Nora Tan-Ngo Pediatrics, P.C.
1200 19th Street
Columbus, GA 31901
Office: 706-494-3820
Fax: 706-494-3930

Patient Information: Please write all information legibly and clearly. Thank you!

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____Gender:_____ SSN#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate Number: _____

Mother's Name: _____ SSN#: _____

Father's Name: _____ SSN#: _____

Legal Guardian(s): _____ Relationship to Patient: _____

Patient Demographics:

Preferred Language: _____ Race: _____

Ethnicity: _____ Religion: _____

Emergency Contact (other than parents):

Name: _____ Relationship to Patient: _____

Address: _____ Contact Number: _____

Insurance:

Name of Primary Insurance: _____

Policy Number: _____ Group Number: _____

Address: _____

Policy Holder Name (if insured is other than self): _____

Date of Birth: _____ SSN#: _____

Insurer's address if different from the patient: _____

Deductible: _____ Copay: _____

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Financial Responsibility:

Please be advised that our office does not accept any type of secondary or supplemental insurance. Sorry for any inconvenience. **If a copay or co-insurance is applicable, the payment is due time of service. If you have any questions regarding coverage or eligibility, you must contact your insurance company. You must *ALWAYS* inform the office if there have been any changes to the patient's insurance coverage and must provide the correct card to the office. If you do not update the insurance information and the claim(s) are filed and denied, the parents or caregivers/guardians are liable for any unpaid claims. **There is a 3% financial surcharge for statements that are not paid within the first month and have to be re-mailed.** By signing below you understand the office policy and regulations. **

Guardian's Printed Name: _____ Date: _____

Signature: _____

Signature on File:

I, _____, authorize any holder of medical or other information in regards to the patient to release records to the Insurance Company, Georgia Division of Family and Children Services or to the Social Security Administration needed for this related claim. I permit a request of insurance benefits either to myself or to the part who accepts assignment.

Authorization to Treat:

The undersigned has given consent for treatment necessary for the patient whose name appears below and that the treatment and procedures will be performed by the physician and employees of the clinic authorization is hereby granted for such treatments and procedures.

Patient's printed name: _____

Authorized Person: _____ Relationship: _____

Signature: _____Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Nora Tan-Ngo, M.D. Pediatrics, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Please refer to Nora Tan-Ngo, M.D. Pediatrics, P.C. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Nora Tan-Ngo, M.D. Pediatrics, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nora Tan-Ngo Pediatrics, P.C. Privacy Officer 1200 19th Street Columbus, Ga 31901.

With my consent, *Nora Tan-Ngo, M.D. Pediatrics, P.C.* may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among other.

With my consent, *Nora Tan-Ngo, M.D. Pediatrics, P.C.* may mail to my home or other designated location any items that assists the practive in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, *Nora Tan-Ngo, M.D. Pediatrics, P.C.* may email my appointment reminders and patient statements. I have the right to request that *Nora Tan-Ngo, M.D. Pediatrics, P.C.* restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing the form, I am consenting to *Nora Tan-Ngo, M.D. Pediatrics, P.C.* use and disclosure of my PHI to carry out TPO.

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 the consent, *Nora Tan-Ngo, M.D. Pediatrics, P.C.* may decline to provide treatment to me.

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

Printed name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Today's Date: _____