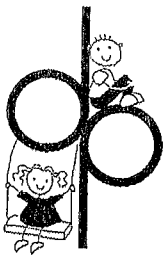

DUNWOODY PEDIATRICS

PATIENT INFORMATION FORM

How did you hear about us:

_____

_____

Patient Name: (Last, First, MI)		Today's Date (mm/dd/yyyy)
Address		City, State, Zip Code
Home Phone Number:		Email Address:
Please circle one below: Male Female	Date of Birth	Social Security Number
Legal Guardian (if other than parent):		Relationship:
Emergency Contact and Phone #:		

PARENT'S INFORMATION:

Parent 1	Marital Status: S M W D Sep	Parent 2	Marital Status: S M W D Sep
Address:		Address:	
Employer:		Employer:	
Work Phone:	Cell Phone:	Work Phone:	Cell Phone:
SS#	DOB:	SS#	DOB:

PRIMARY INSURANCE COMPANY INFORMATION

Name of Insurance Company:	Policy Holder DOB:
Policy Holders Name:	Policy/Member #:
Address:	City/State/Zip
Effective Date:	Group #:

SECONDARY INSURANCE COMPANY INFORMATION

Name of Insurance Company:	Policy Holder DOB:
Policy Holders Name:	Policy/Member #:
Address:	City/State/Zip
Effective Date:	Group #:

SIBLING'S NAMES AND DATES OF BIRTH

1.	DOB:	4.	DOB:
2.	DOB:	5.	DOB:
3.	DOB:	6.	DOB:

I, the undersigned, agree to permit Dunwoody Pediatrics, LLC to render medical services to my child. I also authorize the release of any medical or other information necessary to process my child's insurance claim. This release includes release of medical information to other doctors or to insurance companies. I authorize payment to be made directly to Dunwoody Pediatrics for services rendered and I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature: **Date:**

THANK YOU!

Revised 02/2020
Dunwoody Pediatrics form #021

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____ Date:________________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____ Date:________________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____ Date:________________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____ Date:________________________

I verify that all information on the front side of this sheet is accurate. I agree to permit Dunwoody Pediatrics to process my child's insurance claims. This release includes release of medical information to other doctors for medical treatment or to insurance companies with payment to be made directly to Dunwoody Pediatrics for services rendered.

Signature:____ Date:________________________

PATIENT MEDICAL HISTORY FORM

Date: Name: DOB:

BIRTH HISTORY

Birth Weight_____
Mom's age _____
Premature? Y N
Vaginal or Ceasarean ?

Birthplace _____
During pregnancy did mom:
smoke? Y N drink? Y N
use other drugs or medications? Y N

Any issues after birth?
(jaundice, feeding, respiratory)
_____
_____

MEDICAL HISTORY

	Y	N	Explain
Has your child ever been hosptitalized?			
Has your child ever had surgery?			
Any serious accidents or injuries?			
Any chronic medical conditions?			
Daily medications?			
Reactions to immunizations?			
Does your child have now, or has he/she ever had...			
Asthma or recurrent wheezing			
Allergic rhinitis or eczema			
Recurrent ear infections or hearing concerns			
Problems with eyes or vision			
Frequent headaches or migraines			
Genetic or Metabolic disorders			
Gastrointestinal issues			
Bladder or kidney infections			
Heart problems, murmurs, high blood pressure			
Anemia or bleeding problems			
Endocrine issues (thyroid, growth, diabetes)			
History of cancer			
Mental health issues (ADHD, anxiety/ depression)			
Any other medical conditions?			
Does your child see any specialists?			
Has your child received OT/PT/ Speech therapy?			

Any other medical conditions not listed above?_____

_____

_____

_____

_____

FAMILY HISTORY QUESTIONNAIRE

PATIENT INFORMATION:
Date: _____ (use back of sheet for additional children)
Person Filling out this form: _____ Relationship to child: _____

Child #1: _____ M F DOB_____
Child #2: _____ M F DOB_____
Child #3: _____ M F DOB_____
Child #4: _____ M F DOB_____

FAMILY HISTORY: PLEASE CHECK IF CHILD'S BIOLOGICAL RELATIVES HAVE ANY OF THESE CONDITIONS. USE THE BOTTOM OF THIS FORM IF EXTRA SPACE IS NEEDED.

	Y	N	Who was affected?	Explain
1. Allergies (Asthma, Eczema, Hay Fever)				
2. Blood disorders (Bleeding, Clotting, Sickle Cell, Anemia)				
3. Bone/ Joint/ Rheumatic disorders				
4. Cancer				
5. High Cholesterol				
6. Diabetes				
7. Eye problems (blindness, lazy eye, crossing eyes)				
8. Ear problems (hearing impairment or hearing aid)				
9. Gastrointestinal Disorders (Celiac, Crohns, Ulcerative Colitis, GERD)				
10. Genetic disorders or Birth Defects (Cystic Fibrosis, Downs syndrome, Cleft Lip, Club Foot, Hip Dysplasia)				
11. Heart disease (Heart Attacks, arrhythmia)				
12. Hypertension/ high blood pressure				
13. Infectious diseases or problems with immune system (HIV, Tb, Immunodeficiency)				
14. Kidney problems				
15. Nervous system disorders (migraines, seizures, epilepsy)				
16. Obesity				
17. Psychiatric conditions (Depression, Anxiety, ADHD)				
18. Thyroid problems				
19. Alcoholism or Drug dependence				
20. Regular Smoker				
21. Other				

Reviewed by:_____

Julius Sherwinter, M.D.
A. Gerald Reisman, M.D.
Terrence Gfroerer, M.D.
Linda S. Kelly, M.D.
Samantha Nowak, P.A.

DUNWOODY PEDIATRICS

Gloria Ana Berenson, M.D.
Kelly Wilburn, M.D.
Mustafa Quraishi, M.D.
Kathryn Bland, C.N.P.

1428 Dunwoody Village Parkway • Dunwoody,GA 30338 • 770-394-2358 • Fax: 770-394-3055
The Pediatric Center • 3300 Old Milton Parkway • Suite 200 • Alpharetta, GA 30005 • 770-664-9299 • Fax: 770-667-1704

Patient's Name:_____DOB:_____

This notice shall act as my authorization, as the parent/legal guardian of the above named patient to have treatment and/or be seen by Dunwoody Pediatrics in my absence. The persons listed below have my authorization to bring the above named patient/child to be seen by the Providers and staff at Dunwoody Pediatrics. I understand that I must have an authorization on file for each individual child/patient.

I understand and agree that this permission will cover any future appointments at Dunwoody Pediatrics until and unless I revoke this authorization in writing.

Only the names of the persons listed below on this form are authorized to bring my child in for treatment. (Please PRINT). Caregiver must bring photo ID.

1)_____ 2)_____

3)_____ 4)_____

_____ _____

Parent/Legal Guardian's Signature Date

_____

Please clearly Print name of Parent/Guardian

Julius Sherwinter, M.D.
A. Gerald Reisman, M.D.
Terrence Gfroerer, M.D.
Linda S. Kelly, M.D.
Samantha Nowak, P.A.-C

DUNWOODY PEDIATRICS

Gloria Ana Berenson, M.D.
Kelly Wilburn, M.D.
Kathryn Bland, C.P.N.P.
Crystal Mansfield, C.F.N.P.

MISSED APPOINTMENT / NO SHOW ADMINISTRATIVE FEE

Appointments are on a scheduled basis only, which means that the Provider's time is blocked specifically for them to see your child. In the even you are unable to make the appointment a 24-hour notice is required, so that we may accomodate other patients.

In the event you do not give a 24 hour notice, this fee will generate a Missed Appointment/No Show Administrative Fee of $40.00 per child, per appointment. This fee will not, and cannot be charged to your insurance company; rather, you will be responsible for payment in full. This fee must be paid prior to scheduling any other appointments.

I acknowledge that I have read and understand Dunwoody Pediatrics Missed Appointment/NO Show Fee.

_____ _____

Signature of Responsible Party Date

Child's Name: _____ DOB: _____

Julius Sherwinter, M.D.
A. Gerald Reisman, M.D.
Terrence Gfroerer, M.D.
Linda S. Kelly, M.D.
Samantha Nowak, P.A.

DUNWOODY PEDIATRICS

Gloria Ana Berenson, M.D.
Kelly Wilburn, M.D.
Mustafa Quraishi, M.D.
Kathryn Bland, C.N.P.

Patient Name _____ Date of Birth _____

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors or insurance companies for referrals or continuing medical care. I authorize Dunwoody Pediatrics to access pharmacy records from outside providers to ensure continuity of care.

I authorize payment of medical benefits to Dunwoody Pediatrics for services rendered. I agree to pay Dunwoody Pediatrics for any services not approved or covered by my insurance company.

Signature of Parent/Guardian/Patient _____ Date _____

Revised 05/01/2018
Dunwoody Form #109

Dunwoody Pediatrics

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Patient Name:_____Date of Birth:_____

I, _____, have had the opportunity to review a
(Please Print)

copy of Dunwoody Pediatrics Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent/Guardian Date

_____
Relationship to Patient

FOR INTERNAL PURPOSES ONLY

Patient/Parent/Guardian Refused to sign _____ _____
(Date) *(Initials)*

_____

I hereby grant permission to Dunwoody Pediatrics to contact me and/or leave a message at either my home or work place. These numbers are on file and can be used to confirm an appointment, to notify me that test results are available, to notify me that a form or prescription is ready for pick-up or to conduct any other relevant business that is deemed necessary.

Personal or detailed information will not be left on an answering machine or voice mail.

_____
Signature of Patient/Parent/Guardian

FOR INTERNAL PURPOSES ONLY

Patient/Parent/Guardian Refused to sign _____ _____
(Date) *(Initials)*

Administrative Policies
Dunwoody Pediatrics

We at Dunwoody Pediatrics are committed to offering the best possible medical care for your children. In order to provide this, we need you to be aware of and understand our Administrative policies. Please review these below.

Co-pays: All co-pays are to be paid at the time of the visit. In the event we have to bill you for the co-pay, a $15.00 administrative fee will be added to your account.

Insurance: If we are contracted with your insurance company, we will bill them directly, after you have paid your co-pay. 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. If payment is not received within 30 days, or payment arrangements made, your account will be reviewed for collection action.

If we cannot verify that your insurance is current, you will be responsible for payment in full at the time of services or you can choose to reschedule.

Payment Arrangements: In the event you are unable to pay your balance in full, you must contact our Business Office promptly to make monthly payment arrangements. Payments will be based on your balance and payment arrangements cannot exceed 6 months. In the event you are unable to make a payment, you must contact our billing department
or your account will be sent to our Collection Agency.

Method of Payment: We accept cash, checks, Visa, MasterCard and Debit Cards.

Returned Checks: There is a fee of $35.00 for all returned checks.

Divorced, Separated or Blended Families: Dunwoody 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 Dunwoody Pediatrics responsibility.

Late Policy: If you are more than 10 minutes late for your appointment, you may have to reschedule, or you may have to be bumped to the end of the morning or afternoon session in order to be seen.

Missed Appointment/No show Administrative Fee: In the event you do not give a 24-hour notice, this will generate a Missed Appointment/No show fee of $40.00 per child, per appointment. This fee will not and cannot be charged to your insurance company; rater, you will be responsible for payment in full. This fee MUST be paid prior to scheduling any other appointments.

Prescription Refills: Prescription refills must be made during office hours so that your child's chart is accessible to the Provider. Please have your pharmacy telephone number available when you call. Your prescription will be called in by the end of the next business day.

Release of Medical Records: We do not copy records in office. These are handled by an outside agency. You must complete a Medical Release Form. The records will then be sent to you or to whom you have designated, by the outside agency along with a bill for the copying materials.

Forms: We require 10 business days to complete camp, sports, health, or immunization forms. Fees vary depending on the type of form. Please see our front desk staff for further information.

Saturday Sick Visit Administrative Fee: There is an additional fee for services rendered on Saturday's. This fee will be billed to your insurance carrier. Dunwoody Pediatrics will accept assignment of benefits and the patient will be billed per the insurance carrier EOB. Self-pay patients will pay this fee at the time of service in addition to visit fees.

Deductible: A fee of $100 will be collected towards ALL sick visit appointments that have not met the yearly deductible as stated when health benefits and coverages are verified.

_____ _____

Signature of Responsible Party Date

Revised 2/2020

Dunwoody Pediatrics – Notice Of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

A. OUR COMMITMENT TO YOUR PRIVACY:

Our practice is dedicated to maintaining the privacy of your child's individually identifiable health information (IIHI). In conducting our business, we will create records regarding your child and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: (1) How we may use and disclose your child's IIHI; (2) Your privacy rights in your child's IIHI; and (3) Our obligations concerning the use and disclosure of your child's IIHI.

The terms of this notice apply to all records containing your child's IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of the records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

A. Gerald Reisman, M.D., HIPAA Compliance Officer, 5501 Chamblee Dunwoody Road, Atlanta, GA 30338. The telephone number is 770-394-2358.

C. WE MAY USE AND DISCLOSE YOUR CHILD'S INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your child's IIHI.

1. **Treatment.** Our practice may use your child's IIHI to treat him/her. For example we may ask he/she to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your child's IIHI in order to write a prescription, or we might disclose your child's IIHI to a pharmacy when we order a prescription for him/her. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your child's IIHI in order to treat him/her or to assist others in your child's treatment. Additionally, we may disclose your child's IIHI to others who may assist in his/her care, such as your spouse, children, or parents. Finally, we may also disclose your child's IIHI to other health care providers for purposes related to his/her treatment.
2. **Payment.** Our practice may use and disclose your child's IIHI in order to bill and collect payment for the services and items he/she may receive from us. For example, we may contact your health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your child's treatment to determine if your insurer will cover, or pay for, his/treatment. We also may use and disclose your child's IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your child's IIHI to bill you directly for services and items. We may disclose your child's IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your child's IIHI to operate our business. As examples of the ways in which we may use and disclose your child's information for our operations, our practice may use your child's IIHI to evaluate the quality of care he/she received from us, or to conduct cost-management and business planning

activities for our practice. We may disclose your child's IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your child's IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your child's IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your child's IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your child's care, or who assists in taking care of him/her. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required By Law.** Our practice will use and disclose your child's IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR CHILD'S IIHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your child's identifiable health information:

1. **Public Health Risks.** Our practice may disclose your child's IIHI to public health authorities that are authorized by law to collect information for the purpose of:

   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the parent/guardian agrees or we are required or authorized by law to disclose this information
   - notifying your child's employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your child's IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your child's IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your child's IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - concerning a death we believe has resulted from criminal conduct
   - regarding criminal conduct at our office
   - in response to a warrant, summons, court order, subpoena or similar legal process
   - to identify/locate a suspect, material witness, fugitive or missing person
   - in an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)