



DR. BRITTANY WILSON

3610 PIEDMONT RD NE, SUITE 100, ATLANTA, GA 30305

DATE: _____

CHILD'S FULL NAME:

FIRST

MIDDLE

LAST

_____ SEX: ☐ M ☐ F AGE: _____

DATE OF BIRTH: _____ RACE: ☐ WHITE/CAUC ☐ BLACK/AFR-AMER ☐ HISPANIC/LAT ☐ OTHER

ADDRESS: _____
NO. & STREET APT CITY COUNTY ZIP CODE

HOME PHONE #: _____

PARENT'S INFORMATION:

FATHER'S NAME: _____ S.S. # _____

FATHER'S DATE OF BIRTH: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

CELL PHONE #: _____

MOTHER'S NAME: _____ S.S. # _____

MOTHER'S DATE OF BIRTH: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE: _____

CELL PHONE #: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER D.O.B: _____ Group #: _____

SECONDARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER NAME: _____ SUBSCRIBER D.O.B: _____ Group#: _____

IN CASE OF EMERGENCY, NOTIFY (OTHER THAN PARENTS):

NAME: _____ PHONE: _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____

I hereby authorize Lighthouse Pediatrics to give my child total Pediatric Care, also to release medical information when and if requested by insurance company.

SIGNED: _____ RELATIONSHIP: _____



3610 PIEDMONT RD NE, SUITE 100
ATLANTA, GA 30305
PHONE: 470-697-1396
FAX: 404-806-6688

OFFICE POLICY ON PAYMENT, MANAGED CARE, INSURANCE & APPOINTMENTS

PLEASE READ CAREFULLY! YOUR SIGNATURE INDICATES AGREEMENT.

At Lighthouse Pediatrics we partner with parents to build bright futures for all of our patients. We believe that excellent pediatric care starts with establishing partnership with parents. The administrative/financial policy is designed to ensure you understand your responsibilities as we commit to provide you with excellent healthcare along with stellar service.

Co-pays: All co-pays are to be paid at the time of the visit prior to being seen.

Deductibles: Are the responsibility of the patient. A fee of \$140 will be collected towards ALL Sick visit appointments (i.e. non-well check appointments including sick child, medicine rechecks, growth checks, etc.) that have not met the annual deductible(s) as stated with your insurance when health benefits and coverages are verified. The fee will be collected on the day of service prior to being seen. The above fee is subject to change based on insurance fees.

Co-insurances: Are the responsibility of the patient. Based on your coinsurance percentage set by your insurance plan, we will calculate a payment due at the time of service (using \$140 as the estimated total amount) for ALL sick appointments. Any additional coinsurance fees determined to be patient responsibility by your insurance will be due for payment within 30 days. The above estimated total amount is subject to change based on insurance fees.

Insurance: As a courtesy to you, we will bill your insurance company directly if we are contracted with them after your visit. Insurance companies that we are not contracted with will require the self-pay rate to be paid prior to the visit. Any remaining balance that the insurance company advises us is your responsibility, such as deductibles or non-covered benefits, will be billed to you and payment will be expected within 30 days from the statement date. Note: Co-pays, deductibles, and co-insurance balances from *primary* insurances will *not* be billed to secondary insurances. If payment is not received within 30 days from your primary and/or secondary insurance(s) or payment arrangements made, your account will be reviewed for collections action.

If we cannot verify that your insurance is current, you will be responsible for payment in full at the time of services. If the insurance claim has been denied after submission for reimbursement for services, you will be responsible for the balance.

If you do not have insurance, we will provide an estimate for all services that will be rendered at the time of service. You will need to pay this estimate in full on the day of your appointment in order to be seen.

It is your responsibility to inform the office and doctor/nurse if your insurance requires you to use a specific lab or other outside facility for treatment or testing. Failure to do so may result in charges that your insurance company does not cover.

Account Balances: In the event you are unable to pay your balance in full, you must contact our office promptly to discuss your balance. All balances are expected to be paid in full prior to your next visit. If/When balances are not paid within 60 days, your account will be forwarded to collections for payment and reported to the credit bureaus.

Method of Payment: We accept cash, Visa, MasterCard, American Express, Debit Cards and HSA Cards. We do *not* accept Chime payment cards or checks.

Divorced, Separated, or Blended Families: Lighthouse Pediatrics will not become involved in any agreement,

understanding, and/or court orders. As always, payment is expected at the time of service. If reimbursement is to be from an absent parent, it is your responsibility to collect this reimbursement, not the responsibility of Lighthouse Pediatrics.

Appointment Confirmations: We attempt to confirm all future appointments starting one week prior to the appointment date. Appointments made seven days or less into the future are automatically confirmed. All other confirmations must be responded to via text inquiry, calling the office, via email, or via patient portal messaging. Appointments that are not confirmed within a 48-hour timeframe prior to the appointment time are subject to cancellation.

Late Policy: There is a **10 MINUTE GRACE PERIOD** for appointments, **except for initial appointments, 8:00AM, 11:00AM hour, 1:00PM and 4:00PM hour** appointments. Lighthouse Pediatrics reserves the right to ask you to reschedule for late appointments.

Missed Appointment/No show Administrative Fee: In the event you do not give a 24-hour notice for cancellation of a Well Visit or notify the office prior to a Sick Visit appointment time, this will generate a **Missed Appointment/No show fee of \$75.00** per child, per appointment for Well or Sick visits. This fee is your responsibility and **MUST** be paid prior to scheduling any other appointments. Appointments can be cancelled through phone call, the answering service, email, or portal. Repeated No Show violations may result in dismissal from the practice. This fee is subject to change.

Prescription Refills: Prescription refill requests must be made during office hours so that your child's chart is accessible to the Provider. Please have your pharmacy telephone number/location available when you call. Your prescription will be addressed within 1-3 business days.

Release of Medical Records: You must complete a Medical Release Form. The records will then be sent to you or to whom you have designated. All medical records will be sent electronically. If there is a balance on the account, it must be paid in full before records are sent. Paper or mailed record requests will be charged fees subject to standard rates.

Forms: We require up to three (3) business days to complete camp, sports, health, or immunization forms. Fees may apply depending on the type of form.

After Hour and Weekend Appointments Fee: Lighthouse Pediatrics offers concierge services for after-hours and weekend appointments. There is an additional concierge fee for services as well as the normal office visit costs. The concierge fee must be paid at the time of scheduling the appointment, this fee cannot be billed to your insurance company. All deductibles and co-payments are not included with the concierge fee and will be collected before service.

PATIENT COPY



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ATLANTA, GA 30305
PHONE: 470-697-1396
FAX: 404-806-6688

OFFICE POLICY & PAYMENT AGREEMENT

I have read and understand the Patient Information form, Administrative Policies, and Payment Policies provided to me by Lighthouse Pediatrics and do hereby confirm that all of the information I have submitted in the completion of this form is true and correct, to the best of my knowledge.

I also agree to notify Lighthouse Pediatrics of any changes in the information I have provided, either health status or general patient information, on a timely basis or upon my next scheduled appointment with Lighthouse Pediatrics.

I hereby acknowledge that I am ultimately responsible for the full payment of any and all fees or charges for services provided to me by Lighthouse Pediatrics and that the filling of insurance claims with my health care insurance coverage I may hold is a courtesy to me, and does not in any way relieve me of financial responsibility for any balance remaining after insurance payments, including any amount that exceeds my insurance company's usual, reasonable, and customary rate.

PLEASE NOTE: If we are a participating provider with your insurance company, we will follow the contractual obligations.

I understand that if this visit has not been authorized by my Primary Care Physician and I have no referral number, the service(s) I receive may not be covered by my health care benefits plan and I will be responsible for payment in full for services rendered. (NOTE: This paragraph includes patients who require a referral number from their PCP and/or patients who require Primary Care Physician designation prior to their office visit for their insurance to cover costs, e.g. HMO plans.)

I also understand that certain procedures may not be covered by my insurance plan and that if I request a non-covered service, I will be financially responsible for those services and agree to pay any and all non-covered fees and charges. (NOTE: This paragraph includes patients with Medicaid.)

I am aware that my co-pay, co-insurance and/or deductible are due at the time services are rendered.

I understand that if my account should ever be turned over to a "collection agency", I will be responsible for any and all collection costs, interest fees for late payments, attorney fees, and any court costs.

Patient's Name

Date of Birth

Guardian/Insured Signature

Date



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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

NAME OF PATIENT: _____

DATE OF BIRTH: _____

I hereby acknowledge that I have the option to receive a copy or read the Notice of Privacy Practices from Lighthouse Pediatrics. A digital copy of the HIPAA Policy was also made available to me on Lighthouse Pediatrics's website at www.lighthousepediatriccare.com.

SIGNATURE OF PARENT/GUARDIAN

DATE



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LATE ARRIVAL POLICY

Our doctors and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 10 minutes late for an appointment, the appointment may need to be rescheduled. The 8:00 am, 11:00 -11:45 am, 1:00 pm, and 4:00 – 4:45 pm appointment slots do not have grace periods. Patients must be on time or early to be seen. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment on the same day if one is available. We ask that you contact the office via phone if you are running late for your appointment time, so that we can reschedule the appointment if needed. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our patients.

Appointments that are missed or not canceled less than 24 hours prior to the scheduled appointment are subject to being charged a missed appointment fee of \$75.00 (fee subject to change). Lighthouse Pediatrics reserves the right to not provide medical care to children whose Parents/Guarantors refuse to sign and comply with our financial and late policy.

New patients are encouraged to fill in new patient paperwork from the website and print it out or email it to office@lighthousepediatriccare.com prior to coming in. New patients must arrive to our office at least 15 minutes prior to the scheduled appointment. *The above mentioned 10-minute grace period does not apply to new patient visits.*

Date: _____

Child's Name: _____

Child's D.O.B.: _____

Parent/Guardian's Name: _____

Parent/Guardian Signature: _____



PARENT'S PREFERRED METHOD OF CONTACT

For notification of **MEDICAL ISSUES**, I prefer to receive (***pick ONE***)

- ☐ A CALL on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A CALL on my WORK phone
- ☐ A TEXT to my CELL phone
- ☐ An email to my HOME EMAIL
- ☐ An email to my WORK EMAIL

For **REMINDERS OF UPCOMING APPOINTMENTS**, I prefer to receive (***pick ONE***)

- ☐ A CALL on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A CALL on my WORK phone
- ☐ A TEXT on my CELL phone
- ☐ An email to my HOME EMAIL
- ☐ An email to my WORK EMAIL

For **GENERAL NOTIFICATIONS/RECALLS**, I prefer to receive (***pick ONE***)

- ☐ A call on my HOME phone
- ☐ A CALL on my CELL phone
- ☐ A TEXT on my CELL phone
- ☐ An email to my HOME EMAIL
- ☐ An email to my WORK EMAIL

ALL BILLING STATEMENTS will be **MAILED TO YOUR HOME ADDRESS**, but are also available through your patient portal account.

Child's Name: _____

D.O.B.: _____

Home Email: _____

Work email: _____



WHO HAS PERMISSION TO BRING MY CHILD TO THE DOCTOR (Proxy Form)
Photo ID from the individuals listed below must be provided at time of visit

Date: _____

Name of Child: _____

Child's Date of Birth: _____

Name of Person #1: _____

Relationship to Child: _____

Contact Number: _____

Name of Person #2: _____

Relationship to Child: _____

Contact Number: _____

Name of Person #3: _____

Relationship to Child: _____

Contact Number: _____

I give permission for the above listed individual(s) to transport my child to and from the doctor's office, to provide medical information about my child, to receive medical advice/instructions pertaining to my child, and to make medical decisions pertaining to my child at the time of the visit.

Parent/Guardian's Signature: _____

Date: _____