Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

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 my 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 s 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 (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
18 THROUGH 21 YEAR VISITS

To give you the best possible health care, we would like to know how things are going. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. **Depression screening and Tobacco, Alcohol, or Drug Use assessment are also part of this visit.** Thank you for your time.

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 YOURSELF.

What are you most proud of about yourself?

Do you have any special health care needs? ○ **No** ○ **Yes,** describe:

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

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

Do you live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

GROWING AND DEVELOPING

Check off all the items that you feel are true for you.

- ☐ I do things that help me have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping myself safe.
- ☐ I have at least one adult in my life who I know I can go to if I need help.
- ☐ I have a friend or a group of friends that I feel comfortable to be around.
- ☐ I help others.
- ☐ I am able to bounce back when life doesn't go my way.
- ☐ I feel hopeful and confident.
- ☐ I am becoming more independent and I make more of my own decisions.

PATIENT NAME: _____ DATE: _____

Please print.

18 THROUGH 21 YEAR VISITS

RISK ASSESSMENT

Anemia	Does your diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you eat a vegetarian diet (do not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If you are a vegetarian (do not eat red meat, chicken, fish, or seafood), do you take an iron supplement?	O Yes	O No	O Unsure
	Have you ever been diagnosed as having iron deficiency anemia?	O No	O Yes	O Unsure
	Do you or your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	For females: Do you have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	For females: Does your period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Do you have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	O No	O Yes	O Unsure
	Do you have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
	Do you smoke cigarettes or use e-cigarettes?	O No	O Yes	O Unsure
Sexually transmitted infections/ HIV	Have you ever had sex, including intercourse or oral sex? **IF NO, SKIP TO THE NEXT SECTION (HIV).**	O No	O Yes	O Unsure
	Are you having unprotected sex?	O No	O Yes	O Unsure
	Are you having sex with multiple partners or anonymous partners?	O No	O Yes	O Unsure
	Are you or any of your past or current sexual partners bisexual?	O No	O Yes	O Unsure
	Have you ever been treated for a sexually transmitted infection?	O No	O Yes	O Unsure
	Have any of your past or current sex partners been infected with HIV or used injection drugs?	O No	O Yes	O Unsure
	Do you trade sex for money or drugs or have sex partners who do?	O No	O Yes	O Unsure
	For males: Have you ever had sex with other males?	O No	O Yes	O Unsure
HIV	Do you now use or have you ever used injection drugs?	O No	O Yes	O Unsure
Tuberculosis	Are you infected with HIV?	O No	O Yes	O Unsure
	Were you or was 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)?	O No	O Yes	O Unsure
	Have you had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Have you ever failed a school vision screening test?	O No	O Yes	O Unsure
	Do you have concerns about your vision?	O No	O Yes	O Unsure
	Do you have trouble with near or far vision?	O No	O Yes	O Unsure
	Do you tend to squint?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you and your family?

HOW YOU ARE DOING

Interpersonal Violence			
Do you get along with the people you live with?	O Yes	O Sometimes	O No
Do you have ways that help you deal with feeling angry?	O Yes	O Sometimes	O No
Have you been in a fight in the past 12 months?	O No	O Sometimes	O Yes
Do you know anyone in a gang?	O No	O Sometimes	O Yes
Do you belong to a gang?	O No	O Sometimes	O Yes

PATIENT NAME: _____ DATE: _____

Please print.

18 THROUGH 21 YEAR VISITS

HOW YOU ARE DOING (*CONTINUED*)

Interpersonal Violence (*continued*)			
Have you ever been hit, slapped, or physically hurt while on a date?	O No	O Sometimes	O Yes
Have you ever been touched in a sexual way against your wishes or without your consent?	O No	O Sometimes	O Yes
Have you ever been forced to have sexual intercourse?	O No	O Sometimes	O Yes
Have you been in a relationship with a person who threatens you physically or hurts you?	O No	O Sometimes	O Yes
Do you feel threatened by anyone?	O No	O Sometimes	O Yes
Are you worried that you might ever hurt someone else?	O No	O Sometimes	O Yes
Living Situation and Food Security			
Do you feel safe in your current living situation?	O Yes	O Sometimes	O No
In the past 12 months, did you worry that your food would run out before you got money to buy more?	O No	O Sometimes	O Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	O No	O Sometimes	O Yes
Tobacco, E-cigarettes, Alcohol, and Drugs			
Is there anyone in your life whose tobacco, alcohol, or drug use concerns you?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Do you have a close friend?	O Yes	O Sometimes	O No
Do you get along with members of your family?	O Yes	O Sometimes	O No
Connectedness With Community			
Do you have activities you like to do after school or work or on the weekends?	O Yes	O Sometimes	O No
Do you help others out at home, at school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Have you graduated from high school or completed a GED?	O Yes	O Sometimes	O No
Do you have plans for work or school?	O Yes	O Sometimes	O No
Coping With Stress and Decision-making			
Do you feel really stressed out all the time?	O No	O Sometimes	O Yes
Do you have strategies to reduce or relieve your stress?	O Yes	O Sometimes	O No

YOUR DAILY LIFE

Healthy Teeth			
Do you brush your teeth twice a day?	O Yes	O Sometimes	O No
Do you floss your teeth once a day?	O Yes	O Sometimes	O No
Do you see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble accessing dental care?	O No	O Sometimes	O Yes
Body Image			
Do you have any concerns about your weight?	O No	O Sometimes	O Yes
Are you currently doing anything to try to gain or lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you have access to healthy food options at home and school?	O Yes	O Sometimes	O No
Do you eat fruits and vegetables every day?	O Yes	O Sometimes	O No
Do you have milk, yogurt, cheese, or other foods that contain calcium every day?	O Yes	O Sometimes	O No
Do you drink juice, soda, sports drinks, or energy drinks?	O No	O Sometimes	O Yes
Do you ever skip meals?	O No	O Sometimes	O Yes
Do you eat meals together with your family?	O Yes	O Sometimes	O No

PATIENT NAME: _____ DATE: _____

Please print.

18 THROUGH 21 YEAR VISITS

YOUR DAILY LIFE (*CONTINUED*)

Physical Activity and Sleep			
Are you physically active most days? This includes running, playing sports, or doing physically active things with friends.	○ Yes	○ Sometimes	○ No
How much time do you spend on screen time unrelated to work or school each day?	_____ hours		
Do you have a regular bedtime?	○ Yes	○ Sometimes	○ No
Do you have trouble getting to sleep at night or waking up in the morning?	○ No	○ Sometimes	○ Yes
Transition to Adult Health Care			
Do you feel confident about your ability to begin seeing an adult doctor?	○ Yes	○ Sometimes	○ No
Do you have health insurance coverage?	○ Yes	○ Sometimes	○ No
Do you know your medical conditions, medications, allergies, and family history?	○ Yes	○ Sometimes	○ No

EMOTIONAL WELL-BEING

Mood and Mental Health			
Do you harm yourself, such as by cutting, hitting, or pinching yourself?	○ No	○ Sometimes	○ Yes
Sexuality			
Do you have any questions about your gender identity?	○ No	○ Sometimes	○ Yes

HEALTHY BEHAVIOR CHOICES

Romantic Relationships and Sexual Activity			
If you have been in romantic relationships, have you always felt safe and respected?	○ Yes	○ Sometimes	○ No
Have you ever had sex, including oral, vaginal, or anal sex? *If not, skip to the next section.*	○ No	○ Sometimes	○ Yes
Have you had multiple partners in the past year?	○ No	○ Sometimes	○ Yes
Have you had both male and female partners?	○ No	○ Sometimes	○ Yes
Do you and your partner use condoms every time?	○ Yes	○ Sometimes	○ No
Do you and your partner always use another form of birth control along with a condom?	○ Yes	○ Sometimes	○ No
Are you aware of emergency contraception?	○ Yes	○ Sometimes	○ No
Tobacco, E-cigarettes, Alcohol, and Prescription or Street Drugs			
Do you smoke cigarettes or use e-cigarettes?	○ No	○ Sometimes	○ Yes
Do you chew tobacco or use other tobacco products?	○ No	○ Sometimes	○ Yes
Do you drink alcohol?	○ No	○ Sometimes	○ Yes
Have you used drugs, including marijuana, street drugs, inhalants, or steroids?	○ No	○ Sometimes	○ Yes
Have you ever taken prescription drugs that were not given to you for a medical condition?	○ No	○ Sometimes	○ Yes
Acoustic Trauma			
Do you use earplugs or sound-canceling headphones to protect your hearing around loud noises or at concerts?	○ Yes	○ Sometimes	○ No
Do you often listen to loud music?	○ No	○ Sometimes	○ Yes

STAYING SAFE

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt?	○ Yes	○ Sometimes	○ No
Do you always wear a helmet to protect your head when you ride a bike, a skateboard, a motorcycle, or an ATV?	○ Yes	○ Sometimes	○ No
Do you ever use your phone or tablet while driving, even at stop signs?	○ No	○ Sometimes	○ Yes
Do you have someone you can call for a ride if you feel unsafe driving yourself or riding with someone else?	○ Yes	○ Sometimes	○ No

PATIENT NAME: _____ DATE: _____

Please print.

18 THROUGH 21 YEAR VISITS

STAYING SAFE (*CONTINUED*)

Sun Protection			
Do you use sunscreen?	○ Yes	○ Sometimes	○ No
Do you visit tanning parlors?	○ No	○ Sometimes	○ Yes
Gun Safety			
Do you have access to guns?	○ No	○ Sometimes	○ Yes
Have you carried a weapon to school or work?	○ No	○ Sometimes	○ Yes

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

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Southern Pediatric Clinic, LLC
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Date

Child's Name Date of Birth

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless.	◯	◯	◯	◯

STOP HERE if you ANSWERED "not at all" to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3. Trouble falling or staying asleep, or sleeping too much.	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating.	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all	Somewhat difficult	Very difficult	Extrememly difficult

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Patient Name: _____ **Today's Date:** _____

Please answer the following questions by checking a box to the right of the question.

BULLYING	**YES**	**NO**
Do you ever feel afraid to go to school?		
Have you ever been bullied at school, in your neighborhood, or online?		
Have you seen other kids being bullied?		
Do you know who you can go to for help?		

SUICIDE RISK SCREENING	**YES**	**NO**
In the past few weeks, have you wished you were dead?		
In the past few weeks, have you felt that you or your family would be better off if you were dead?		
In the past week, have you been having thoughts about killing yourself?		
Have you ever tried to kill yourself? If yes, how?_____ When? _____		
Are you having thoughts of killing yourself right now? If yes, please describe: _____		

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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

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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 my 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

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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 _____