McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough, GA. 30253

Last Updated 03/13/2025

PATIENT REGISTRATION FORMS

1st Child's Name: _____ MI _____ Last Name _____

Date of Birth _____ Gender (circle one) Male Female

2nd Child's Name: _____ MI _____ Last Name _____

Date of Birth _____ Gender (circle one) Male Female

3rd Child's Name: _____ MI _____ Last Name _____

Date of Birth _____ Gender (circle one) Male Female

4th Child's Name: _____ MI _____ Last Name_____

Date of Birth _____ Gender (circle one) Male Female

Home Address_____
Street City State Zip

Main Phone _____ Work _____ Other Phone_____ Cell Phone _____

Email address: _____

PARENT/GUARDIAN INFORMATION:

First _____ MI _____ Last Name _____

Date of Birth _____ SSN: _____-_____-_____

HEALTH INSURANCE INFORMATION

Name of insurance _____

Group Member ID Number #_____

Subscriber's name _____

Relationship with the patient: □ parent □ spouse □ partner □ another

Address (if different from the patient's) _____
Street City State Zipper

I hereby assign all medical and/or surgical benefits to which I am entitled to McDonough Pediatrics. This assignment remains in effect until revoked by me, in writing. A copy of this assignment will be considered valid as the original. I hereby authorize such assignee to disclose all information necessary to secure payment. I consent to the release of my information by McDonough Pediatrics and my health insurance and/or payer to McDonough Pediatrics and its employees or representatives to facilitate peer review and my treatment, including utilization and quality management. I understand that McDonough Pediatrics will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I understand that my health insurance is a contract between this insurance company and me. McDonough Pediatrics is not a party to this contract. I understand that I am responsible for any legal and/or collection fees necessary to settle the accounts, should they become late.

Parent/ Guardian's SIGNATURE: _____ Date: _____

Permission to Treat a Child in the Absence of Parents or Guardians

I, (parent/guardian's name) _____ , give permission to the names listed below to bring my child(ren) listed below for medical treatment. I understand the purpose of disclosing personal health information to the individuals listed below. I also understand my right to refuse to sign this consent form.

1st Child's Name: _____

2nd Child's Name: _____

3rd Child's Name: _____

4th Child's Name: _____

Mother's Name: _____

Phone Number: _____

Father's Name: _____

Phone Number: _____

Name of person: _____

Phone Number: _____ Relationship: _____

Name of person: _____

Phone Number: _____ Relationship: _____

Name of person: _____

Phone Number: _____ Relationship: _____

Name of person: _____

Phone Number: _____ Relationship: _____

Name of person: _____

Phone Number: _____ Relationship: _____

Parent/ Guardian's SIGNATURE: _____ Date: _____

Vaccination Policy Acknowledgement

It is now the policy of McDonough Pediatrics, P.C. that all children who visit our office for care receive ALL vaccines recommended by the American Academy of Pediatrics (A.A.P.). These immunization schedules change from time to time as new vaccines become available.

WE ARE NOW UNABLE TO PROVIDE CARE FOR NEW FAMILIES IN OUR OFFICE WHO DO NOT FOLLOW THESE GUIDELINES.

McDonough Pediatrics, P.C. believes that vaccines are vitally important to the health of children and the general population. **There are NO exceptions to the policy**. If you have questions about this policy, please feel free to let us know. You can also check the AAP website for vaccination practices and recommendations.

My signature below indicates that I have been informed of the policy and will follow the AAP's guidelines on vaccinations for my child(ren).

Prescription Requests

While we make every effort to respond to prescription refill requests in a timely manner, requests may take up to 2 business days to complete (excluding weekends and holidays). Refill requests received on Fridays will be processed the following week and completed on Tuesday.

For chronic conditions, such as asthma, unless otherwise directed by your provider, maintenance medications will be approved if the patient has had an office visit in the past 3 months for that condition. If the patient has not been seen, an appointment will need to be scheduled, and a 30-day supply of the medication may be prescribed. A follow-up appointment must be scheduled for us to process the refill request. Only 1 rescheduling will be allowed. Talk to your provider during your next visit to see if your Maintenance medications may be prescribed for 6 months of refills. This is usually a factor in the stability of the condition and DEA regulations.

We cannot prescribe medication without the patient seeing a provider for non-chronic conditions.
This includes requests for antibiotics and narcotics.
Please do not ask our schedulers and nursing assistants to message our clinical staff for these types of requests.

All messages to clinical providers must include:

- the child's name
- date of birth
- a description of the problem / need
- current phone number
- Your name and relation to patient

****** Lack of information will lead to a lack of response ******

Below are guidelines regarding medication refills:

• Unless otherwise directed by your provider, maintenance medications, such as asthma, will be approved if the patient has had an office visit in the past 3 months.
• Narcotics, other controlled substances such as ADD/ADHD medications, and sleeping pills will require a mandatory visit every 3 months, unless otherwise directed by the provider.
• An office visit is required for antibiotics and most prescription medications and will not be prescribed without a visit.

Sign below stating that you understand and agree to the above Terms and Conditions:

Parent/ Guardian's SIGNATURE: _____ Date: _____

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____ Date of Birth: _____

3rd Child's Name: _____ Date of Birth: _____

4th Child's Name: _____ Date of Birth: _____

Telemedicine Patient Consent Form for Virtual Visit

Telemedicine involves the use of electronic communications to allow health care providers to review health information in order to improve patient care.

The electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

Possible risk:

As with any medical procedure, there are potential risks associated with using telemedicine. These risks include, but are not limited to:

- In rare cases, the information transmitted may not be sufficient (e.g., poor resolution of images) to allow the provider to make appropriate medical decisions.
- Delays in medical evaluation and treatment may occur due to equipment deficiencies or failures.
- Reasonable and appropriate efforts have been made to eliminate the confidentiality risk associated with telemedicine consultation. However, in very rare cases, security protocols could fail, causing a breach of privacy of personal health information.
- In rare cases, lack of access to complete medical records can result in adverse drug interactions or allergic reactions or other errors in judgment.

I, (Parent/Guardian) _____, agree to have my child participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my child's medical information and/or videoconferencing sessions so that it can be viewed by a physician and others involved in my child's medical or mental health care. [Note: The probability of this transmission being intercepted by persons other than those at the location is extremely small.]

I have discussed the risk of telemedicine with my provider and all of my questions have been answered. I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I feel are inappropriate or that I am not willing for others to hear. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that would cause a delay in my child's care and that we may still seek an in-person consultation.

I understand that, as with any technology, telemedicine has its limitations. Therefore, there are no guarantees that this telemedicine session will eliminate the need for your child to see a specialist in person.

Parent/ Guardian's SIGNATURE: _____ Date: _____

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____ Date of Birth: _____

3rd Child's Name: _____Date of Birth: _____

4th Child's Name: _____ Date of Birth: _____

HIPPA

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice contains a section on Patient's Rights that describes your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may be modified. If we change our Notice, you can get a revised copy by contacting our office. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement. By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation will not affect disclosures we have already made based on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Clinic does not have to agree to the restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- The Practice may condition the receipt of the processing on the execution of this Consent.
- The patient acknowledges that they have received the option to obtain a copy of our HIPPA practice brochure.

Acknowledgment of Privacy Notice

Your signature below indicates that you have been provided a copy of our updated privacy policies and have had an opportunity to review them. If you would like a printed copy for your records, please request it at the front desk.

The consent was signed by: _____ _____

Parent/Guardian's Signature Date

Relationship with the patient: □ Parent □ Foster □ Guardian □ Other: _____

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____Date of Birth: _____

3rd Child's Name: _____ Date of Birth: _____

4th Child's Name: _____ Date of Birth: _____

Policies and Procedures for McDonough Pediatrics, P.C.

APPOINTMENTS: Our office is by appointment only, except in cases of extreme emergency. This policy helps our office keep up with our appointments and keeps our wait to a minimum. It is our policy to provide care for all sick children who need to be cared for. When making an appointment for your sick child, this allows us to decide if the patient needs to be seen in our office or referred to a specialist. This helps our office prioritize our appointments, saving you time and expense. It is our policy to schedule Well checks every 30 minutes. Please make sure you arrive on time for these appointments. When you are late, you are on the schedule of upcoming appointments and will be incorporated into our current schedule. This may also require you to reschedule your appointment. Remember that when you are late, our schedule is delayed for the rest of the day.

REMINDER NOTIFICATIONS: It is the policy of this office to make reminder phone calls of scheduled appointments 1-2 days in advance. Appointment reminders are available via phone, text message or e-mail. Be sure to give the receptionist the correct daytime phone number and email when you schedule your appointment. It is the patient's responsibility to be at the appointment on the correct date and time. Our office and staff pride themselves on being able to offer you the best medical care with the least amount of wait time. In order to provide this level of service to our patients, we are unable to offer walk-in appointments to our patients. If you do not schedule an appointment and your child needs to be seen, one of our nurses will triage the patient and decide if they need to be worked in. Please note that if we incorporate it into our schedule, you may experience delays in wait times, but you WILL be taken care of.

OUR OFFICE IS NOT A WALK IN FACILITY: Our office and staff are proud to offer you the best medical care with the least amount of waiting time. In order to offer this level of service to our patients, we cannot offer walk-in appointments to our patients. If you do not schedule an appointment and your child needs to be seen, one of our nurses will triage the patient and decide if he/she needs to be worked in. Please note if we do work you into our schedule, you may experience delayed wait times, but you will be seen.

CANCELLATIONS: If you are unable to make it to your scheduled appointment time, please call and cancel at least 24 hours in advance. If you do not call to cancel your appointment, it will appear as a no-show appointment.

RE-CHECK APPOINTMENTS: It is our physician's policy to order rechecks for recurrent ear infections, strep infections, bronchitis, pneumonia, severe sinus infections, other serious infections, or illnesses that may require control. It is imperative that you attend these review appointments. This helps the doctor plan a treatment method that is best for your child. For younger children who still have regular checkup appointments, we do our best to incorporate this new checkup into their monthly checkups.

MCDONOUGH PEDIATRICS, P.C. FINANCIAL POLICIES: Payment is due at the time of service. This includes copays, coinsurance, and self-pay policies. PPO, HMO, POS, and EPO insurance plans: We have a schedule of contracted rates with these insurance companies. You are responsible for your co-pay and any other amounts that the insurance company indicates as your responsibility or any non-covered services. These rates are non-negotiable as we have already negotiated these rates and contracted with your insurance company. The fee schedule for our self-pay patients is separate and will be provided upon request. Please keep your receipts. You may need them for your secondary insurance or for tax purposes. Our computer system does not print duplicate receipts or statements line by line.

BALANCE BILLING: It is the policy of this office to mail statements each month. The balance is due within 10 days of receipt of the statement. If you are unable to pay the balance in full, please call the billing office to make payment arrangements. Finance charges will accrue on any account past due for 30 days. If you set up payment arrangements, make payments on the agreed date and the amount or collection procedures will be initiated. All of our collections are handled through the courthouse or by our collection agency. If your account is past due, and if there are special circumstances or legitimate reasons, please call us so we can find a mutually acceptable solution. Please do not let this affect your children's medical care. If our office makes every effort to assist you and your account is past due, appropriate collection action will be taken within 90 days of initial billing. Our office makes the best effort to make arrangements with you in the best interest of both parties, but please understand that this is a business and is run as cost-effectively and efficiently as possible. Many insurance companies are covering routine exams at 100%. Because of this, we do not collect your copay at the time of service. Please note that during a routine exam, if your child has anything additional that is discussed during that exam, including a chronic condition, acute illness, or any other problem that is occurring, there will be an additional charge per sick visit and may be subject to a co-pay. If you have any questions about financial expectations, please call our billing office at **770-957-8626.**

I have read and understand the MCDONOUGH PEDIATRICS, P.C. POLICIES AND RULES.
***** I have been given the option to request a copy for my records. *****

Parent/ Guardian's SIGNATURE: _____ Date: _____

McDonough Pediatrics, P.C. * 101 Regency Park Drive * Suite 140 * McDonough, GA 30253 * Office: 770-957-8626 * Fax: 770-957-7200

No-Show and Late Cancellation Policy for McDonough Pediatrics

At McDonough Pediatrics, our goal is to provide quality healthcare in a timely manner. To help us achieve this, we have implemented the following **No-Show and Late Cancellation Policy**.

Policy Details

1. **Appointment Reminders:**
   - We provide reminders by phone, text and /or e-mail to help you remember your appointment. Please ensure we have your updated contact information.

2. **Cancellations and Tardiness:**
   - If you need to cancel or reschedule an appointment, we kindly request **at least 24 hours' notice** to accommodate other patients in need of care. For late arrivals, a **10-minute grace period** is allowed. If you arrive beyond this timeframe and cannot be seen by a provider, you will be subject to a **$25 NO-SHOW FEE**, depending on your insurance status.

3. **No-Show Fees:**
   - **Commercial Insurance Patients:** Patients who fail to show up for their appointment without prior notice will be charged a **$25 NO-SHOW FEE**
   - **Medicaid Patients:** While Medicaid does not allow no-show fees, repeated missed appointments may lead to restricted scheduling options, possible dismissal from the practice, and potential reporting to Medicaid.
   - **Self-Pay Patients:** Patients who fail to show up for their appointment without prior notice will be charged a **$25 NO-SHOW FEE**.

4. **Excessive No-Shows:**
   - Patients with **three (3) or more no-shows within a 12-month period** may be required to schedule same-day appointments only or risk dismissal from the practice.

5. **Emergencies and Special Circumstances:**
   - We understand that emergencies happen. If you have an urgent situation that prevents you from attending your appointment, please contact us as soon as possible. We will do our best to accommodate your situation.

Why This Policy Matters

Missed appointments prevent us from providing timely care to other children in need. By notifying us in advance when you can't attend, you help us maintain efficient care for all our patients.

Acknowledgment

By signing below, you acknowledge that you have read and understand McDonough Pediatrics' No-Show and Late Cancellation Policy.

Parent/ Guardian's SIGNATURE: _____ Date: _____

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____ Date of Birth: _____

3rd Child's Name: _____ Date of Birth: _____

4th Child's Name: _____ Date of Birth: _____

McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough, GA. 30253

Authorization to Obtain Medical Information

DR. Shekhar Sankaran, MD
101 Regency Park Drive, Suite 140
McDonough, Georgia 30253
Office: 770-957-8626 Fax: 770-957-7200

I authorize my child's previous doctor, _____,

Doctor's Address: _____

City, State, Zip Code: _____

Provide McDonough Pediatrics, P.C. with the medical records of:

1st Child's Name: _____ Date of Birth: _____

2nd Child's Name: _____ Date of Birth: _____

3rd Child's Name: _____ Date of Birth: _____

4th Child's Name: _____ Date of Birth: _____

***** PLEASE DO NOT FAX RECORDS LONGER THAN 15 PAGES *****

Information to be Disclosed: **ALL medical records, including immunization records**

By signing below, I understand that:

- I have the right to receive a copy of this authorization.
- You can inspect your records, and we can charge a $30.00 minimum fee for duplicating and printing such records.
- I authorize the release of this health information voluntarily. I can refuse to sign this release.
- You have the right to revoke this authorization at any time, except to the extent that action has been taken based on this authorization.
- This authorization will expire, without my express revocation, 90 days after the requested date specified below.

By signing below, you authorize McDonough Pediatrics, P.C. to request/disclose the requested information.

Parent/ Guardian's SIGNATURE: _____ Date: _____

Parent/Guardian's Printed Name: _____

Relationship with the patient: □ Parent □ Foster □ Guardian □ Other: _____

Witness / Received By: _____