



PATIENT

Last Name	First Name	MI	Date of Birth
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PARENT/GUARDIAN

Last Name	First Name	MI
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Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider’s office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits as long as the child’s eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of \$21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child...		
(A) is enrolled in Medicaid (PeachState, WellCare, AmeriGroup, CareSource or SSI Medicaid).	<input type="radio"/>	OR
(B) is American Indian or Alaskan Native.	<input type="radio"/>	OR
(C) does not have health insurance.	<input type="radio"/>	OR
(D) has health insurance that does not pay for vaccines.	<input type="radio"/>	OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	<input type="radio"/>	OR
(F) has health insurance that pays for vaccines.	<input type="radio"/>	

Parent/Guardian Name (print)

Signature

Date

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

6 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? No Yes, describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? No Yes, describe:

Have there been major changes lately in your child's or family's life? No Yes, describe:

Have any of your child's relatives developed new medical problems since your last visit? No Yes Unsure If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? No Yes, describe:

Check off each of the tasks that your child is able to do.

- | | | |
|--|---|---|
| <input type="checkbox"/> Ride a standard bike. | <input type="checkbox"/> Tie shoes. | <input type="checkbox"/> Play and interact with at least one "best friend." |
| <input type="checkbox"/> Hop on one foot 3 to 4 times. | <input type="checkbox"/> Is dry day and night. | <input type="checkbox"/> Print 3 or more simple words without copying. |
| <input type="checkbox"/> Catch a small ball with 2 hands. | <input type="checkbox"/> Tell a story with a beginning, a middle, and an end. | <input type="checkbox"/> Count 10 objects. |
| <input type="checkbox"/> Draw a 12-part person. | <input type="checkbox"/> Choose preferred foods at breakfast and lunch. | <input type="checkbox"/> Do simple addition and subtraction with objects. |
| <input type="checkbox"/> Write first and last names in uppercase or lowercase letters. | <input type="checkbox"/> Start and continue conversations with peers. | |
| <input type="checkbox"/> Cut most foods with a knife. | <input type="checkbox"/> Master all consonant sounds and combinations, such as "d" or "ch." | |

Please print.

6 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence (Bullying and Fighting)		
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever been bullied or hurt physically by someone?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever bullied or been aggressive with others?	<input type="radio"/> No	<input type="radio"/> Yes
Food Security		
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Alcohol and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Yes
Emotional Security and Self-esteem		
Does your child usually seem happy?	<input type="radio"/> Yes	<input type="radio"/> No
Are there things your child is really good at doing or is proud of?	<input type="radio"/> Yes	<input type="radio"/> No
Connectedness With Family		
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> No

FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> No
When your child breaks the rules, are you consistent with consequences and discipline?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child know when she is being good?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have problems dealing with angry feelings?	<input type="radio"/> No	<input type="radio"/> Yes
Do you help your child control his anger?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

6 YEAR VISIT

SCHOOL

Did your child attend a preschool program?	<input type="radio"/> Yes	<input type="radio"/> No
Has your child started elementary school?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any concerns about your child's school experience?	<input type="radio"/> NA	<input type="radio"/> No <input type="radio"/> Yes
Are you able to attend activities or functions at your child's school?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No
Is your child involved in after-school activities?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No
Does your child receive any special education services?	<input type="radio"/> No	<input type="radio"/> Yes

STAYING HEALTHY

Healthy Teeth		
Does your child brush his teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> No
Nutrition		
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes
Does your child drink soda, juice, or other sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child eat breakfast every day?	<input type="radio"/> Yes	<input type="radio"/> No
Physical Activity		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have trouble going to sleep or does he wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes

SAFETY

Car Safety		
Does your child always use a car safety seat or belt-positioning booster seat securely fastened in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle always wear a lap and shoulder seat belt or belt-positioning booster seat?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know how to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know to always have an adult watching him in the water and never to swim alone?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use sunscreen when playing outside?	<input type="radio"/> Yes	<input type="radio"/> No
Home Fire Safety		
Do you have working smoke alarms installed on every level of your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have carbon monoxide detectors/alarms in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have an emergency escape plan in case of a fire?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know what to do if the fire alarm rings?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

6 YEAR VISIT

SAFETY (CONTINUED)

Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.





Patient Demographics Form

Child's Name _____ Birthdate _____ Sex M / F
 Address _____ Zip Code _____ Social Security _____
Race Black or African American
 White (Caucasian) Asian Other: _____
Ethnicity Hispanic or Latino Not Hispanic or Latino Other: _____
Preferred language English Spanish Other: _____

MOTHER/LEGAL GUARDIAN'S NAME: _____ Birthdate _____
 Social Security # _____ Marital Status : _____ Email: _____
 Address _____ Mobile Phone _____
 Employer _____ Occupation _____ Work Phone _____

FATHER/LEGAL GUARDIAN'S NAME: _____ Birthdate _____
 Social Security # _____ Marital Status: _____ Email: _____
 Address _____ Mobile Phone _____
 Employer _____ Occupation _____ Work Phone _____

EMERGENCY CONTACT OTHER THAN PARENT

Name: _____ Relationship _____ Mobile Phone Number: _____
 Physical Address: _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Insurance	Policy Number	Policy Holder's Name / Date of Birth / Sex (M/F)
Secondary Insurance	Policy Number	Policy Holder's Name / Date of Birth / Sex (M/F)

**WE STRONGLY BELIEVE IN VACCINATING OUR PATIENTS ACCORDING TO THE
 RECOMMENDED AMERICAN ACADEMY OF PEDIATRICS AND CENTER FOR DISEASE
 GUIDELINES.
 BY SIGNING BELOW, YOU ARE AGREEING TO ALLOW US TO VACCINATE YOUR CHILD.**

Parent/Guardian Printed Name

Signature

Date



**Consent & Disclosure of PHI & Treatment of Patient &
 Statement of Persons Allowed to Accompany Patient to Office Visits**

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

I authorize Dr. Blache to release any medical information necessary to process an insurance claim for my son/daughter and request the insurance company to make payment to Dr. Blache. I also authorize Southern Pediatric Clinic, LLC staff and/or Dr. Blache to use the contact information listed above.

 Parent/Guardian Printed Name

 Signature

 Date



Financial Consent

1. **ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:**

___ Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s). In the event that sick symptoms or concerns are discussed outside the health check your co-pay or co-insurance may apply once insurance has been billed.

___ Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).

___ State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

___ For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. **NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:**

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name _____ Date of Birth _____

Responsible Party Name and Signature _____ Today's Date _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name		Primary Insurance	Primary Insurance Policy Number
M	F		
Primary Policy Sex / Date of Birth		Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

Office Staff Initials