giCARE FOR KIDS

993-D Johnson Ferry Road, N.E.
Suite 440, Atlanta, GA 30342
404-257-0799

Jeffrey A. Blumenthal, M.D.
Stanley A. Cohen, M.D.
Jose M. Garza, M.D.
Benjamin D. Gold, M.D.
Jay A. Hochman, M.D.
L. Glen Lewis, M.D.
Jeffery D. Lewis, M.D.
Steven Liu, M.D.
Seth B. Marcus, M.D.
William F. Meyers, M.D.
Aminu Mohammed, M.D.
Dinesh G. Patel, M.D.
Edith S. Pilzer, M.D.
Larry M. Saripkin, M.D.
Olga M. Sherrod, M.D.

Fax (404) 256-5475 - Nurse's Line

Dear Parents,

The enclosed forms will provide us with very important information needed for the diagnosis of your child's illness. Please take your time to complete this form as accurately as possible and bring it with you to your first appointment. Please **DO NOT** mail this form back to our office. If you have copies of medical records or x-rays relating to your child's condition, please **BRING** these to be reviewed during the visit.

Your first appointment consists of a comprehensive history and physical. We will then fully explain our findings and recommendations. If additional testing is necessary this will be fully explained. Please try to limit the amount of family members accompanying the patient due to the lack of space in the waiting area and consultation rooms. The fee for the evaluation depends on the complexity of your child's medical problems and normally starts at $355.00, if you are self-pay. There are additional charges for lab work, if necessary. If lab work or other testing is done outside of our office it will be billed separately by that facility.

Patients covered by insurance will need to bring their insurance card and parent's driver's license for the visit as we will need to make a copy for our records to file your insurance claims. Patients will need to present both cards at every visit to be verified in the future as well. If you are covered by a managed care plan, which requires a referral from your child's primary care physician, it will be your responsibility to make sure it is in place for the visit.

If you have been instructed to bring a stool sample, please collect it no more than 24 hours before the appointment and refrigerate it until you come to our office.

If you child is over the age of 2 years, please bring a recent picture of him/her for our chart. If the child is under the age of 2, please bring a family photo.

Visit our website www.gicareforkids.com for directions and location information. We look forward to meeting you and your child. Thank you.

Your appointment is scheduled with Dr._____

at our_____location on_____

at _____ AM / PM.

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Patient Name: _____

FAMILY HISTORY

	AGE	HEIGHT	WEIGHT	MEDICAL PROBLEMS
Patient's father				
Patient's mother				
Brothers/Sisters (B/S)				
(B/S)				
(B/S)				
(B/S)				

Check all problems that apply to patient and family members and label using the following abbreviations: M- Mother, F - father, B - brother, S - sister, MGM - maternal grandmother, PGM - paternal grandmother, MGF - maternal grandfather, PGF - paternal grandfather, MA - maternal aunt, PA - paternal aunt, MU - maternal uncle, PU - paternal uncle, P - patient.

- ☐ Abdominal Pain
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Vomiting
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eczema
- ☐ Food Allergies
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Headache/Migraine
- ☐ Intestinal Polyps
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Psychiatric Problems
- ☐ Stomach Ulcers
- ☐ Seizures/Epilepsy
- ☐ Thyroid Problems
- ☐ Ulcerative Colitis

SOCIAL HISTORY

Who lives in child's home? _____

Is patient adopted or in foster care? ☐ Yes ☐ No

Grade level? Daycare Preschool Pre-K Kindergarten 1 2 3 4 5 6 7 8 9 10 11 12 College

Has child repeated grade? Is so, when and why? _____

Missing school? _____ # of days/months Missing school activities? ☐ Yes ☐ No

Recent travel or camping? ☐ Yes ☐ No Where and when? _____

Exposure to creek, lake, or well water? ☐ Yes ☐ No Where? _____

Is patient around animals? What kind? _____

Emotional problems? _____

Family stressors? (Financial, marital, moves, deaths, illnesses, new school, bullying)? _____

_____

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Patient Name: _____

PLEASE BRING A COPY OF LAB AND XRAY RESULTS TO OUR OFFICE WITH YOU.
ALSO BRING GROWTH CHART IF HERE FOR WEIGHT PROBLEMS.

MEDICATION ALLERGIES & REACTIONS:

_____

REASON FOR GI EVALUATION: _____

_____

How long have symptoms been present? _____Weight change (gain or loss)? _____ Pounds

What test have been done and where were they done? **PLEASE BRING RESULTS TO OUR OFFICE**

Blood tests: _____

Stool or urine tests: _____

X-Rays/Procedures: _____

What treatments/medications have been tried? (when and how long?):_____

_____

Current medications and dosages: _____

_____

_____

Vitamins/supplements/OTC meds: _____

CURRENT DIET

Infants:_____ Breast fed _____ Formula fed (which formula):_____

Other formulas tried: _____

Toddlers and older: _____ Regular diet _____ Special diet (please describe):_____

PATIENT HISTORY

Birth weight and length:_____ Full Term _____ Preterm (# of weeks): _____

Problems at birth/Problems with pregnancy:___

_____

Past Medical history/other medical/Psychiatric Illnesses: _____

_____

_____

Past hospitalizations and surgeries (list dates and age): _____

_____

_____

_____

_____

CHILDREN'S CENTER FOR DIGESTIVE HEALTH CARE/GI CARE FOR KIDS

NOTICE OF PRIVACY PRACTICES

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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact [insert name], Privacy Officer, [insert phone number], [insert address]. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**

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Practice Financial Policies

Patient Name: _____ **Appointment:** _____

The adult accompanying the patient is considered the responsible party for the services billed.

Responsible Party Name: _____

Children's Center for Digestive Healthcare (CCDHC) is committed to meeting your child's health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this we ask that you adhere to the following guidelines. **Please initial** on each line.

• _____ All co-payments, co-insurance, and deductibles are due **at the time of service**, or **before** your procedure, as per our contract with your insurance carrier. If not paid, a $25 service fee will be assessed. We accept **check**, **cash**, **MasterCard**, and **Visa**. Any check dishonored by your bank may result in a $30 returned check charge being added to your account and your account going to a cash only payment basis.

• _____ It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. If you do not have proof of current insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in full that day.

• _____ It is your responsibility to provide us with any legal documentation or divorce decree dictating a specific parent/guardian responsible for primary health coverage.

• _____ It is your responsibility to contact your insurance carrier to confirm that our physicians participate on your plan and you understand your insurance benefits and requirements.

• _____ If we do not have a contract with your insurance provider you will be responsible for the entire bill at time of service. We can provide you with an encounter form to file the claim with your insurance carrier if needed.

• _____ If your child has a procedure, our doctors will bill ONLY for their services. You should receive a separate bill from the facility or other providers. (Ex. Anesthesia, lab, etc.)

• _____ If you miss your appointment and/or cancel your appointment within 24 hours of your appointment time, you may be charged a **"No-Show" fee of $50** for that appointment.

• _____ All medical records requests must be in writing and received in our office 7-10 days prior to the date needed. Records will only be mailed, and all medical records requests will have a fee based on the number of pages.

• _____ It is our policy that we will continue to bill the parent once the child turns 18 unless otherwise notified.

• _____ We do not validate parking. The maximum fee for parking is $6.00. They take checks, cash and credit cards. There is an ATM on the 2nd floor of our building if needed.

• _____ **Please be aware that this is a specialty office and you cold experience long wait times.**

Responsible Party Signature: _____ **Date:** _____

GI CARE FOR KIDS, L.L.C

PATIENT INFORMATION

Patient's Legal Name: _____ Nickname: _____

Date of Birth:_____/_____/_____ Sex: Male Female

Address: _____

City: _____ ST:_____ Zip Code:_____ Best Contact #: _____

Email: _____ **Preferred Pharmacy:** _____

Pharmacy Address: _____ Pharmacy Phone: _____

(Required Questions Per Government Meaningful Use) **Please CIRCLE ONE ON EACH QUESTION Below**

ETHNICITY: Hispanic or Latino / Non Hispanic or Latino / Patient Not Present / Unknown / Declined

RACE: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander White / Declined / Unknown / Patient Not Present

Preferred appointment confirmation method: (Please circle one) Text Email Phone

PARENTS' INFORMATION

Mother's Information	***Father's Information***
Name: _____ DOB: _____	Name: _____ DOB: _____
Address: _____	Address: _____
City: _____ State:_____ Zip: _____	City: _____ State:_____ Zip: _____
Home Ph #: _____ Cell #:_____	Home Ph #: _____ Cell #:_____
Employer: _____ Occupation:_____	Employer: _____ Occupation:_____
Work #: _____	Work #: _____

With whom does the child live? ☐ Mom & Dad together ☐ Mom ☐ Dad ☐ Other: _____

Who has Legal custody? ☐ Mom & Dad together ☐ Mom ☐ Dad ☐ Other: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relation: _____ Phone # : _____

PEDIATRICIAN INFORMATION

Primary Care Physician (PCP): _____

Address: _____ Phone #: _____ Fax #: _____

If referred by another physician, Who? _____

INSURANCE INFORMATION

Is there a court order/divorce decree dictating who is responsible for primary health coverage? ☐ Yes ☐ No

If so, Who is listed?: _____

Primary Insurance Company:_____ Insurance Phone #:_____

Policy Holder's Name:_____ Policy Holder's DOB:_____

Policy Effective Date: ___/___/___ ID #:_____ Group #:_____

Secondary Insurance Company: _____ Insurance Phone #:_____

Policy Holder's Name:_____ Policy Holder's DOB:_____

Policy Effective Date: ___/___/___ ID #:_____ Group #:_____

AUTHORIZATION

- **I authorize that I brought in the patient and I am responsible for payment for services rendered to my dependant.**
- I authorize the release of medical information necessary to process my insurance claim for services rendered by CCDHC.
- I authorize payment of medical benefits to CCDHC for medical treatment rendered to my dependant.
- I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signed _____ Print _____ Date_____