# 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: ____________ SSN: ____________
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: ____________ SSN: ______ Date of Birth: ______
Address (If Different than Patient): ____________
City: ____________ State: ______ Zip: ______
Employer: ____________ Occupation: ____________
Work Phone: ____________ Cell: ____________
Mother's Name: ____________ SSN: ______ 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 | Secondary |
|---|---|
| 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: | | | Skin Problems: | | |
| Fevers | ☐ Yes | ☐ No | Frequent Rashes | ☐ Yes | ☐ No |
| Chills | ☐ Yes | ☐ No | Other: ______ | | |
| Headaches | ☐ Yes | ☐ No | Muscle/Joint Problems: | | |
| Other: ______ | | | Back Pain | ☐ Yes | ☐ No |
| Eye Problems: | | | Leg Pain | ☐ Yes | ☐ No |
| Needs Glasses | ☐ Yes | ☐ No | Other: ______ | | |
| Other: ______ | | | ENT Problems: | | |
| Neurologic Problems: | | | Ear Infections | ☐ Yes | ☐ No |
| Learning Problems | ☐ Yes | ☐ No | Congestion/Sinus Trouble | ☐ Yes | ☐ No |
| Other: ______ | | | Other: | | |
| Endocrine (Gland) Problems: | | | Pulmonary (Breathing) Problems: | | |
| Excessive Thirst | ☐ Yes | ☐ No | Wheezing/Coughing | ☐ Yes | ☐ No |
| Too Hot/Cold | ☐ Yes | ☐ No | Other: ______ | | |
| Other: ______ | | | Heme/Lymph Problems: | | |
| GI (Gastrointestinal Problems: | | | Blood Transfusions | ☐ Yes | ☐ No |
| Constipation | ☐ Yes | ☐ No | Clotting Problems | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No | Swollen Glands | ☐ Yes | ☐ No |
| Nausea/Vomiting | ☐ Yes | ☐ No | Other: | | |
| Other: ______ | | | Psych Problems: | | |
| Cardiac (Heart) Problems: | | | Depression | ☐ Yes | ☐ No |
| Turning Blue | ☐ Yes | ☐ No | Anxiety | ☐ Yes | ☐ No |
| Palpitations | ☐ Yes | ☐ No | Other: ______ | | |
| 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:** ______