Pediatric Associates of Johns Creek, PC
4310 Johns Creek Parkway, Suite 150
Suwanee, GA 30024
770-476-4020

Patient & Family History

Your kindness in furnishing the following information is appreciated.
The information will be used in strict confidence to prepare your child's chart.

Today's Date ______________

Child's Name ________________________DOB_________ Male___ Female__

Child's Name ________________________DOB_________ Male___ Female__

Child's Name ________________________DOB_________ Male___ Female__

Child's Name ________________________DOB_________ Male___ Female__

Child's Name ________________________DOB _________Male___ Female__

Child's Name ________________________DOB _________Male___ Female__

Address _____________________________City ________State___ Zip______

Home Phone __________________ Child's Cell Phone __________________

Pharmacy Name________________ Phone Number _____________________

Email Address ____

Would you like to subscribe to our e-Newsletter? Y N

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Father's Full Name ______________________________Birthdate___________

Social Security Number _________________ Ht __________ Wt ___________

Father's Address ____

Home Phone ____________________ Business Phone ____________________

Cell Phone __________________ Business Name ______________________

Education Level ______________Medical Problems: _____________________

Mother's Full Name ____

Birthdate _____________________________ Maiden Name ________________

Social Security Number ___________________ Ht. ________ Wt. __________

Mother's Address ____

Home Phone ____________________ Business Phone ____________________

Cell Phone __________________ Business Name ______________________

Education Level _____________ Medical Problems _____________________

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Child's Insurance Company ____

Who is the Subscriber of this Insurance Policy?_________________________

Who referred you to our office? ______________________________________

Patient History *Please write the child's name/date of occurrence for any of the following:*

Allergies	___________	Heart Concerns	___________
Asthma	___________	Mumps	___________
Allergy Shots	___________	Pneumonia	___________
Appendectomy	___________	Roseola	___________
Blood Disorders (IPT, SCA)	___________	Rubella	___________
Chicken Pox	___________	Tonsillectomy/Adenoidectomy	___________
Convulsions	___________	Urinary Infections	___________
Ear Infections	___________	Other hospitalizations	___________
Ear Tubes	___________		

Family History *Anyone in the family with the following?:*

❑Allergies
❑Asthma
❑Bleeding Problems
❑Cancer
❑Convulsions or seizures
❑Cystic fibrosis

❑Diabetes
❑High Cholesterol
❑High Blood Pressure
❑Heart Attack
❑Heart Disease
❑Kidney Disease

❑Lung Disease
❑Psychiatric Disorders
❑Thyroid Disease
❑Tuberculosis
❑Alcoholism
❑Drug Abuse
❑Tobacco Use

❑Other ____

I hereby authorize these individuals to bring my child for medical care to and/or to be contacted in case of emergency by Pediatric Associates of Johns Creek:

Name ______________________ Relationship _____________ Phone______________

Name ______________________ Relationship _____________ Phone ______________

Name ______________________ Relationship _____________ Phone ______________

***

Please remember that effective insurance is not a guarantee of payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
If this account is assigned to an attorney and/or collection agency for suit and/or collection, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.
To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: Pediatric Associates of Johns Creek, PC.
The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed ____ Date _________________

Pediatric Associates of Johns Creek, PC **Effective 9/23/13**
Notice of Privacy Practices

This notice describes how your PROTECTED HEALTH INFORMATION(PHI) may be used and disclosed, and how you can get access to your PHI.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your PHI. In conducting our business, we will create records regarding your care and the treatment and services we provide. We are required by law to maintain the confidentiality of health information that identifies your care. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide to you, the following important information:

*How we may use and disclose your PHI *Your privacy rights in their PHI *Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and on our website, you may request a paper or electronic copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, CONTACT: Stacy Cragg, Privacy Officer 4310 Johns Creek Pkwy. Ste. 150 Suwanee, GA 30024

C.WE MAY USE AND DISCLOSE YOUR PHI(PHI) IN THE FOLLOWING WAYS

1. Treatment Our practice will use or disclose your PHI to provide, coordinate or manage your care. This includes communication and consultation between you healthcare team within and outside or our practice. For example; following a surgery your doctor may refer you for rehabilitation. Information would be shared between caregivers to ensure continuity of care.

2. Payment Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

3. Health Care Operations Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality of care your care received from us and to evaluate the performance of our team members. We may disclose your PHI to other authorized health care providers and entities for educational and learning purposes.

4. Appointment Reminders Our practice may use and disclose your PHI to contact you and remind you of your appointment.

5. Treatment Options Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives available to your care.

6. Health-Related Benefits Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to your care.

7. Minors We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

8. Disclose of Information to Family/Friends Our practice may disclose your PHI to a friend or family member that is involved in your care, or who assists in taking care of your care.

9. Disclosures Required By Law Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

10. Research We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

11. Business Associates We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

12. Data Breach Notification Purposes We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. Public Health Risks Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting care abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting to the federal government adverse reactions to medication or safety problems with FDA regulated products
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency and authority regarding the potential abuse or neglect of an adult or child patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

5. Coroners, Medical Examiners, and Funeral Directors Our practice may disclose PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may disclose information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation Our practice may disclose your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if your care is an organ donor.

7. Serious Threats to Health or Safety Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. Inmates Our practice may disclose your PHI to correctional institutions or law enforcement officials if your care is an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to your care, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' Compensation Our practice may disclose your PHI for workers' compensation and similar programs.

E. YOUR RIGHT TO OBJECT OR OPT OUT

1. Individuals Involved in Your Care or Payment for Your Care Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

2. Disaster Relief We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

3. Fundraising Activities We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

4. Resident Directory *(Optional – typical for nursing homes, resident type facilities)* Unless you object, we may use and disclose in our resident directory your name, your location in the community, your general condition and your religious affiliation. All of this information, except religious affiliation, may be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

F. YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization.

If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV information, Alcohol and Substance Abuse information, Mental Health Information and Genetic Information *(Check your state specific law)* Federal law provides additional protection for certain types of health information, including drug and alcohol abuse, mental health, HIV/AIDS, and may limit where and how the practice may disclose information.

G. YOUR RIGHTS REGARDING PHI

1. See and Request a Copy You have the right to see and request copies of your PHI that may be used to make decisions about your care or payment for your care. You will receive a response from the practice within 30 days of receiving your request. We may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. Under certain circumstances, we may deny your request. If we do deny your request, we will notify you in writing and with an explanation and explain your right to have the denial reviewed.

2. Summary or Explanation We can also provide you with a summary of your Protected Health Information, rather than the entire record. So long as you agree and pay the associated fees.

3. Electronic Copy of Electronic Medical Records If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

4. Get Notice of a Breach You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

5. Right to an Accounting of Disclosures You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

6. Restrict Communications You have the right to request that our practice restrict communications in certain situations. For example, in custody and/or other legal situations, parents might request a restriction of communications with certain individuals. In order to request the restriction, you must submit the request in writing to our Privacy Official. Our practice will accommodate reasonable requests.

7. Right to Request Confidential Communication You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

8. Restrict Your PHI You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. In order to request a restriction in our use or disclosure of your PHI, you must submit your request in writing to our Privacy Official.

9. Out-of-Pocket-Payments If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

10. Amendment You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment, your request must be submitted in writing to our Privacy Official. You must provide us with a reason that supports your request for amendment. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

11. Paper Copy of This Notice You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, ask a *"Practice fill in"* or submit a written request to our Privacy Official, or on our website: *"Practice fill in"*.

12. Complaints If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, submit your complaint in writing and within 180 days of when you knew or should have known of the suspected violation, to our Privacy Official. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. You will not be penalized for filing a complaint.

13. How to Exercise Your Rights To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

14. Changes To This Notice We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Stacy Cragg 4310 Johns Creek Pkwy. Ste.150 Suwanee, GA 30024, Phone (770)476-4020.

PEDIATRIC ASSOCIATES OF JOHNS CREEK, PC

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practices for PHI before signing the Consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice: Stacy Cragg, Privacy Officer, 4310 Johns Creek Pkwy. Ste.150 Suwanee, GA 30024 Phone: 770-476-4020.

You have the right to request, in writing, that the Practice restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it.

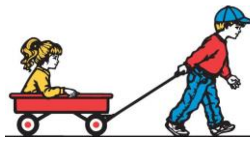
Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

We may communicate confidential information using any mailing address, email address and/or phone numbers that have been provided to the Practice in order to carry out healthcare operations.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pediatric Associates of Johns Creek, P.C. may decline to provide treatment.

______________________________ ______________________________
Patient Name DOB

______________________________ ______________________________
Signature of Patient or Legal Guardian Date



Pediatric Associates, PC
Pediatric Associates of Johns Creek, PC

FINANCIAL POLICY

Thank you for choosing our practice. Our office is committed to providing the best possible treatment, as well as assisting you with insurance filing and payment of your account. In order to accomplish this, we ask that you adhere to the guidelines listed below.

1. Our office requires that your current insurance card and photo ID be presented at **each** visit.
2. We will file a claim to your insurance carrier if we are given complete and current demographic and insurance information. If information is incomplete, we will require payment in full of your charges the day of your visit.
3. We realize that many patient's insurance plans may change over the course of the year. We require that the patient keep us updated on these changes. Failure to provide updated information in an expedient manner may result in timeliness denials from your insurance carrier which the patient will ultimately be responsible for. **There will be a $10 refiling fee if the correct insurance information is not provided at time of service.**
4. If your account is 30 days or more past due and reflects insurance responsibility, please help us by contacting our billing department to obtain a detailed summary of your account so that you may contact your insurance company for information regarding outstanding claims. Claims not paid by your insurance company in a timely manner will ultimately be the responsibility of the patient.
5. **Co-payments and outstanding balances from deductibles and coinsurance are due at time of service.** A $25.00 billing fee will be assessed for failure to pay co-payment at time of service.
6. Since we are unaware of each insurance plan's specific benefits and which of our services are covered by your plan, we will not be held responsible for unpaid amounts as result of denials from your insurance company due to non-covered service clauses. It is your responsibility to know your insurance benefits PRIOR TO services being rendered; our billing department will be happy to assist you with any questions you may have.
7. Most laboratory charges ordered through our office are billed separately to your insurance by either LabCorp, Quest Diagnostics, Solstas, or LabOne. If you receive a bill from one of these companies, we ask that you contact them to resolve any questions you may have.
8. If your child is scheduled for a Well Child Exam or a Shot only appointment but is experiencing symptoms that are addressed by the physician, you may be charged for a "sick" office visit. Depending on your insurance, you may be responsible for a copayment, coinsurance and/or deductible.
9. The following fees are charged by our office. **These fees are NOT paid by your insurance and are due and payable at time of request.**
   - There will be a $10 fee for completing camp and school forms. This fee will not be billed to your insurance company and must be paid before the forms can be released. This does not include immunization forms (3231/3300 forms), for which there is no charge. Please allow 3-5 business days for completion of all forms.
   - There will be a $50 fee for missed appointments, or appointments not cancelled with at least 24 hours notice. This fee is not covered by your insurance company, and will be billed to you directly. Multiple missed appointments may lead to dismissal from our practice.
   - If you arrive more than 15 minutes late for an appointment, it may be necessary to reschedule your appointment. This is up to the discretion of the doctor.
   - There will be a fee of $17 for walk-in appointments. This fee will be collected at the time of service, in addition to any copayments that may be due. This fee will not be filed to your insurance company.
   - There will be a fee of $20 for letters requested to be written on a patient's behalf.
   - A copying fee of up to $35 per chart each time a copy of medical records is requested for any reason (fee is based on number of pages copied, in accordance with Georgia Law). There is an additional charge if records must be retrieved from off-site storage (records are generally place in storage when a child has not been seen in 3 years or more). Our medical records manager will be glad to discuss these specific charges with you as necessary.
   - There will be a 30% fee added to your balance if you are sent to an outside collection agency.

I have read, understand and agree to the financial responsibilities outlined above.

____

Parent Signature　　　　　　　　　　　　　　　　　　　　　　Date

____

Patient's Name & DOB (list all children seen in our office)

Pediatric Associates of Johns Creek, P.C.

ROBERT M. LICATA, M.D., F.A.A.P. KAREN M. CARROLL, M.D., F.A.A.P. PENNY M. FORMAN, M.D., F.A.A.P.
KARA L. BARLOW, M.D., F.A.A.P. AARON M. WORTH, M.D., F.A.A.P.

CONSENT TO RELEASE MEDICAL RECORDS TO PAJC

I DO HERBY AUTHORIZE THE RELEASE OF RECORDS FOR THE FOLLOWING PATIENTS:

Patient Name: ______________________ DOB: ___/___/_____

Patient Name: ______________________ DOB: ___/___/_____

Patient Name: ______________________ DOB: ___/___/_____

Patient Name: ______________________ DOB: ___/___/_____

PREVIOUS DOCTOR'S INFORMATION:
NAME OF PRACTICE: ______________________
PHONE: ______________________ **FAX:** ______________________

AT THIS TIME, I WOULD LIKE TO REQUEST THE FOLLOWING :

- o BASICS [immunization record, growth chart, summary of encounters, & copy of last check-up]
- o ENTIRE CHART [previous MD may have a copying fee]
- o OTHER ______________________

REASON FOR REQUESTING RECORDS:

- o RECORDS FROM ER/URGENT CARE VISIT FOR CONTINUATION OF CARE: Date(s) of Service ____________
- o RECORDS FROM SPECIALIST FOR CONTINUATION OF CARE: Date(s) of Service ____________
- o TRANSFERRING FROM PRACTICE
  - o Moved
  - o New Pediatrician
  - o Other ______________________

PLEASE FORWARD THE INDICATED MEDICAL RECORDS TO:

o MAILED: Address: **PEDIATRIC ASSOCIATES OF JOHNS CREEK**
4310 JOHNS CREEK PARKWAY, SUITE 150
SUWANEE, GEORGIA 30024

o FAXED: Fax #: **770-476-1674**
Phone #: **770-476-4020**

PRINT PARENT/PATIENT (18+YEARS OLD) NAME: ______________________ DATE: ___/___/_____

PARENT/PATIENT (18+YEARS OLD) **SIGNATURE:** ______________________

PHONE NUMBER: