THE WORLD OF PEDIATRICS

Dr. Lyudmila Vayman
3005 Royal Blvd S., STE 100 Alpharetta, GA 30022
Tel: 770-442-5437 Fax: 770-674-3777

Medical Records/Health Information Release

(Please fill out and fax or send to your current practice or pediatrician)

Date: _____

To: _____

Fax: _____

Please release a copy of medical records for the following patient(s):

1) Patient's Name: _____
Patient's DOB: _____

2) Patient's Name: _____
Patient's DOB: _____

3) Patient's Name: _____
Patient's DOB: _____

4) Patient's Name: _____
Patient's DOB: _____

5) Patient's Name: _____
Patient's DOB: _____

Please send the records to the following address:

Lyudmila Vayman, MD
3005 Royal Blvd S, STE 110
Alpharetta, GA 30022 USA
Tel: 770-442-5437
Fax: 770-674-3777

If you have any questions, please, contact me at _____.

Thank you,

_____ _____ _____
Parent/Guardian printed name Parent/Guardian signature Date

THE WORLD OF PEDIATRICS 3005 Royal Blvd S., STE 110, Alpharetta, GA 30022 Tel: 770-442-5437

PATIENT INFORMATION (PLEASE PRINT & Fill Out Completely) Date:_____

Patient's Name: First _____ Middle_____ Last _____

Preferred Name: _____ Date of Birth:_____ Age: _____ Sex: ❑M ❑F

Patient's Street Address: _____City, State, Zip Code: _____

Person Responsible for Bill (person under which insurance is carried): _____

Relationship to Patient: _____ ***Date of Birth:*** _____ EMAIL: _____

Address:_____ Home Phone: (____)_____

City: _____ State:_____ Zip:_____ Mobile Phone: (____)_____

Marital Status of Parents: ❑ Married ❑Divorced ❑Separated ❑Other:_____

IF NOT MARRIED, Who Has Custodial Rights: ❑ Mother ONLY ❑Father ONLY ❑Both Parents ❑Other _____

Father's Name: _____ DOB: _____ Cell Phone: (____)_____

Name of Employer: _____ Work Phone: (____)_____

Address of Employer: _____

Mother's Name: _____ DOB: _____ Cell Phone: (____)_____

Name of Employer: _____ Work Phone: (____)_____

Address of Employer: _____

Name of Friend/Relative not Living with You:_____ Phone: (____)_____

Address: _____ Relationship:_____

Pharmacy Name: _____ Tel: _____ Fax: _____

Address:_____

INSURANCE INFORMATION

Name of Insured:_____

Name of Insurance Company:_____ Phone: (____)_____

I.D. Number:_____ Group Number: _____

MEDICAID PATIENTS ONLY

Medicaid Plan: ❑ Peachstate ❑Amerigroup ❑Straight Medicaid Medicaid Number: _____

I certify that I will be financially responsible for all medical expenses for the above patient in the event they should lose coverage of Medicaid, Peachstate, or Amerigroup during the course of treatment. **Sign**_____

PLEASE READ: Payment is requred ***in full*** at the time of each visit. The patient, their parent, or their guardian are responsible for all fees, regardless of insurance coverage. We will file insurance only as a courtesy, but ultimately our patients are responsible for all outstanding balances regardless of coverage.

AUTHORIZATION:

I understand that I will be charged (not my insurance) for canceled appointments unless I give 24 hours notice.
All of the office policies have been provided to me and I understand all policies. I agree to all policies that have been provided to me in writing.

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize and request payment of medical benefits directly to Dr. Vayman or The World of Pediatrics.

I CERTIFY THAT I AM THE RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE AND THAT I HAVE THE AUTHORITY TO AGREE TO and SIGN ON BEHALF OF THE PATIENT FOR ALL SERVICES RENDERED. I, ALSO, CERTIFY THAT I AM THE FINCIALLY RESPONSIBLE PARTY FOR THE PATIENT LISTED ABOVE and THAT I HAVE THE AUTHORITY TO AGREE TO ALL PRACTICE POLICIES AND FINANCIAL POLICIES.

Printed Name _____ **Relationship** _____

Signature_____ **Date**_____

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Patient Authorization for Use and Disclosure of Protected Health Information (PHI)

I authorize The World of Pediatrics to use and/or disclose certain protected health information (PHI) about me. Failure to authorize release of PHI may prevent the exchange of vital information associated with care delivery.

This authorization permits The World of Pediatrics to use and/or disclose the following health information:

Office Notes (MD notations)

Lab Results (includes bloodwork, urine and stool cultures, bacterial and viral tests, etc.)

Radiology reports (includes ultrasound, MMR, Cat Scans, x rays, ets.)

Hospital records (includes operative notes, pathology reports, admission & discharge summaries, etc.)

Other Physicians Notes (includes reports and notes from previous physicians or specialists that have cared for your child)

Immunization Records

Medication Logs

Problem Lists and Treatment as requested by Health Care Specialists that are caring for your child

The information will be used for the following purposes:

At the request of the Patient

To carry out treatment, receive payment, collaborate with other physicians or healthcare entities, and/or to carry out health care operations (TPO).

To comply with Federal, State, or Local laws, regulations, or requests.

I consent for The World of Pediatrics to call my home or other location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. These messages may include, but are not limited to appointment reminders, insurance items, and any calls pertaining to clinical care, including lab and radiology results.

I consent to The World of Pediatrics mailing to my home or other location any items that assist the practice in carrying out TPO, such as reminder cards and statements.

The purposes of disclosing PHI have been provided so that you may make an informed decision whether to allow release of information or not. The World of Pediatrics will not receive payment or other remuneration from a third party in exchange for disclosing PHI, however there are fees associated with copying medical records, filling out forms, and/or preparing letters at the request of the patient.

I understand that I do not have to sign this release to receive treatment at The World of Pediatrics. I, also, understand that I have the right to revoke this authorization at any time by written request to the Privacy Officer of The World of Pediatrics. However, please, remember that failure to authorize release of PHI may prevent the timely exchange of vital information associated with the care of a patient.

X _____ X_____ X_____
Print Name Signature Date

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Practice Policies

Thank you for choosing us as your health care provider. We are committed to the care of your child.

Appointments:
Appointments can be made during our regular office hours 9:00am-5:00pm M, T, TH, F or 10:00am-6:00pm W. If your child is sick, we can usually work-in your child for a same day appointment. Sometimes it is necessary for us to triage your child's illness and we may offer you an appointment on another day. Well child appointments tend to book 2-4 weeks from any given day, so please call in advance for these appointments. Walk-in patients will be worked into the schedule and will be seen after our scheduled patients. We prefer that you phone first for an appointment rather than walk-in.

We sincerely try to meet our appointment schedule, but on occasion, due to medical emergencies, we are unavoidably delayed. Thank you for your patience in this matter. A staff member will try to notify you of any delay.

Cancellation or Missed Appointments
Much effort goes in to preparing for your visit. If you are unable to keep your appointment, please, be considerate of other patients needing to be seen and contact us no later than the day before your scheduled appointment to cancel.

All "same day" cancellations and "no show" well child appointments will be charged a $50.00 missed appointment fee. Two "unexcused" missed appointments may result in discharge from the practice.

After Hours:
Coverage is provided during after hours and weekends. You may call our main office number and our answering service will transfer you to the Children's Healthcare of Atlanta Kids Line for nurse advice or contact the physician on call. If your condition is a life threatening emergency, please, call 911.

Prescriptions/Refills:
Please call your pharmacy and have them contact us during regular office hours for any approved refills. You may, also, request refills on line through our patient portal. We will refill prescriptions within 24-48 hours of receiving a call from your pharmacy or an on-line request.

Prescriptions requests for CII drugs (i.e.: Adderall, Concerta, Ritalin etc…) should be requested one week prior to need. These prescriptions must be picked up at our office during normal business hours.

We will not authorize refills during after hours, weekends, or refill another physician's prescription(s).

Requests for new medications or antibiotics will not be filled without first making an appointment for your child to be seen.

Referrals:
If your insurance requires a referral in order for your child to see a specialist, it is your responsibility to contact our office as soon as an appointment is made. We require one week notice to process your referral. Same day referral requests will be denied.

Insurance:
You are personally responsible for all services provided by The World of Pediatrics. It is your responsibility to know what type of insurance you have and the type of coverage it provides. It is your responsibility to know what your insurance covers. If you do not inform us of any special requirements and services are subsequently not covered, you are still personally responsible for your bill. Please, do not hesitate to contact us with any questions regarding your bill.

Payment:
All professional services are charged to the patient, their parent, or their guardian. Payment is expected in full at the time of service. We accept cash, checks, Discover, MasterCard, and Visa. A service charge of $25.00 will be due for each bounced check.

We will file insurance for those patients that or covered by private insurance or Medicaid. You must present a valid insurance card for all patients at each office visit. Any co-payments or deductibles are to be paid at time of service. If a co-pay is not paid at the time of visit, a service charge equivalent to your co-pay will be added to your account. The patient, their parent, or their guardian is ultimately responsible for all outstanding balances regardless of insurance coverage. All insurance payments of medical benefits must be made directly to Dr. Vayman or The World of Pediatrics.

Patients not covered by insurance must pay for each visit in full at the time services are rendered.

Medicaid patients, their parents, or their guardians are responsible for ALL medical expenses in the event that the patient loses Medicaid coverage during the course of treatment.

School & Camp Forms:
Due to the increasing demand of forms needed to be filled out for various school, camp, and sports programs, we have found it necessary to charge $15.00 -$25.00 for each health form to be filled out. If your form is brought in with your child on the day of their well child exam, there will be no charge. We, also, request that all forms be dropped off at least a 7-10 days in advance, so that we may have ample time to complete all forms.

Medical Records:
If requesting your child's medical records, please, allow two weeks for our office staff to process your request. There is an administration fee of $25.00 per chart, for the first 25 pages, and $0.85 per each additional page up to 50, $0.35 for pages 51-100, and $0.25 per each page over 100. We do not charge an administration fee to send a copy of your child's immunization record and growth chart to another physician's office.

Miscellaneous Paperwork:
Other forms, letters, or paperwork not listed above. These charges depend on the quantity and depth of forms and documents that a patient requests us to prepare. The cost for notarization of these forms is included. These forms will be ready for pick up or for fax within 7 to 10 days of request. Minimum charge is $5.00, but typical charges are usually $15.00 to $25.00. Charges can exceed these amounts depending on the time required to write or complete your request. Payment will be required prior to mailing, faxing, or pick up.

Release of Information:
I authorize the release of any medical information necessary to process an insurance claim or receive payment, needed during the course of treatment, to consult with other physicians, or operational needs.

Assignment of Benefits:
All insurance payments of medical benefits must be made directly to Dr. Vayman or The World of Pediatrics.

Cell Phones: Cell Phones must be turned off while patients are in The World of Pediatrics. Please be courteous to others and step out of the waiting room if you need to converse on your phone.

Smoking: Our office is located in a non-smoking building. If you must smoke, please, step outside and well away from the doorways and sidewalks of the building, so as to not subject others to second hand smoke.

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OUR FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment.

FULL PAYMENT OF DUE AMOUNTS MUST BE PAID AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

Regarding Insurance
We will file and accept assignment of insurance benefits as a convenience to you. However, the balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your timely updated and correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services, and/or not considered reasonable and necessary under your insurance plan.

You will be responsible for contacting your insurance company prior to your scheduled appointment to obtain benefit information. Some insurance policies do not cover in-house labs with well exams. These labs will be optional to you. If they are not covered by your insurance, you will be responsible for the balance.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Any balance not paid by your insurance company for well child care physicals, including immunizations, must be paid in full before the next scheduled appointment. All required health forms filled out by us at the time of the visit will be done at no charge, for the forms filled out at a later time we shall charge a minimum of $15 each.

Missed Appointments
Unless an appointment is canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. All no-shows will be noted in the patient's chart.

Two (2) no-shows will constitute dismissal from this practice.

Medical Records
Any medical records brought or mailed to our practice from another physician's office will become property of The WOP. If in the future, should you leave our practice we will gladly forward a copy of your child's immunization record and growth chart to another Pediatrician of your choice. It is the policy of this office not to charge for the release of these documents to another physician.

Waiver Agreement
This Waiver Agreement states that you, the parent or guardian of the patient, will be responsible for all charges incurred for services rendered that are not covered by your primary or secondary insurance carrier, whether private or Medicaid. These services include, but are not limited to immunizations, well-child appointments, sick visits, labs, and other requested or necessary medical procedures performed in this office.

If outstanding balances are not paid in full by a date specified by the practice, you will be turned over to collections without further notice and dismissal from the practice will follow.

X_____ X_____ X_____
Signature of Patient or Responsible Party Relationship Date

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Procedures and Services Agreement

We would like to inform you that the following procedures or services will be filed with your insurance company as a courtesy to you. Your insurance plan may or may not reimburse us for these services if they are performed in our office. Further, these services may not be covered by your insurance plan no matter where they are performed. Please note that if these services are not covered or applied to your deductible, you will be financially responsible for the charges.

All patients have the right to elect for us not to perform these services in our office. We can present you with alternatives to have these services provided at another location (labs) or we can direct you to a specialist for screenings.

Services & Procedures Insurances May or May Not Fully Reimburse For

Labs, Screenings, Diagnostic Procedures

Insurance policies may or may not cover labs and screenings drawn or performed in the office. Insurance may or may not cover particular labs, screenings, or diagnostic procedures ordered by Dr. Vayman regardless of where they are performed. Fees not covered for these services will be the patient's sole responsibility. The most common of these are listed below, although this policy applies to any Labs, Screenings, or Diagnostic Procedures that are not listed.

Vision and Hearing Screening when done as part of a physical
Urinalysis when done as part of a physical
Hemoglobin when done as part of a physical
Hemoccult
Blood Stick Glucose

Injections, Vaccines, and Fees for Administering Vaccines

Insurance policies may or may not cover some vaccines or injections that are administered to our patients. Insurance policies, also, vary in whether or not they cover the administration costs for all vaccines or injections that are given. Each injection will be charged an administration fee. Charges not covered for these services and the vaccines or injections themselves will be the patient's sole responsibility. Several of these are listed below, although this policy applies to any Injections, Vaccines, or Vaccine Admin. Fees that are not listed.

Rocephin Injections
Decadron Injections
Penicillin Injections
Hormone Injections
Vaccines or Immunizations
Influenza Shot or Intranasal Influenza Vaccine
Administration Fee for EACH Injection

Telephone Consultations – Insurance policies typically do not cover telephone conferences with physicians to discuss problems or medical issues. Fees not covered for these services will be the patient's sole responsibility.

I have elected to have all procedures listed above performed in the office by Dr. Lyudmila Vayman's office, regardless of whether reimbursement will be rendered by my insurance or not. I agree to be solely responsible for the full cost of these services or the difference not covered by my insurance company.

_____ _____
Signature Printed Name

_____ _____
Printed Name Date

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The World of Pediatrics is experiencing a high number of "NO SHOW" patients. This constitutes an undue burden on the practice and causes serious schedule delays and hardships for other patients. Out of courtesy to your doctor and other patients, please, arrive for your appointments in a timely manner or cancel them 24 hours in advance if you have scheduling conflicts.

NOTICE

ALL PATIENTS WILL BE CHARGED A FEE FOR "NO SHOW" APPOINTMENTS.

As of January 1, 2008 the "NO SHOW" Fee is $50.00.

_____ It is the Patient's, Parent's, or Guardian's responsibility to cancel an appointment at least 24 hours in advance.

_____ You will not be charged a "NO SHOW" fee if we receive a telephone call canceling the appointment prior to the day of your appointment (24 hours) or receive a message via our answering service prior to the day of your appointment.

_____ I understand that failure to pay "NO SHOW" charges may result in discharge from the practice.

_____ You will be charged if you cancel via our answering service after 5:00pm on the day prior to your appointment, since this is less than 24 hours before your scheduled appointment. In these circumstances your appointment is not considered cancelled, it will be treated as a "NO SHOW" appointment.

_____ If you have a well child appointment (i.e. physical) scheduled and your child becomes ill, then we will change the appointment to a sick visit and reschedule your well child appointment for another date. You still must bring your child into the office for their scheduled appointment time and date.

_____ I understand that multiple "NO SHOW" appointments may result in discharge from the practice.

This agreement is a policy agreement strictly between the patient and Dr. Lyudmila Vayman / The World of Pediatrics.

By signing this agreement you acknowledge notice of our office policy and agree to accept the terms of this policy, regardless of the type of insurance or managed care plan you may have. Further, you are stating that you clearly understand your obligation to cancel appointments 24 hours in advance.

_____ _____
Patient's Name **Patient's Date of Birth**

_____
Parent or Legal Guardian's Name (Printed)

_____ _____
Parent or Legal Guardian's Signature **Date**

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Authorization for Treatment of a Minor without the Parent or Legal Guardian Present

Re: Patient's Name: _____ Patient's Date of Birth:_____

To whom it may concern:

I, _____, the legal guardian or parent of _____ ____, give authorization for the individuals listed below to make medical decisions in my absence for the health and well-being of the child listed above. These individuals may authorize and sign for all medical procedures and/or treatments performed in Dr. Lyudmila Vayman's office. This authorization extends to urgent care centers, hospitals or other medical specialists and medical offices that may be needed to treat my child in my absence. I will be responsible for all financial obligations incurred for procedures performed.

_____

_____

_____

_____

This authorization will remain in effect indefinitely from the date listed below until receipt of written withdrawal of this authorization.

Regards,

_____ _____
Signature Date

_____ _____
printed name relationship to patient

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Authorization for Treatment of a Minor without an Authorized Adult Present

Note: Minors must be at least 16 years of Age. We prefer that a Parent or Legal Guardian attend all physicals or appointments where immunizations will be given.

Re: Patient's Name: _____ Patient's Date of Birth:_____

To whom it may concern:

I, _____, the legal guardian or parent of _____, give authorization for _____ to make medical decisions in my absence. The minor child listed above may authorize and sign for all medical procedures and/or treatments performed in Dr. Lyudmila Vayman's office, The World of Pediatrics. This authorization extends to urgent care centers, hospitals or other medical specialists and medical offices that may be needed to treat my child in my absence. I will be responsible for all financial obligations incurred for any procedures performed.

_____

_____

_____

_____

This authorization will remain in effect indefinitely from the date listed below until receipt of written withdrawal of this authorization.

Regards,

_____ _____
Signature Date

_____ _____
printed name relationship to patient