Chattahoochee Pediatrics
~Caring for the Whole Child~

**Patient Information:**

**First Name:** _____ **Middle:** _____ **Last Name:** _____
**Preferred Name:**_____ **Birth Date:** _____ **Gender: Male☐ Female☐**
**Address:** _____ **City:** _____
**State:** _____ **Zip:** _____ **County:** _____
**Languages:** ***Primary***_____ ***Secondary*** _____

**Parent Information:**

| | |
|---|---|
| **Parent's Name:**_____ | **Parent's Name:** _____ |
| **Date of Birth:** _____ | **Date of Birth:** _____ |
| **Address: ☐same or:**_____ | **Address: ☐same or:**_____ |

***Please fill out all phone numbers and check box next to the Phone Number you would prefer us to contact first.***

| | |
|---|---|
| **Home Phone: ☐**_____ | **Home Phone: ☐**_____ |
| **Cell Phone: ☐**_____ | **Cell Phone: ☐**_____ |
| **Work Phone: ☐**_____ | **Work Phone: ☐**_____ |
| **Email:** _____ | **Email:** _____ |
| **Employer Name:** _____ | **Employer Name:** _____ |
| **Occupation:** _____ | **Occupation:** _____ |

**Emergency Contact (Someone other than parent/guardian):** _____
**Emergency Contact Phone:**_____

**Who may we thank for referring you to Chattahoochee Pediatrics?** _____

**Primary Insurance:** _____ **Policy Holder/Subscriber Name:**_____
**Secondary Insurance:** _____ **Policy Holder/Subscriber Name:**_____

I authorize the release of any information necessary for the filing of insurance claims and authorize payment from my insurance company to be sent directly to Vaishali B Kute, MD, LLC dba Chattahoochee Pediatrics. I understand that unless a preexisting agreement exists between my insurance company and this office, I will be responsible for any unpaid balance not covered by insurance.

**Information Privacy:** Vaishali B. Kute, MD LLC has prepared a detailed NOTICE OF PRIVACY PRACTICES to help me better understand how health information is used and shared. Vaishali B. Kute, MD LLC will use and disclose my personal health information to treat me, to receive payment for the care they provide, and for other health care operations. I understand that Vaishali B. Kute, MD LLC has the right to change this notice at any time. The current notice will be posted in the offices. My signature below acknowledges that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

**Canceling Appointments, No-Show (Missed Appointment), & Late Arrivals Policy:**
Chattahoochee Pediatrics kindly requests that parents/guardians/patients call the office at least **24 hours** in advance to give notice of canceling and/or rescheduling an appointment. Any missed appointment in which the office was not notified in advance will be considered a "**No-Call/No-Show**." A No-Call/No-Show may be charged a **$30 fee**, and multiple No–Show appointments can lead to dismissal from the practice. It is the parent/guardian's responsibility to remember his/her child's scheduled appointment time and arrive promptly for it. Late arrivals may need to reschedule their appointments so we can avoid schedule conflicts and delays. We understand there are emergencies and situations that will affect how soon you can provide us notice and we will give each case proper consideration when deciding a course of action. Your signature below confirms that you understand this policy and agree to its terms and conditions.

**Signature Parent/Legal Guardian:** _____ **Date:** _____