ACKNOWLEDGEMENT & AUTHORIZATION

PLEASE READ CAREFULLY: All charges or co-payments, if applicable are due at the time of service. The patient is responsible for all fees, regardless of insurance coverage, unless the services are for a properly authorized workmen's compensation or for services covered under a contractual agreement between this Medical Practice and your insurance carrier. I realize that I am responsible for fees that are not covered by my insurance carrier. If hospitalization is indicated, the patient is responsible for ensuring that GEORGIA UROLOGY, PA is informed of the necessary pre-certification requirements.

The doctors of Georgia Pediatric Urology have an ownership interest in Children's Healthcare at Atlanta Surgery Center at Meridian Mark Plaza, LLC, 5445 Meridian Mark Road, Suite 340, Atlanta, Georgia 30342 and Horizon Lithotripsy, LLC, 175 Country Club Drive, Bldg. 300, Suite D, Stockbridge, Georgia 30281. Depending on your medical needs, you may be referred to the facilities listed above. Your ongoing care is not conditioned on your acceptance of this referral. You have the right to obtain the services from the facility to which you are referred or from a healthcare provider of your choice.

ASSIGNMENT OF BENEFITS: I hereby assign payment of medical Benefits, as may be payable to me, to GEORGIA UROLOGY, PA, for any benefits due me for medical or surgical care, by reason of such treatment rendered to me or the patient/insured.

HIPAA COMPLIANCE NOTICE: I hereby acknowledge that I have read the GEORGIA UROLOGY, PA NOTICE OF PRIVACY POLICIES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of the information for my records. Copies are available at any of our offices. GEORGIA UROLOGY, PA will abide by all HIPAA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY POLICIES.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that GEORGIA UROLOGY'S policy is to notify patients of any abnormal lab or diagnostic test results. We will notify you as soon as possible. I indicated below which results may be released and to whom that information may be released. (You may choose more than one option).

☐ Give my or my child's results to me personally. My daytime phone number is: _____
(If you are not available to speak to us, we will leave a message to call our office.)

☐ If my or my child's results are benign (within normal limits), you may leave results on my answering machine at (check all that apply):

- ☐ Home Telephone Number: _____
- ☐ Work Telephone Number: _____
- ☐ Mobile Telephone Number: _____

☐ If you cannot reach me personally, I authorize GEORGIA UROLOGY, PA to release my or my child's results to another person, specifically:

Name: _____

Relationship: _____

Daytime Phone Number: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize GEORGIA UROLOGY, PA to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means, including but not limited to, Medicare.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to, the use of lab and radiographic studies) as ordered by my child's attending physician. I have read this consent, am aware of its contents, and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby affirmed by the signature of the undersigned.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient's Name	**Signature of Parent/Guardian**	**Date**

Georgia Urology Pediatrics

PATIENT: This section refers to PATIENT ONLY – NOT PARENT

NAME: _____ Sex: _____ Date of Birth: _____

Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

1st Choice Contact #: _____ Cell: _____

Home Phone: _____ Email: _____

PARENT/LEGAL GUARDIAN INFORMATION:

Legal Guardian Name (If Different than Parent): _____

Father's Name: _____ Date of Birth: _____

Address (If Different than Patient): _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell: _____

Mother's Name: _____ Date of Birth: _____

Address (If Different than Patient) _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell: _____

FRIEND or RELATIVE who may be contacted if unable to reach at above phone numbers:

Name: _____ Relation (friend/relative): _____

Telephone Number: _____

REFERRAL INFORMATION

Who is your child's Primary Care Physician/Pediatrician?: _____

Address: _____

Office Number: _____ Fax Number: _____

Pharmacy Name: _____ Pharmacy Number: _____

INSURANCE

Primary Insurance Name: _____	Secondary Insurance Name: _____
Policy Holder: _____	Policy Holder: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
ID/Policy Number: _____	ID/Policy Number: _____
Group Number/Name: _____	Group Number/Name: _____
Effective Date: _____	Effective Date: _____
Telephone Number: _____	Telephone Number: _____

Last Name: _____ **MR# or Date of Birth:** _____

First Name: _____ **Today's Date:** _____

Regular MD: _____

Reason for visit today? _____

Urologic Problems (Please select answer. If not applicable or unsure, please leave blank).

Has child had Bladder/Kidney/Urinary Tract Infections?	☐ No	☐ Yes	How often?	_____
Was there fever with these infections?	☐ No	☐ Yes	Highest temp:	_____
Does child have pain when urinating?	☐ No	☐ Occasionally	☐ Frequently	
Has there been blood in the urine?	☐ No	☐ Yes (on urine test)	☐ Yes (visible)	
Is child toilet trained?	☐ No	☐ Yes		
Does child leak urine during the day?	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently
How often does child get up to urinate at night?	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
How often does child wet the bed?	☐ Never	☐ Rarely	☐ Occasionally	☐ Frequently
When child needs to urinate, is it **sudden**?	☐ No	☐ Rarely	☐ Occasionally	☐ Frequently

How often does child urinate during the day? _____

Height: _____ Weight: _____

Constitutional Problems:
- Fevers ☐ Yes ☐ No
- Chills ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- Other: _____

Eye Problems:
- Needs Glasses ☐ Yes ☐ No
- Other: _____

Neurologic Problems:
- Learning Problems ☐ Yes ☐ No
- Other: _____

Endocrine (Gland) Problems:
- Excessive Thirst ☐ Yes ☐ No
- Too Hot/Cold ☐ Yes ☐ No
- Other: _____

GI (Gastrointestinal Problems:
- Constipation ☐ Yes ☐ No
- Diarrhea ☐ Yes ☐ No
- Nausea/Vomiting ☐ Yes ☐ No
- Other: _____

Cardiac (Heart) Problems:
- Turning Blue ☐ Yes ☐ No
- Palpitations ☐ Yes ☐ No
- Other: _____

Skin Problems:
- Frequent Rashes ☐ Yes ☐ No
- Other: _____

Muscle/Joint Problems:
- Back Pain ☐ Yes ☐ No
- Leg Pain ☐ Yes ☐ No
- Other: _____

ENT Problems:
- Ear Infections ☐ Yes ☐ No
- Congestion/Sinus Trouble ☐ Yes ☐ No
- Other:

Pulmonary (Breathing) Problems:
- Wheezing/Coughing ☐ Yes ☐ No
- Other: _____

Heme/Lymph Problems:
- Blood Transfusions ☐ Yes ☐ No
- Clotting Problems ☐ Yes ☐ No
- Swollen Glands ☐ Yes ☐ No
- Other:

Psych Problems:
- Depression ☐ Yes ☐ No
- Anxiety ☐ Yes ☐ No
- Other: _____

MEDICATIONS (taking now): ☐ None

ALLERGIES (medications/other): ☐ None

Past Medical History (Please check all that apply.)

Eyes:	☐ Glaucoma	☐		Other: _____
Neurologic:	☐ Seizures	☐	ADD/Hyperactivity	
Endocrine (Gland):	☐ Diabetes	☐	Adrenal Disease	Other: _____
Pulmonary (Breathing):	☐ Asthma/Wheezing	☐	Pneumonia	Other: _____
Cardiac (Heart):	☐ High Blood Pressure	☐	Congenital Heart Disease	Other: _____
Gastrointestinal:	☐ Crohn's/UC	☐	GE Reflux	Other: _____
Infections:	☐ Hepatitis	☐	Tuberculosis (TB)	Other (HIV): _____

Syndromes/Chromosomal/OTHER Problems: _____

Surgeries: _____

Problems During Pregnancy: _____

Drugs or Medications Taken During Pregnancy: _____

Baby born at: ____ ____ Weeks (40 is normal) Birth Weight? _____

Problems at Birth: _____

Child Lives: ☐ At Home ☐ In a Foster Home ☐ In a Facility

Child Lives With: ☐ Mother ☐ Father ☐ Guardian/Relative ☐ Siblings/Other Children : _____

Does Child Attend School? ☐ Yes ☐ No If yes, what time does child get home? _____

Girls Only: Age of First Menses _____ Any Menstrual Problems? _____

Family Medical Problems: _____