SANDBAR Pediatrics
BRUNSWICK, GA

Bejamin Sandifer, MD | John Fisher, FNP-C

PATIENT DEMOGRAPHIC INFORMATION **Today's Date:** _____

Last Name:_____First Name: _____MI.: ____ Nickname: _____

Date of Birth: ____/____/____ Age: _____ Male or Female Race: _____

Mailing Address: _____City/State:_____Zip Code: _____

Primary Phone Number:_____Alternate Phone Number: _____

RESPONSIBLE PARTY INFORMATION:

Parent/Legal Guardian 1:
Name: _____
Date of birth: _____
Relation to Patient: _____
Primary Phone: _____
Alternate Phone: _____
Employer: _____
Work Phone: _____

Parent/Legal Guardian 2:
Name: _____
Date of birth: _____
Relation to Patient: _____
Primary Phone: _____
Alternate Phone: _____
Employer: _____
Work Phone: _____

INSURANCE INFORMATION:

Primary Insurance:
Insurance Company: _____
Member ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Social Security #: _____
Relation to Patient: _____

Secondary Insurance:
Insurance Company: _____
Member ID Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Social Security #: _____
Relation to Patient: _____

PHARMACY INFORMATION

Name: _____ Address: _____ Phone Number: _____

PATIENT PORTAL

Sandbar Pediatrics offers a patient portal, where you can access your child's medical information online, anytime, as well as schedule appointments, and send communications to office staff. Please provide us with your email if you would like to sign up.

Email Address:_____

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Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your child's immunizations at a reduced fee. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: _____ **Date of Birth:** _____

Parent/Guardian: _____

INELIGIBLE FOR STATE-SUPPLIED VACCINE ***(Check if applicable)***

☐ The child 18 years of age or younger has insurance that pays for immunizations. (*Fully-insured / Private Pay, includes high deductible plans*)

ELIGIBLE FOR STATE-SUPPLIED VACCINE

This child 18 years of age or younger qualifies for vaccination with state-supplied vaccine because (*check only one box*):

☐ The child is enrolled in Medicaid
☐ The child is American Indian or Alaska Native
☐ The child does not have health insurance (*Not Insured*)
☐ The child has health insurance that does not pay for vaccines (*Underinsured*)
☐ The child is enrolled in PeachCare for Kids

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. ***While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.***

HIPAA Contacts

Please list anyone you wish to receive test results, medical, or billing information on your behalf, including anyone you wish to accompany your child to office visits. **Only people on this list may bring the patient to an appointment**.

Name	Relationship to Child	Phone Number

X _____ _____ _____

Print Name (Parent/Guardian if Patient is under 18) Signature Date

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Patient Name: _____ Patient DOB: _____

Financial, Privacy, and Treatment Policies & Procedures Authorization and Agreement

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the patient and that such medical care, treatment, and procedures will be performed by Sandbar Pediatrics employees. I hereby grant my authorization and consent to such treatment and procedures and certify that no guarantee or assurance has been made to the results which may be obtained.

RELEASE OF MEDICAL INFORMATION: I hereby authorize Sandbar Pediatrics to release my medical information in connection with these services for health insurance purposes or to the patient's personal physician or to a referral physician. I authorize direct payment of all benefits to Sandbar Pediatrics and authorize submission of insurance forms with this signature on file.

FINANCIAL RESPONSIBILITY: I understand that I must provide proof of insurance at each visit. If I do not have insurance, are unable to provide proof of insurance, or are on a plan in which the Practice does not participate, I will be considered a self-pay patient. Full payment for self-pay patients is required at the time of service. It is my responsibility to be aware of any lapses in coverage and to notify the Practice of any changes. **Co-payments are due at the time of service. This is a contract between you and the insurance carrier and must be collected. For scheduled appointments, prior balances must be paid prior to the visit.**
Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. Any service determined not to be covered by your plan will be your responsibility.

NO SHOW POLICY: We understand that events may occur that keep you from attending your scheduled appointment, however, you need to let us know in advance. This will allow us to see other patients who may need to be seen during that time. Our policy is that if a patient misses three visits without notification within a 12-month time period, we reserve the right to dismiss the patient.

MEDICAL RECORDS/FORM FEES: Medical records are the property of the Practice. I may request copies of medical records by completing a medical records request form. Copies required for the continuation of care are free of charge. All other copies are subject to processing costs, as permitted by law (GA Code § 31-33-3). The Practice will provide copies within 30 days of receiving a written request. Medical forms 3300, 3231 and Sports Physical forms for services performed during well child visits will be given at the time of service. FMLA forms or any additional forms are subject to a $25.00 fee. Medical form requests require 72 hours for processing.

STUDENT OBSERVATION/ASSISTANCE: I consent that students, including fellows, residents, Physician Assistants students, Medical Students, interns, clinical nursing or technical students, and manufacturing or company representatives, may observe or assist in the care which will be undertaken at Sandbar Pediatrics.

PATIENT ACKNOWLEDGEMENT: I acknowledge that I have been provided with an opportunity to receive the *Sandbar Pediatrics* Notice of Privacy Practices and have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that I may request a printed copy of the Notice at any time. I also understand Sandbar Pediatric providers may use ambient listening technology, which is software that records information spoken by me, my personal representatives, and my care team and transcribes the information into my medical record. I can opt out of the use of this technology at any time by informing my care team. I further acknowledge that I may request a chaperone during my care, even when I have brought another person with me. For certain examinations, a chaperone will be provided automatically. If I want a chaperone, I will notify my care team.

I have read and fully understand the above acknowledgments and agreements.

X _____ _____ _____

Print Name (Parent/Guardian if Patient is under 18) Signature Date