DECATUR PEDIATRIC GROUP, P.A.

Providing medical care for newborns, children, and teens

Decatur Pediatric Group recognizes that many families may have lost or have limited health care insurance. In these difficult situations, we now offer:

Children's Health Plan (CHP)

Decatur Pediatric Group's Children's Health Plan (DPG CHP) is a health plan designed to provide medical services for patients with minimal or no health care insurance. Medical service packages are available to purchase for a reduced fee and may be paid under an installment plan. DPG CHP offers:

- Board Certified Medical Doctor and Nurse Practitioners
- On-site Health Screenings, Vision and Hearing Screenings
- Packages available for children: newborn to 18 years old
- Top quality healthcare

Call our office for more information at (404) 296-7133, email us at dpg@decpedgrp.com or to download an application, visit our website www.decaturpediatricgroup.com.

The CHP program may not be used with insurance plans that pay 60% or higher. The CHP program is not an insurance plan and shall not be in any way interpreted as such.

Covered Office Visits

Well Examination Office Visits

Recheck/Follow-up Office Visits

Sick Office Visits

Sports Physicals

Covered Procedures

Immunizations

Hearing Screening Test

Vision Screening Test

Hemoglobin Test (9 months-18 years of age during WELL EXAM ONLY)

Flu Shots or Flu Mist

Sports Physicals

Urinalysis (3 years-18 years of age during WELL EXAM ONLY)

***** Any lab tests or screening tests repeated or conducted without a Well Exam are subject to additional fees.*****

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Diagnostic Tests NOT Covered

Rapid Strep Tests
Rapid Flu Tests
Urine Cultured
Pregnancy Tests
Cholesterol & Lipid Panels
Complete Metabolic Panels

Procedures NOT Covered

Specialist Care
Medications or Prescriptions
Asthma Breathing Treatment
Asthma Supplies (e.g. medications, mask, tubing, nebulizers)
Labs (Not included with Well Exam)
After-Hours Phone Calls (in excess of 3 per plan year)
Ear Piercings
Any additional procedures not listed under Well Exam

*** Non-covered lab tests and procedures are subject to additional fees. ***

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Forms included with Well Examination:

Form 3300- Hearing, Vision, and Dental Form

Form 3231- Immunization

Pre-participation Physical Evaluation Form (Sports Clearance)

Administration of Medicine Form doe Daycares and School

Plan Packages:

Newborn to 12 months

1 year to 3 years

4 years to 10 years

11 years to 15 years

16 to 18 years

*** All office visits require a $15.00 co-payment per child. ***
***Co-payments are in addition to plan fee. ***

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Date:
Total Cost of Plan(s):

Decatur Pediatric Group Children's Health Plan

Guarantor (Person Responsible for payments/bill) Name: ☐ M ☐ F			DOB:
Address:			
City:	State:	Zip:	Email Address:
Home:#	Cell:#		

FAMILY INFORMATION		
Children's Names	**Date Of Birth**	**Sex**
		☐ M ☐ F
		☐ M ☐ F
		☐ M ☐ F

HOW DID YOU HEAR ABOUT US?

INTRODUCTION

Welcome and thank you for your interest in Decatur Pediatric Group's Children's Health Plan. At Decatur Pediatric Group your child's health is our primary concern. Decatur Pediatric Group recognizes that many families may have lost or have limited health care insurance. In these difficult situations, we are pleased to offer our Children's Health Plan. Please e-mail us with questions at dpg@decpedgrp.com.

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$15.00 co-pay per member per visit

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MEMBERSHIP BENEFITS

COVERED SERVICES

Well Examination Office Visits
Recheck/Follow-up Visits
Sick Office Visits
Sports Physicals
Immunizations
Hearing Screening Test (with WELL EXAM ONLY)
Vision Screening Test (with WELL EXAM ONLY)
Hemoglobin Test (9 months-18 years of age with WELL EXAM ONLY)
Flu Shots
Flu Mist
Urinalysis (3 years- 18 years of age with WELL EXAM ONLY)
After- Hours Phone Calls (up to 3 per plan year)

FORMS INCLUDED WITH WELL EXAM

Administration of Medicine Form for Daycares and Schools
GA Form 3300- Hearing, Vision, and Dental Form
GA Form 3231- Immunization
Pre-participation Physical Evaluation Form (Sports Clearance)

SERVICES NOT COVERED

Specialist Care
Medications or Prescriptions
Any labs (e.g. blood test, PKU, etc.)
Ear Piercings
Asthma Breathing Treatments and Supplies (e.g. medications, mask, tubing, nebulizers)
Any additional procedures not listed under well exam
Any lab test or screening tests repeated or conducted without a Well Exam.

DIAGNOSTIC TESTING NOT COVERED

Rapid Strep Test
Urine Culture
Pregnancy Test
Cholesterol & Lipid Panel
Complete Metabolic Panel

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SELECT A PLAN	
☐ NEWBORN- 1 YEAR PLAN	$1,898.40
☐ 2 YEAR PLAN	$639.90
☐ 3 YEAR PLAN	$623.60
☐ 4 YEAR PLAN	$682.80
☐ 5 YEAR PLAN	$620.60
☐ 6 YEAR PLAN	$656.60
☐ 7 YEAR PLAN	$656.60
☐ 8 YEAR PLAN	$656.60
☐ 9 YEAR PLAN	$656.60
☐ 10 YEAR PLAN	$656.60
☐ 11 YEAR PLAN	$730.60
☐ 12 YEAR PLAN	$672.40
☐ 13 YEAR PLAN	$672.40
☐ 14 YEAR PLAN	$672.40
☐ 15 YEAR PLAN	$672.40
☐ 16 YEAR PLAN	$672.40
☐ 17 YEAR PLAN	$672.40
☐ 18 YEAR PLAN	$672.40

Each Plan Includes:
Well Examination Office Visits
Recheck/Follow-up Office Visits
Sick Office Visits
Age Approprate Vaccines and Flu Shots/Flu Mist
Hearing/Vision Screening and 3300-Hearing, Vision, and Dental Forms with Well Exam visit (3 years-18 Years only)
Hemoglobin Test
Sports Physical and Pre-Participation Physical Evaluation Form (Sports Clearance) (6 years-18 years only)
GA 3231 Immunization record Forms for Daycare and Schools
After-Hours Phone Calls (up to 3 per plan year)

Services cannot be substituted. $15.00 co-pay applies per office visit.

TOTAL AMOUNT $____________

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DECATUR PEDIATRIC GROUP, P.A.
CHILDREN'S HEALTH PLAN CONTRACT

This agreement is made this _______ day of ______________________, 20_________

by and between _____________________________________ (Guarantor) for

___________________________________(Patient) (hereinafter referred to "CHP"-

Patient) and Decatur Pediatric Group, P.A.

PURPOSE AND INTENT

The sole purpose and intent of this agreement is to provide an economical way to pay for medical services. This program is not an insurance plan and should not be interpreted as such.

Decatur Pediatric Group, P.A. agrees to provide primary care physician services (medical care) and annual prepaid office visits for the CHP-Patient, except when certain procedures are not covered, which will then the responsibility of the patient/guarantor. All office visits require a $15.00 co-payment per patient, in addition to this plan total amount.

The Guarantor represents that they are over the age of eighteen years and desire to enter into this agreement. Further, this agreement represents that the Guarantor is respectively capable of fulfilling their payment obligations to Decatur Pediatric Group, P.A. By signing, this Guarantor agrees to fulfill all payment obligations of this plan agreement.

Decatur Pediatric Group, P.A. makes no misrepresentations as to our ability to permanently cure any conditions or ailments. We will, however, do everything we feel medically necessary to diagnose and treat any and all illnesses. We also recognize that some illnesses may require further treatments in hospitals or with specialists (secondary/tertiary).

These secondary and tertiary services are not covered under the Children's Health Plan. However, Decatur Pediatric Group, P.A. will arrange for these services by referring patients to specialists and/or admission to hospitals.

SELECTION OF PHYSICIANS

Decatur Pediatric Group, P.A. certifies that all patients will be seen by a Board Certified Medical Provider to examine and prescribe necessary treatments and medications. Guarantors may select the preferred provider of their choice, within Decatur Pediatric Group.

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TERMINATION

At the discretion of the Guarantor or Decatur Pediatric Group, P.A, this agreement may be terminated by providing a written notice of termination. In the event of early termination, the Guarantor will be responsible for Decatur Pediatric Group's cost incurred up to the date of termination. All office visits and medical procedures will be tabulated and any outstanding balances will be due upon termination of this agreement. Guarantor expressly understands that refunds or credits cannot be administered for any early termination of this agreement.

SIGNATURES

This agreement shall insure to the benefit of and be binding on the parties, their heirs, personal representations, successors and assigns. In WITNESS WHEREOF, the parties have executed this agreement on the date first written below.

Dated this______day of________________________________, 20_____.

______________________________________	______________________________________
Guarantor's Signature	Practice Representative's Signature
______________________________________	______________________________________
Guarantor's Printed Name	Practice Representative's Printed Name

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CHILDREN'S HEALTH PLAN
INSTALLMENT PAYMENT AUTHORIZATION

- *This plan may be paid in full upon enrollment or in monthly installments.*
- *Plans pain in full will receive a 105 discount; monthly installments incur 5% monthly service fee.*
- *Monthly installments may be made by credit card.*

INITIAL PAYMENT $________________ (MUST BE MINIMUM OF 60% OF TOTAL PLAN COST)

NUMBER OF INSTALLMENT PAYMENTS__________ (WILL INCUR ADDITIONAL SERVICE FEE OF 5% PER MONTH)

MONTHLY AMOUNT TO BE CHARGED FOR INSTALLMENT PAYMENT $_____________

DATE INSTALLMENTS PAYMENTS WILL BEGIN _____________20_________

PAYMENTS BY CREDIT CARD

CARHOLDER'S NAME (as it appears on card) ____________________________________

CARDHOLDER'S BILLING ADDRESS ___________________________________

____

CARD NUMBER ________________________________ EXPIRATION DATE ____________

3 DIGIT CVV # (located on back of card)__________

I HEREBY AUTHORIZE DECATUR PEDIATRIC GROUP TO CHARGE MY CREDIT CARD FOR THE AGREED UPON MONTHLY INSTALLMENT PAYMENTS FOR THE CHILDREN'S HEALTH PLAN.

CARDHOLDER'S SIGNATURE________________________________ DATE ______________

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