Peach Clinic

3030 Old Atlanta Rd, Ste 500 Cumming GA 30041 (770) 203 -2000

Information of child Nick name _____

Last Name_____First_____Middle_____

Street Address_____Home Phone_____

City_____State_____Zip_____

Social Security #_____Date of Birth_____Age_____Sex_____

Mother's Name_____

Mother's Address_____

City _____ State_____Zip _____

Mother's cell phone _____

home phone _____

D.O.B._____

SS#_____

Employer's Address_____

Father's Name_____

Father's Address_____

City _____ State_____Zip _____

Father's cell phone _____

home phone _____

D.O.B._____

SS#_____

Employer's Address_____

PERSON RESPONSIBLE FOR ACCOUNT

❑ Check if same as above: proceed to next section.

Name _____ SS# or ID# _____

Address _____ City _____ State _____Zip _____

Relationship to Patient _____ Birthdate _____

Phone _____ Employer _____

MEDICAL INSURANCE

Primary Insurance _____Secondary Insurance _____

GETTING TO KNOW YOU

How did you find us? ☐ Peach Clinic Website ☐ Web search ☐ Referred by _____

Person to contact in case of emergency (Person not leaving with patient)

Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

ACKNOWLEDGMENT AND CONSENT TO PRIVACY POLICY

I have read Peach Clinic's Notice of Privacy Practices, version effective April 23, 2014. I consent to the uses and disclosure of my health information as outlined in the notice.

Use this section If you want to give someone *ongoing* access to your child's medical information:

I give Peach Clinic permission to discuss my child's medical care with the following persons on ongoing basis.

Name: _____ Relationship: _____

Signature _____ Date _____

Peach Clinic

- **Evaluation and Treatment:** I authorize Peach Clinic and the physicians for evaluation and treatment for my child's current and future medical problems.
- **Co-pay, Deductible and Past Balance:** I understand that in order to control the costs co-pay, deductible and past balance are due at time of each visit.
- **Collection of benefit directly from Insurance Company:** I authorize payment of benefits from my child's medical insurance directly to Peach Clinic. I understand that I will be responsible for any amount not paid by my insurance company.
- **In case Insurance company does not pay**: If my child's insurance payment is not received within 60 days from the date of service, I agree to pay the entire amount of the balance due, unless my child's insurance company has contractual agreement with Peach Clinic or its physicians to the contrary.
- **In case of non-payment:** I agree to pay interest at a rate of 1.5% per month if my child's bill is not paid within 90 days of service. I also agree to pay all cost of collection, including by not limited to, court costs, collection fees and attorney fees.
- **Release of information for claim processing**: I authorize Peach Clinic to release all the information necessary to process my child's insurance claim to my child's insurance company or the appropriate government agency.
- **Obtaining prescription medication history:** I authorize Peach Clinic to view or obtain my child's prescription medication history from external sources like other healthcare providers, pharmacies and government agencies for purpose of providing medical treatment.

Signature _____ Date _____