



GEORGIA PEDIATRIC PULMONOLOGY ASSOCIATES, P.C.

Perimeter
1100 Lake Hearn Drive, N.E.
Suite 450
Atlanta, Georgia 30342-1524

Telephone – 404.252.7339
Facsimile – 404.257.0337

Alpharetta
3300 Old Milton Parkway
Suite 300
Alpharetta, Georgia 30005

Telephone – 404.252.7339
Facsimile – 404.257.0337

Peter H. Scott, MD *+
Gary L. Montgomery, MD *+*
LeRoy M. Graham, MD, FCCP *+
Kevin Kirchner, MD *+
Burton L. Lesnick, MD +
Steven M. Julius, MD +
Julia C. Sedor, MD +
Randall Brown, MD, MPH *+
Ann-Marie Brooks, MD +
LaTresa Lang, MD *
Robert Cohen, MD –
Jon Stahlman, MD –

Renee Bomar, RN-C, PNP
Kelly Morgenstein, PA-C
Tracy Paterson, PA-C
Elizabeth Johnson, PA-C
Brian Wingrove, PA-C
Lisa Waller, PA-C
Terrie Dixon, PA-C
John Pracht, PA-C
Amy Garten, PA-C

*Diplomate, American Board
of Pediatrics

+Diplomate, Sub-Board
of Pediatric Pulmonology

•Diplomate, American Board
of Sleep Medicine

– Certified by the American Board
of Allergy & Immunology

Date _____

Patient Name _____

Appointment Date _____ Time _____

Location: Perimeter Alpharetta Hughes Spalding Columbus

Physician Name _____

Dear Mr/Mrs. _____

We look forward to seeing your child as scheduled at the location and time shown above. A map is attached for your convenience. You may also obtain directions by calling our office and following the prompts to reach our direction line.

In an effort to decrease your wait time, we ask that you **fill out the enclosed patient information forms, completely, before your appointment. Please make sure to bring all paperwork to your appointment.** Also, please make sure to bring your insurance cards, including Medicaid Cards, as we will need to make copies for our records. Present your completed forms and insurance information to the receptionist upon check-in. **Please remember that if your original appointment date is changed, then your original appointment will be canceled and the date on this form becomes null and void.** Please allow approximately two hours for the initial consultation visit and thirty to 60 minutes for subsequent follow-up visits. You may want to bring something to entertain your child in the exam room. (books, gameboy, cards, etc.) While we do play movies in the waiting room, for hygiene reasons, we do not have toys available in the office.

Please note the following Georgia Pediatric Pulmonology policies in regard to insurance filing and reimbursement. If you are on one of the Managed Care Plans that our office participates with or on Medicaid, our office will file with your insurance company. We will ask for you to pay any deductibles or co-payments at the time of your appointment. You will need to contact your insurance company to find out what your benefits are. If your child is covered under a Commercial Insurance or on a Managed Care Plan that we DO NOT participate with, then the services must be paid in full at the time of your appointment and you will be given the proper documentation to file for reimbursement to your carrier. We do not file to insurance companies, for office services, that we do not participate with. **If your insurance is Medicaid, an HMO or POS plan, it will be your responsibility to obtain a referral from your child's primary pediatrician that is listed on your insurance card. If there is not a valid referral on file we will have to reschedule your child's appointment.** Please recognize that you and not your insurance company are responsible for payment of your medical bill.

Please provide us with a 24-hour notice, in the event that you cannot keep your appointment. This will allow another child to have the opportunity to be seen. If you are more than 15 minutes late to your appointment, you will need to reschedule. In addition, if you miss your appointment, without notifying our office, you will be charged a \$25.00 no-show fee.

At our Perimeter location our office provides covered parking. There is a fee to park so please bring \$5 cash to pay to park. At all of our other locations it is uncovered parking and there is no fee to park.

Thank you for helping ensure your visit will be a pleasant one. We look forward to seeing you. If you have any questions, please contact our office at 404-252-7339 (8:00 am – 5:00 PM)

Sincerely,

Georgia Pediatric Pulmonology Associate, P. C.

PATIENT INFORMATION SHEET

Patient Last Name: _____ First: _____ Initial: _____ Date of Birth: _____
Address: _____ Sex: _____
City: _____ County: _____ State: _____ Zip: _____ HomePhone: _____
Parent's Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Ethnicity(race) _____

Mother's Name: _____ Father's Name: _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____
Employer: _____ Employer: _____

Responsible Party: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to Patient: _____
In Case of Emergency Contact: _____ Relation: _____ Phone: _____
Primary Email Address: _____

Primary Insurance Company: _____ Phone: _____
Claim Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy # _____ Group: _____ Date of Birth: _____

Secondary Insurance Company: _____ Phone: _____
Claim Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship to Patient: _____
Policy # _____ Group: _____ Date of Birth: _____

Primary Physician or Pediatrician (not group name) _____ Phone# _____

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

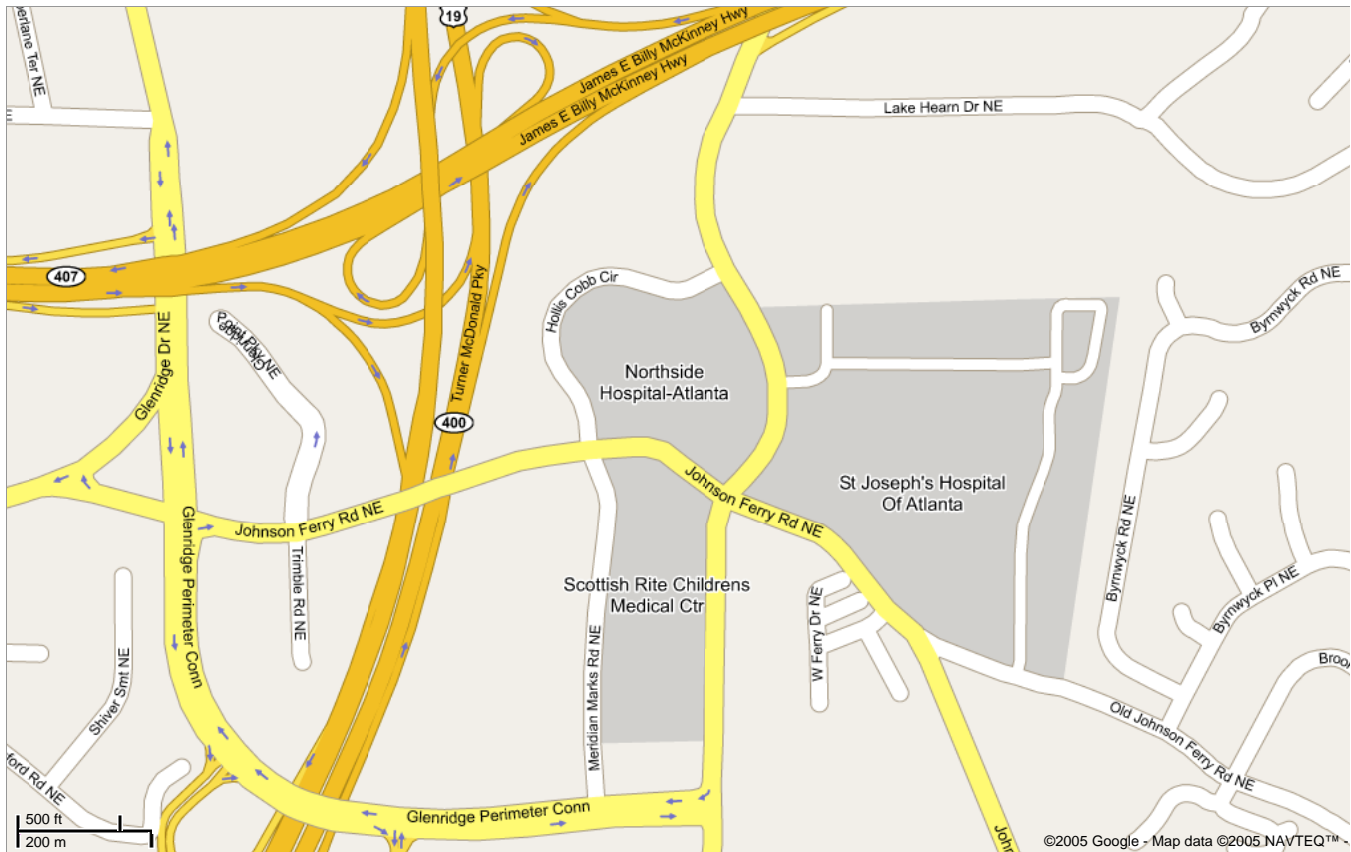
Allergies: _____ Does Anyone in Your Family Smoke? _____ Who? _____

Reason For Visit: _____

I hereby authorize the above physician to obtain records from other sources as may be needed in the treatment of this patient. I hereby authorize the release of information concerning this patient's treatment to other physicians involved in the care and treatment of this patient. I hereby authorize the release of information to the insurance company as needed to file the charges incurred by this patient. I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital. I understand that I am responsible for any amount not covered by the insurance company. A copy of this information shall be valid as the original. I have received a copy of the GPPA's Notice of Privacy Practices.

Signature of Parent or Responsible Party Date Patient #

Google Local Lake Hearn Drive near Atlanta, GA



Search results for Lake Hearn Drive near Atlanta, GA

- | | |
|---|---|
| <p>A Hilton Towers Downtown
255 Courtland St NE, Atlanta, GA
(800) 445-8667</p> <p>B Hilton Garden Inn
1501 Lake Hearn Dr NE, Atlanta, GA
(800) HIL-TONS</p> <p>C Southern Telecom
3003 Summit Blvd NE # 700, Atlanta, GA
(678) 443-4120</p> <p>D Atlanta Oral & Facial Surgery
1100 Lake Hearn Dr NE # 160, Atlanta, GA
(404) 255-2559</p> <p>E Associated Credit Union: Perimeter/Lake Hearn Office
6205 Peachtree Dunwoody Rd NE, Atlanta, GA
(770) 448-8200</p> <p>F Cox Communications Inc
1400 Lake Hearn Dr NE, Atlanta, GA
(404) 843-4238</p> | <p>K Gyn & Fertility Specialists
5673 Peachtree Dunwoody Rd NE, Atlanta, GA
(404) 851-9300</p> <p>L Southeastern Fertility Inst
1150 Lake Hearn Dr NE # 400, Atlanta, GA
(404) 257-1900</p> <p>M Home Depot
2455 Paces Ferry Rd Se, Atlanta, GA
(770) 434-4109</p> <p>N Montgomery Gary L MD
1100 Lake Hearn Dr NE, Atlanta, GA
(404) 252-7339</p> <p>O Crowne Plaza Atlanta-Ravinia
4355 Ashford Dunwoody Rd NE, Atlanta, GA
(800) 227-6963</p> <p>P Medical Center Station
5711 Peachtree Dunwoody Rd, Atlanta, GA</p> <p>Q Zweig Center-Facial Plastic
1100 Lake Hearn Dr NE # 410, Atlanta, GA</p> |
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GEORGIA PEDIATRIC PULMONOLOGY ASSOCIATES, P.C.
Patient Authorization to RELEASE Protected Health Information

This authorization permits Georgia Pediatric Pulmonology Associates, P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.). I am aware that I do not have to sign this authorization in order to receive treatment from Georgia Pediatric Pulmonology Associate, P.C..

Medical Information on:

PRINT PATIENT'S Full Name

PATIENT'S date of birth

PRINT NAME of Parent/Legal Guardian or Patient
 (if 18 years of age or older)

DAY phone number

Check (✓) one, I am the: **Patient (must be 18years of age or older)** **Parent or**
 Legal Guardian with custody (please state relationship to the patient: _____)

FOR OFFICE USE ONLY:

CALL to pick up records:

OR

MAIL records to:

 DAY phone number

 PRINT Name of Individual(s) or Agency

 Date Picked Up

 PRINT (Street Address or Box Number)

FAX RECORDS TO:

 PRINT name of Agency or Individual(s)

 PRINT (City, State and Zip Code)

(_____) _____
 FAX Number

- I place no limitations on history or illness (including HIV, and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of a Photostat or other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information prior to Georgia Pediatric Pulmonology Associates receiving a written notice of withdrawal.
- I hereby release Georgia Pediatric Pulmonology Associates, PC and its officers, directors, agents, and employees from any and all liabilities, responsibilities, damages, losses, and claims, which might arise from the release of information, authorized above.
- In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I understand that the Practice may receive payment from a third party in exchange for using or disclosing the PHI.
- I hereby acknowledge that I have read (or had someone read to me) the above statements and that I fully understand the above statements and do expressly and voluntarily authorize the disclosure of this medical information to the individual, agency named above.

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or in 6 months (12months for school requests), whichever is shorter, and no further use/disclosures as described above may be made after the expiration. Authorization applies on for specified treatment dates prior to and on the date of signature, unless otherwise specified. Specified exceptions for future-dated releases are:

Signature: _____ **Date:** _____

INTERNAL OFFICE USE ONLY

Faxed Mailed Pick-up/Called: _____ Date: _____ Initials: _____