SETH BUSH MD

Middle Georgia Pediatrics, LLC

DANA MAYO MD

NOTICE OF PRIVACY PRACTICES AND HIPAA CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my care directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices document containing a more complete description of the uses and disclosures of my health information. I understand that Middle Georgia Pediatrics, LLC has the right to change the Notice of Privacy Practices and any time and that I may contact this organization at any time at the address below for a current copy of the Notice of Privacy Practices document.

Patient's Name	Date of Birth
Parent/Guardian's Name (Print)	Relationship to Patient
Parent/Guardian's Name (Signature)	Date

You may communicate with the following individuals regarding my child's condition or course of treatment (other family members, etc.) The following people may be contacted as an alternate form of communication in the instance that my primary phone numbers cannot be reached.

Name (Print)	Relationship to Patient	Phone Number
Name (Print)	Relationship to Patient	Phone Number
Name (Print)	Relationship to Patient	Phone Number

MIDDLE GEORGIA Pediatrics

Today's Date: _____

CIRCLE YOUR PRIMARY DOCTOR:

Dr. Seth Bush / Dr. Dana Mayo

PATIENT INFORMATION

Child's Name: _____ DOB: _____ MALE / FEMALE Patient Cell# (ages 15 & ↑): _____

Child's Name: _____ DOB: _____ MALE / FEMALE Patient Cell# (ages 15 & ↑): _____

Child's Name: _____ DOB: _____ MALE / FEMALE Patient Cell# (ages 15 & ↑): _____

Address: _____ City / State / Zip: _____

PARENT / LEGAL GUARDIAN #1 (Living in the same house as patient & primary contact for appointment reminders.)

Name: _____ DOB: _____ Relationship to Patient: _____

SSN# (for insurance purposes): ___-___-___ Cell Phone: _____

Employer: _____ Work Phone: _____

Employment Address: _____ City / State / Zip: _____

Email (used for Healow Patient Portal): _____

PARENT / LEGAL GUARDIAN #2

Name: _____ DOB: _____ Relationship to Patient: _____

SSN# (for insurance purposes): ___-___-___ Cell Phone: _____

Employer: _____ Work Phone: _____

Employment Address: _____ City / State / Zip: _____

Email (used for Healow Patient Portal): _____

INSURANCE INFORMATION – Billing Address & Responsible Party: ☐ Parent/Guardian #1 ☐ Parent/Guardian #2

PLEASE PROVIDE COPY OF INSURANCE CARD.

Name of Primary Insurance: _____ Subscriber ID#: _____ Group #: _____

Name of Secondary Insurance: _____ Subscriber ID#: _____ Group #: _____

*** If your child is a newborn, please call your insurance and add the baby to your plan. If not, your visit may not be covered.

PREFERRED PHARMACY

Pharmacy Name: _____ Phone Number: _____

Address: _____ City / State / Zip: _____

I certify that the information above is correct and authorize the release of medical or insurance information for payment of claims. I understand that I am responsible for any balance not covered by my insurance and agree to pay it within a reasonable time.

Signature of Parent: _____ Print Name: _____