Heart trouble before age 50	Congenital malformations or deformities
High blood pressure	Chromosomal anomalies or genetic diseases
High cholesterol or hyperlipidemia	Cancer
Stroke before age 60	Tuberculosis
Lung disease before age 40	Diabetes
Blindness before age 50	Anemia
Color blindness	Sickle cell disease
Nervous breakdown	Migraine
Convulsions or seizures	Asthma
Learning Disabilities	Allergies or hay fever
Attention Deficit Hyperactivity Disorder (ADHD or ADD)	Obesity
Kidney trouble	Retardation
Easy bleeding	Deafness
Crohn's disease or Inflammatory Bowel Disease	Thyroid trouble
Cystic Fibrosis	Hepatitis B or C

Please list any other diseases that run on either side of your child's family. _____

_____

_____

Are there any significant family or marital problems? No Yes If yes, please explain: _____

_____

_____

_____

PATIENT NAME: _____ DOB: _____

SOCIAL HISTORY:

Do both parents live in the home with this child? Yes No If no, please describe your custody arrangement?

_____

Who lives in your home? (Parents, grandparents and others)_____

_____

What is the occupation of the head of household? _____

How old is your home? _____

Are any of your children in day care? Yes No If yes, where? _____

Are any of your children in school? Yes No If yes, where? _____

Is your home child proofed? Yes No

Do you and your children **ALWAYS** wear seatbelts or sit in car/booster seats when riding in vehicles? Yes No

If English is NOT the language spoken most in your child's home:

What language is primarily spoken in your home? _____

If English is your second language, do you read English? Yes No If not, what languages do you read?

_____

Circle any of the following which you have in or around your home:

Smokers—even if they smoke outside?	Swimming pool?
Smoke alarms on all levels of your home?	Fire extinguishers for all levels of your home?
Locked medicine cabinet?	

If there are guns in your home:

Are the guns stored in a locked gun safe or cabinet? Yes No

Is the ammunition locked away? Yes No

(Be sure only adults know the combination to the safe or where the key is.)

Thank you for your cooperation in providing this information to help us care for your family.

_____

Signature and relationship to patient (mother, father)

For office use only:

Initial Review on: _____ By: _____

Date of Review	Signature of reviewing physician	Date of Review	Signature of reviewing physician

PATIENT NAME: _____ DOB: _____

GALEN
MEDICAL GROUP

EAST INTERNAL MEDICINE & PEDIATRICS

IMMUNIZATION POLICY

The physicians of Galen Medical Group East Internal Medicine & Pediatrics believe in, and support the importance of immunizing children according to the American Academy of Pediatrics (AAP) immunization schedule. We recognize that deviations may occur for an individual patient due to circumstances. However, when medically appropriate, our physicians will make every attempt to catch the child up at each visit to our office. For this reason, parents who refuse to immunize their child(ren) will not be accepted into our practice.

☐ YES – I plan to immunize my child

☐ NO – I do not plan to immunize my child

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

GALEN
MEDICAL GROUP

EAST INTERNAL MEDICINE & PEDIATRICS

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, we ask that you contact us at least 24 hours in advance. This will allow us to schedule patients that are having acute problems.

New patients that fail their original appointment without notice, or a valid reason, will not be rescheduled with Galen Medical Group East Internal Medicine & Pediatrics.

Failure to keep your appointment affects the flow of the office and creates many inconveniences to our patients. We consider a failed appointment to be: canceling on short notice, failing to arrive for an appointment, or appearing too late to be seen.

We will send out a reminder letter when you fail your first appointment. If you continue to fail two additional appointments, you will be dismissed from the practice.

If you are dismissed, we will provide emergency care for 30 days only. During this time, we recommend that you find another physician to provide your care. Upon receiving a signed release of medical information form, we will then transfer your medical records.

Thank you for your cooperation.

_____ _____

Signature of Patient Date

GALEN
MEDICAL GROUP

Financial Policy

Insurance Verification

At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Galen Medical Group makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance

Insurance companies require Galen Medical Group to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

A $12.00 processing fee will be added for co-pays that are not paid at the time of service.

Outstanding Balances

Patients will be asked to settle any outstanding balances with Galen Medical Group before their appointment. As a patient, you may pay any outstanding balances at any of our Galen Medical Group facilities.

Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.

Patient balances which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay

Galen Medical Group recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Galen will try to work with the patients to help them anticipate charges and manage their healthcare expenses.

Patients without insurance who pay in full at the time of service may be eligible for a discount.

For patients without insurance or the resources to pay for care, Galen supports the Volunteers In Medicine Clinic, a free primary care clinic located at 5705 Marlin Road in Chattanooga. Residents of Hamilton County who qualify can receive free care from Galen Medical Group physicians and other physicians who volunteer at the clinic.

Billing Insurance

Galen Medical Group contracts with most insurance companies for patient services. The patient remains financially responsible for all his or her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received. If payment is not received within 30 days, 10% interest will be applied to the outstanding balance until the account is paid in full.

No-show and Late cancellation Fee

Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $25.00 fee, not for any service, but for the lost opportunity to see another patient. Patients who cancel appointments with less than 72 hour's notice may be subject to a $200 fee for procedures.

Payments

Galen Medical Group accepts cash, check, Visa, MasterCard or Discover. There is a $30.00 fee for all returned checks.

Payment can be sent to:	**To bring payment in person:**	**To Pay Online:**
Galen Medical Group	Galen Medical Group	www.galenmedical.com
P.O. Box 1030	4976 Alpha Lane	
Chattanooga, TN 37401	Hixson, TN 37343	

To make a payment by phone and/or if you have any questions regarding your statements or our financial policies, please contact our Patient Business Services Representative at **(423) 894-3725**.

NOTE:

Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay interest on the balance at 10%, plus all costs associated with such collection activity, including reasonable collection agency fees, attorney fees, and court costs.

_____ _____

Patient Signature Date

_____

Printed Patient Name

GALEN

Notice of Personal Health Information Practices

Revised effective October 17, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

We are required by federal law to give you this notice.

We reserve the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Galen Medical Group, P.C. will post a copy of this Notice as amended in a prominent place in our offices and on our web site.

This notice becomes effective September 1, 2013 and amends our previous form of notice. We do not deem any current amendment to constitute a material change notice. No amendment relates to any substantive right of a Galen patient or any duty of Galen. If you have any questions about the Notice of Personal Health Information Practices, please contact our Privacy Officer at 423-308-0280 ext. 133 or by e-mail at privacy@galenmedical.com.

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Galen Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Health Oversight Activities. We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Family Members. We may release medical information, including mental health information, about you to a family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates. We have contracted with other entities to provide services to Galen Medical Group. When these "associates" require your personal health information in order to accomplish tasks asked of them by Galen Medical Group it will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training. Your personal health information may be used for the purpose of research, teaching and/or training.

Appointment Reminders. Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation. We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illnesses. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Special circumstances requiring your authorization. Most uses and disclosures of psychotherapy notes, health information for marketing purposes, and as part of a sale of protected health information require your authorization. Galen does not maintain psychotherapy notes, nor sell your health information. Your receipt of this notice authorizes Galen to use your health information for marketing purposes. Galen does not receive financial remuneration in exchange for communicating information to you for marketing purposes.

Individual Rights

You have certain rights under the federal privacy standards.

These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment by alternative means or at alternative locations if you request, your request is reasonable, and you acknowledge that such alternative means or locations could risk the disclosure of all or part of your protected health information
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice, even if you have an electronic copy

Galen Medical Group's Duties We are required by law to maintain the privacy of your protected health information, to provide you with this notice of our legal duties and privacy practices regarding protected health information, to notify you of a breach of any unsecured protected health information as defined by applicable regulations, and to abide by the terms of this notice then currently in effect.

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit and on our website, unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department of the Galen Medical Group office which you are a patient.

Requests for Restrictions on Protected Health Information You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to agree with your request in certain situations, including emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, disclosures to your health plan unless you pay out of pocket in full for the item or service, and any uses and disclosures described on the front page of the Notice. However, if we decide to grant your request, we are bound by our agreement.

Nondiscrimination Galen Medical Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Galen Medical Group will make available language assistance services free of charge.

Complaints If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: HIPAA Privacy Officer, Galen Medical Group, P.C., 5600 Brainerd Road H-100, Chattanooga, TN 37411

If you believe that your privacy rights have been violated, you should call the matter to our attention by calling the Privacy Officer at 423-308-0280 and press option 8, or by sending an e-mail to privacy@galenmedical.com or a letter describing the cause of your concern to the address provided. You may also address any complaint to the United States Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Health Information Practices. I understand Galen Medical Group, P.C. has the right to change this Notice at any time, subject to Galen's obligation to inform me of material changes.

_____ Date:_____

Signature of Patient or Legal Representative

_____ _____

Print Name of Person Signing

Relationship to Patient, *if signed by legal representative*