Welcome to the YouBelong Pediatrics Family!

Thank you so much for choosing **YouBelong Pediatrics** to care for your child.

Our mission is simple: we want every child and parent to feel like they truly belong here. We are honored to be your partner in watching your little one grow!

To help your first visit go as smoothly as possible, we've put together a few helpful tips:

1. **Forms & Records:**
    a. Fill out your patient information forms and bring them with you to your first appointment.
    b. Have a copy of your child's medical records sent to us **prior** to your appointment. If immunization records are not received by the appointment date, your child's well visit may be rescheduled.
    c. Bring a **photo ID and your child's insurance card** to every visit.

2. **Insurance:**
    a. Our office participates in multiple insurance plans.
    b. It is your responsibility to make sure that YouBelong Pediatrics is in network with your particular insurance plan.
    c. If your plan **requires** you to select a PCP (Primary Care Physician), you should have **Dr Rabia Akbar listed as the designated PCP** before your initial appointment.

3. **Payment:**
    a. We require payment at the time of the service.
    b. Full payment is expected from those patients that YouBelong Pediatrics is not filing insurance for.
    c. Patients that YouBelong Pediatrics will file insurance for are expected to pay the designated amount required by the insurance plan which include copayments, deductibles and/or coinsurance.
    d. We accept the following: Cash, Check, Visa, MasterCard

If you need to change or cancel your appointment, please notify the office 24 hours in advance. Failure to notify the office will result in a $35 fee.

We look forward to partnering with you in the healthcare needs of your child and developing a lasting relationship with your family.

New Patient Registration:

Patient Information:

Patient First Name	Middle	Last
Date of Birth	Gender	SSN#
Address		
City	Sate	Zip Code
Home Phone	Cell Phone	

Parent/Guardian Information:

Mother/Legal Guardian 1	Father / Legal Guardian 2
First Name	First Name
Last Name	Last Name
Address (is not same as child)	Address (is not same as child)
City, Sate, Zip code	City, Sate, Zip code
Birth date	Birth date
Home Phone	Home Phone
Cell Phone	Home Phone
Employer Name	Employer Name
Work Phone	Work Phone
Email Address	Email Address

Insurance Information:

PRIMARY Insurance	Policy#	Group
Insured's Name	Relationship to Patient	Insured's Date of Birth
SECONDARY Insurance	Policy#	Group
Insured's Name	Relationship to Patient	Insured's Date of Birth

Pharmacy Information:

Pharmacy Name	Pharmacy street & City	Pharmacy Phone#
Insured's Name	Relationship to Patient	Insured's Date of Birth

How did you hear about us?

Parental Consent for Alternate Decision Maker

I give permission to persons listed below to bring my child to YouBelong Pediatrics, LLC for medical treatment and make medical decisions about care received while in the office.

Name	Relationship to Patient	Phone Number
1		
2		
3		
4		
5		

Protected Health Information (PHI) Contact Consent

Select one:

❏ No one besides parents/legal guardian(s) can be contacted regarding my child's lab results, billing information, and other PHI.

❏ The persons listed below can be contacted regarding my child's lab results, forms, billing, prescriptions and other PHI.

❏ Check here if same as "Parental Consent" section above _____.

Patient/Parent/Guardian Signature

Name	Relationship to Patient	Phone Number
1		
2		
3		
4		
5		

YBP can leave normal results on the following phone number: _____, belonging to (name) _____

Emergency Contact

In the event of an emergency, I give YouBelong Pediatrics, LLC permission to contact the persons listed below.

Name	Relationship to Patient	Phone Number
1		
2		

_____ _____ _____

Parent/Guardian Name: **Parent/Guardian Signature:** **Date**

Assignment of Benefits

All professional services are billed to the patient and payment is due at the time of service, unless insurance coverage is verified and YouBelong Pediatrics is a participating provider. We will complete the necessary forms to file for insurance payments.

Assignment of Benefits
I authorize the following:

1. By requesting medical services, I accept financial responsibility for all charges incurred.
2. I understand that fees are due on the date services are provided, and I agree to pay all charges (copay, coinsurance, and/or deductible) in full upon receiving a statement.
3. My insurance carrier(s), including private insurance and any other health/medical plan, to send payment directly to YouBelong Pediatrics for services provided to me and/or my dependents.
4. I understand I am responsible for any charges not covered by insurance.

Authorization to Release Information
I give permission for YouBelong Pediatrics to:

1. Release any information needed to insurance carriers about my or my dependent's illness and treatment.
2. Process insurance claims related to my care.
3. Use a photocopy of my signature to process insurance claims.
4. This authorization remains in effect until I revoke it in writing.
5. A photocopy of this assignment is as valid as the original.

Parent/Guardian Name:	Parent/Guardian Signature:	Date

Acknowledgement Of Receipt Of Notice Of Privacy Practices

YouBelong Pediatrics is required by State and Federal law, including HIPPA rules, to protect your health information. Our Notice of Privacy Practices explains how your information may be used and disclosed. Copies are available on our website, in the waiting room, or by request.

By signing below, you acknowledge that:

- YouBelong Pediatrics has offered or provided you with a copy of its Notice of Privacy Practices.
- You may refuse to sign this acknowledgment if you wish. This does not indicate agreement or disagreement with the content—only that you were offered or received the notice.
- You are entitled to receive updates if changes are made to this policy.

Parent/Guardian Name:	Parent/Guardian Signature:	Date

For Office Use Only:
I made a good faith effort to obtain the patient's written acknowledgment of receipt of the Notice of Privacy Practices, but was unable to because:
❑ Patient declined to sign this Written Acknowledgment.
❑ Other (Specify): _____
Name & Title of Employee: _____ Date: _____

Authorization for Release of Medical Information

Patient Name	Date of Birth
1	
2	
3	
4	

As the parent/legal guardian for the child(ren) listed above, I hereby authorize the release of medical information for continuation of care

Send records To:	**From:**
YouBelong Pediatrics 3525 Lawrenceville-Suwanee Rd Suite 101 Suwanee, GA 30024 **Phone:** 770-585-0190 **Fax:** 833-764-6081	Name of Facility:_____ Address 1: _____ Address 2: _____ Phone: _____ Fax: _____

Please release the following information:

- ❑ All health information
- ❑ Growth Chart and Vaccination Record only
- ❑ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

- ❑ Yes, I consent to the release of this information.
- ❑ No, I do not consent to the release of this information.

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until it is revoked in writing.

Parent/Guardian Name:	**Parent/Guardian Signature:**	**Relationship to Patient(s):**	**Date:**

Financial Policies (page 1/2)

We're committed to making your experience as smooth and supportive as possible. Below you'll find important information about our financial policies—designed to help you understand what to expect and how we can best serve your family.

Insurance

- We accept most insurance plans. Proof of current insurance and photo ID are required at each visit.
- Please contact your insurance company to confirm your coverage and payment responsibilities.
- **New Born Babies:**
    - Please confirm insurance coverage within 30 days of the baby's last visit.
    - After 30 days, if insurance is not verified, you'll be responsible for any outstanding charges.
- We follow recommended guidelines for screenings, but not all plans cover every service—so it's important to know your benefits.
- Some lab work may be sent to outside labs, which will bill you separately.
- If you need care at an outside facility, please check if it's covered and whether a referral is required.
- We do not file automobile, liability, or homeowner's insurance.

Copayments and Deductibles

- Copays and deductibles are due at time of your visit, as required by your insurance.
- High-deductible plans may mean more out-of-pocket costs until your deductible is met.
- After insurance processes your claim, any unpaid balance will be charged to your card after 30 days of insurance processing.
- A $30 fee applies for declined payments without a payment plan.

Patients Without Insurance Coverage (Self Pay)

- Families without insurance are welcome.
- Payment is due at the time of service (We can accept Cash, Check or most major Credit cards)

No-Show/Late Arrival Fee

- We schedule by appointment only. Walk-ins will be scheduled for the next available.
- Please arrive 15 minutes before your appointment time.
- If you arrive more than 15 minutes late, you may be asked to reschedule.
- If you need to change or cancel your appointment, please notify the office 24 hours in advance.
- Failure to notify the office, Missing or being late to your appointment may result in a $35 fee.
- More than two missed or late appointments may lead to dismissal from our practice.

Sick visit combined with Well visit

- Upon examination during a Preventative/Well Child visit, sometimes a child may also have symptoms of illness or an acute issue that needs attention
- In these cases, we'll provide care for and bill for both the **preventative visit** AND the **sick visit**—as recommended by national guidelines from CMS (Centers for Medicare & Medicaid Services) and the AMA (American Medical Association)
- Your insurance may apply a co-pay, co-insurance, or deductible, based on your plan's terms.

Parent/Guardian Name:	Parent/Guardian Signature:	Date

Financial Policies (page 2/2)

After Hours Calls

- In an emergency, please call 911 or visit the nearest ER.
- For Urgent issues, providers are available 24/7.
- Please note: Non-urgent, after-hours calls (e.g. refills) may be charged $15 per call.

Form Fee & Medical Records

- Forms completed during your annual physical are free.
- Forms requested outside of your visit are $25 each, payable before completion. Please allow 2 business days for processing.
- Medical records requests require a signed "Authorization for Release of Medical Information" form.
- Fees for records are based on pages, retrieval, certification, and postage. Please allow 7–10 days for processing.
- Prior authorization requests are $25 each, payable at the time of request.

Financial Responsibility

- The adult who accompanies the child is responsible for payment.
- We continue to bill the parent once the child turns 18 unless notified in writing.
- Dishonored checks will result in a $35 fee and future payments must be made in cash.

Unpaid balances and Credit Card on File Policy

- We securely keep a credit card on file to simplify billing, including for TeleMedicine.
- After insurance processes your claim, any unpaid balance will be charged to your card after 30 days of insurance processing.
- Future appointments may be rescheduled or denied for overdue accounts.
- Unpaid balances transferred to collections may result in dismissal from the practice.
- You can update your payment method at any time.

Thank you for choosing YouBelong Pediatrics!

We're honored to care for your child and support your family. If you have any questions about these policies, please don't hesitate to ask—we're here to help.

Parent/Guardian Name:	Parent/Guardian Signature:	Date

Please list all patients

Name	Date of Birth
1	
2	
3	

Credit Card on File

Until further notice, I give permission to YouBelong Pediatrics, LLC to charge any unpaid balances on my account to the credit card listed below. I understand the following:

1. I am responsible for all unpaid balances on my account and prompt payment is expected.
2. 30 days after insurance processes my claim, I authorize YouBelong Pediatrics to charge this credit card for unpaid balances.
3. I may choose to pay my balance by other means.
4. **My card will NOT be charged unless my account remains unpaid**

Credit Card #: _____

Expiration Date (mm/yy): _____

Security Code: _____

Card Type (please circle): ❑MasterCard ❑Visa ❑Discover ❑American Express

Once your card information is securely entered into our system, it is encrypted and cannot be viewed by our office staff.

Credit Card Holder's Name:	**Credit Card Holder's Signature:**	**Date**

STOP

The remaining forms are for
<u>DOCTOR/CLINIC</u> USE ONLY

Mother's Pregnancy History

Did mom have an abnormal ultrasound during pregnancy? ❑Yes ❑No

Did mom smoke during pregnancy? ❑Yes ❑No

Did mom drink any alcoholic beverages during pregnancy? ❑Yes ❑No

Has mom had any miscarriages, still births, or abortions? ❑Yes ❑No

Were there any complications during pregnancy? If so, please list:
_____

Child's Birth History

❑ Full term pregnancy ❑ Premature birth at ___weeks ❑ Twin or multiple births at___weeks

Were there any problems during labor? If so, please list: If so, please list: _____

_____

Baby's weight at birth? _____

Type of Delivery: ❑ Vaginal ❑ C-Section Apgars_____ Was the baby ever breech (feet first)? ❑ Yes ❑ No

Did the baby have any problems during the newborn period? If so, please list: _____

Was the child the product of IVF? ❑ Yes ❑ No Was the child the product of artificial insemination? ❑ Yes ❑ No
Was the child the product of a donor egg? ❑ Yes ❑ No Was the child adopted? ❑ Yes ❑ No

Child's Developmental History

Baby sat alone at_____mos. Walked at_____mos. Words at_____mos. Sentences at_____mos.

Were there any concerns for your child's development in the past? ❑ Yes ❑ No

Does the child have any disability? ❑ Yes ❑ No If yes, please specify: _____

Has your child ever needed to see a physical, speech or occupational therapist? If so, please list: _____

Past Medical History Form

Has your child ever been diagnosed with any of the following health issues? Please indicate each one.

Allergies
- Environmental ❑Yes ❑No
- Food ❑Yes ❑No
- Allergy Testing ❑Yes ❑No
- Allergy Shots ❑Yes ❑No
- Eczema ❑Yes ❑No
- History of Anaphylaxis? ❑Yes ❑No
- Other (Please List)_____

Cardiac
- Heart Defect ❑Yes ❑No
- Other (Please List)_____

Developmental/Genetic Disorders
- Down Syndrome ❑Yes ❑No
- Turner Syndrome ❑Yes ❑No
- Mitochondrial Disease ❑Yes ❑No
- Autistic Spectrum Disorder ❑Yes ❑No
- Other (Please List)_____

Ear/Nose and Throat
- Ear Infections (more than 5 in a year) ❑Yes ❑No
- Tonsillitis (recurrent) ❑Yes ❑No
- Sleep Apnea ❑Yes ❑No
- Other (Please List)_____

Endocrine
- Hypothyroid ❑Yes ❑No
- Hyperthyroid ❑Yes ❑No
- Type I Diabetes ❑Yes ❑No
- Type II Diabetes ❑Yes ❑No
- Other (Please List)_____

Eye
- Strabismus (crossed eyes) ❑Yes ❑No
- Amblyopia (decreased vision) ❑Yes ❑No
- Other (Please List)_____

Gastrointestinal
- Reflux ❑Yes ❑No
- Constipation ❑Yes ❑No
- Chronic Abdominal Pain ❑Yes ❑No
- Celiac Disease ❑Yes ❑No
- Other (Please List)_____

Genitourinary
- Urinary Infections ❑Yes ❑No
- Menstrual Problems ❑Yes ❑No
- Vesicoureteral Reflux (kidney reflux) ❑Yes ❑No
- Bedwetting (over the age of 6) ❑Yes ❑No
- Other (Please List) _____

Hematology
- Anemia ❑Yes ❑No
- Other (Please List)_____

Infections/Immunology
- Chicken Pox ❑Yes ❑No
- MRSA ❑Yes ❑No
- Immunodeficiency ❑Yes ❑No
- Other (Please List)_____

Lung
- Pneumonia ❑Yes ❑No
- Asthma or wheezing ❑Yes ❑No
- RSV (respiratory syncytial virus) ❑Yes ❑No
- Other (Please List)_____

Mental Health
- Depression ❑Yes ❑No
- Anxiety ❑Yes ❑No
- Other (Please List)_____

Neurologic
- Recurrent Headaches ❑Yes ❑No
- Cerebral Palsy ❑Yes ❑No
- Seizure Disorder ❑Yes ❑No

ADHD
- Predominantly Inattentive ❑Yes ❑No
- Predominantly Hyperactive ❑Yes ❑No
- Combined ❑Yes ❑No
- Other (Please List) _____

Obesity ❑Yes ❑No

Oncology/Cancer ❑Yes ❑No
- Other (Please List)_____

Orthopedic
- Fractures and When ❑Yes ❑No
- What bone? _____
- What bone? _____
- What bone? _____
- Scoliosis
- Other (Please List)_____

Please list any details if you answered "Yes" to any of the above:	
List any hospitalizations that your child has had:	Other illnesses:
Sees Specialist Doctor? ❑Yes ❑No	If yes, what kind?
For what?	Name of Specialist Doctor(s):

Family History Form

Has anyone in your family been diagnosed with the following health issues? Please be sure to only consider the **CHILD'S parents, siblings, grandparents, aunts, uncles, first cousins, etc. Please also indicate/write next to each diagnosis which first degree family member has or had each health issue (i.e. maternal aunt, paternal grandfather, etc.).**

Allergies
Asthma ❑Yes ❑No
Environmental ❑Yes ❑No
Food ❑Yes ❑No

Birth Defects ❑Yes ❑No

Bleeding Disorders ❑Yes ❑No

Cancer ❑Yes ❑No

Cardiovascular
Heart Attack before 50 ❑Yes ❑No
Stroke before 50 ❑Yes ❑No
High Blood Pressure ❑Yes ❑No
High Cholesterol ❑Yes ❑No
High Triglycerides ❑Yes ❑No
Other ❑Yes ❑No

Development
Learning Disorder ❑Yes ❑No
Developmental Disorder ❑Yes ❑No
Autism ❑Yes ❑No
ADD/ADHD ❑Yes ❑No
Other ❑Yes ❑No

Diabetes
Type I (Juvenile) ❑Yes ❑No
Type II (Adult) ❑Yes ❑No

Gastrointestinal
Celiac Disease ❑Yes ❑No
Inflammatory Bowel Disease ❑Yes ❑No
Irritable Bowel Syndrome ❑Yes ❑No
Peptic Ulcer Disease ❑Yes ❑No
Other ❑Yes ❑No

Genetic Disorders ❑Yes ❑No

Hearing Loss/Deafness ❑Yes ❑No

Kidney Disease
Kidney Reflux ❑Yes ❑No
Recurrent Infections ❑Yes ❑No
Congenital Malformations (abnormally formed kidneys) ❑Yes ❑No
Kidney Failure/Transplant ❑Yes ❑No
Other ❑Yes ❑No

Lazy Eye ❑Yes ❑No

Mental or Emotional Disorders
Anxiety ❑Yes ❑No
Bioplar Disorder ❑Yes ❑No
Depression ❑Yes ❑No
Schizophrenia ❑Yes ❑No
Substance Abuse (drugs or alcohol) ❑Yes ❑No
OCD ❑Yes ❑No
Other ❑Yes ❑No

Migraines ❑Yes ❑No

Obesity ❑Yes ❑No

Seizure Disorder ❑Yes ❑No

Thyroid Disease
Hypothyroid ❑Yes ❑No
Hyperthyroid ❑Yes ❑No
Thyroid Tumor ❑Yes ❑No

Please list any other problems in the family:

Social History Form

Please complete the following information for your child.

Who lives in the household with the Child:

❑ Mother ❑ Father ❑ Stepmother ❑ Siblings ❑ Grandparents ❑ Stepfather
❑ Stepsiblings ❑ Boyfriend / Girlfriend of parent ❑ Other: _____

Recent Changes: ❑ Move ❑ Loss of Job ❑ Other, please list: _____
❑ Travel ❑ Death Date of Change: _____

Parent's Marital status ❑ Married ❑ Divorced, Date: _____ ❑ Separated, Date: _____
❑ Single ❑ Widowed, Date: _____ ❑ Unmarried, Living Together

FAMILY HISTORY

	Name	Age	Health	Occupation	
Mother					
Father					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Sibling 5					

Other living arrangements:

❑ Legal Guardian ❑ Adopted ❑ Foster Care ❑ Parent(s) Incarcerated ❑ Parent(s) in Drug/Alcohol Rehab
❑ Child Protective Services Involved Who is the primary caregiver?: _____

Is there tobacco or smoke exposure? ❑Yes ❑No

Are there guns in the home? ❑Yes ❑No ❑Decline to answer If yes, are they? ❑Secured ❑ Unsecured

School Arrangements: ❑Daycare ❑Preschool ❑In School ❑Home School
What grade? _____ Name of school _____
Academic performance ❑Excellent ❑Good ❑Average ❑Poor
Any club's or athletic teams? ❑Yes ❑No

Any pets in the home? ❑Dog ❑Cat ❑Other, please list: _____

TB exposure risks: ❑None ❑Contact w/TB ❑Contact w/HIV ❑Contact w/Immigrant ❑Contact w/Prisoner
❑Contact w/Homeless ❑Immunosuppression ❑Foreign Travel (for 1 month+) ❑High Risk Community
❑Other, please list: _____

Lead exposure risks (if your child is under 6 years of age): ❑None ❑Older Home (before 1978)
❑Recent Remodeling ❑Paint Removal ❑Occupational Exposure
❑Pica (child eats dirt, rocks, paper, plastic, etc.)
❑Other, please list: _____