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

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

Patient Demographics Form

Are you applying for your child to be a new patient? □ Yes or □ No

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: _____

Name & birthdates of child's brothers and/or sisters (include last name if different). Has your child been seen in our practice? □ Yes or □ No

Name of child's previous doctor _____

Name of Mother's OB/GYN and Parent's family doctor? _____

How did you hear about SPC?
□Physician / Hospital □Marketing Ads □ Social Media (Facebook / Instagram)
□ Google □ SPC's Website □ Patient □ Signage (building)
□ Related Profession (Physical Therapy etc.):_____
□ Other: _____

REASON FOR CHANGING PROVIDERS (Only if your child is a new patient.) _____

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 Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

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

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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Patient Medical History

PATIENT

Last Name First Name MI Date of Birth

1. Please answer the following questions about your child's birth.

City and hospital where child was born. _____ Birth weight? _____

Was baby born vaginally or by C- section? _____ Was baby premature? □ no □ yes How many weeks? _____

Was baby breech? □ no □ yes Did baby have a hip problem? □ no □ yes _____

Were there any complications at birth**?** □ no □ yes _____

Did baby have any problems after birth? □ no □ yes _____

2. Please answer the following questions about your child's social history.

Who takes care of your child most of the time? _____

Who lives at home with the child? _____

Does child attend daycare/school? Where? _____

Does anyone smoke inside or outside the home? _____

3. Please list all medications that your child is currently taking. _____

4. Does your child have any medicine or food allergies? _____

5. Does your child have a history of any of the following? Please check all that apply.

□ ADHD	□ blood disorders	□ eczema	□ pneumonia	□ other:
□ allergies	□ bronchiolitis/RSV	□ febrile seizures	□ psychiatric disorder	_____
□ anemia	□ chronic ear infections	□ heart condition	□ urinary tract infections	_____
□ asthma/wheezing	□ developmental disorder	□ kidney problem	□ vision/eye problems	_____

6. If your child has ever been hospitalized or had surgery, please list approximate dates and reasons.

7. If your child has ever been injured please list injuries, approximate dates and any treatment given.

8. Is there a <u>family</u> history of any of the following? Check all that apply & indicate which member had/has the condition.

	Mom	Dad	Brother	Sister	Mom's parents/siblings (please specify)	Dad's parents/siblings (please specify)
□ asthma						
□ allergies						
□ eczema						
□ diabetes						
□ obesity						
□ high cholesterol						
□ hypertension						
□ heart disease						
□ ADHD/ADD						
□ seizures						
□ developmental delay						
□ mental disorder						
□ anemia/blood disorder						
□ thyroid disorder						
□ cancer						
□ other						

Parent/Guardian Printed Name Signature Date

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Patient Authorization for Practice to Release Protected Health Information to Third Parties

I authorize (office records are coming from): _____
Address: _____ City, State: _____ Zip: _____
Phone #: _____ Fax #: _____

To use and disclose the specific protected health information (PHI) that I have selected below to:

Southern Pediatric Clinic, LLC
Charlene Blache, M.D.
406-M Northside Drive
Valdosta, GA 31602

The information requested is contained in the medical records of:

Patient's Name: _____ DOB: _____

Information Requested

____ Summary of Care
____ Most Recent Health Check
____ Immunization Record
____ Other (specify): _____

Purpose of Request

____ Changing Doctors
____ Changing Insurance
____ Moving
____ Other (specify): _____
____ More convenient location

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Charlene Blache, M.D. has acted in reliance upon this authorization. My written revocation must be submitted to:

Charlene Blache, M.D.
Attn: Revocation Notice
406-M Northside Drive
Valdosta, GA 31602

_____ _____
Signature of Patient/Parent or Legal Guardian Date

If sending medical records to Southern Pediatric Clinic, records over 15 pages do not need to be faxed. Please mail these records to the address listed above attention Records Department.

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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	Disclose PHI	Accompany to Appointment
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no

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).

_____

Signature of Parent/Guardian Date

_____

Printed Name of Parent/Guardian

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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).

____ 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 _____

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_____ _____
Child's Name DOB

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone ("cellphones") and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as "communication devices") at *Southern Pediatric Clinic, LLC.* These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC,* along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**
   This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**
   a. All devices that can be used for recording.
   b. All devices that can be used for communicating with others.
   c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**
   The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**
   Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

_____
Signature of Parent/Guardian or Patient Date

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Office Policies & Procedures

In order for us to operate in the most effective way, we have implemented office policies to protect both the interest of our patients and our practice. The policies are meant to help you understand the expectations at Southern Pediatric Clinic. Dr. Blache strives to maintain up-to-date healthcare guidelines via equipment, testing, and insurance regulations. Therefore, our policies may change from time to time, but you will be informed of any changes. Additionally, we appreciate any suggestions that will improve our practice. Suggestions may be submitted in writing and given to any staff member. Again, welcome to our practice! Should you have questions regarding our office procedures, please ask any staff member for assistance. Please become familiar with the following policies and procedures:

1. Our office is open from 8:30-5:00 Monday through Thursday and 8:30-12:00 on Friday.
2. All patients under 18 years must be accompanied by a parent/guardian OR a person who the parent/guardian has indicated is able to accompany the patient. You will be asked to complete a Statement of Persons Allowed to Accompany Patient to Office Visits form.
3. We do not encourage walk-ins. However, we leave space on our schedule for sick visits. Therefore, if your child is sick, please call the office for an appointment. If your child is very sick, please let us know so we can evaluate him/her as soon as possible.
4. Patients who are more than 10 minutes late for a scheduled appointment could be asked to reschedule. If you are new to the practice, please plan on arriving 10-15 minutes early to complete any necessary paperwork.
5. Please have your insurance and/or member card available at each appointment.
6. We care about the safety of our patients. Therefore, while waiting to be seen, please do not allow your child/children to run though the waiting room or climb on any furniture, as these are hazards and your child could be seriously injured. Also, we ask that you do your best to keep your child(ren)'s noise level at a minimum so that other patients are not disturbed as we see a wide range of patients who have various health concerns.
7. Electronic devices, including cell phones, must be turned off or on silent while in the triage area and exam room.
8. ADHD prescription refills called in to the refill line will be ready in 2 business days. When requesting a refill, please leave your name, your child's name and date of birth, the prescription name and dosage information, as well as a contact number at which you can be reached.
9. Any patient being treated for ADHD or Asthma will not receive a prescription refill if that patient fails to keep his/her scheduled appointments.
10. Phone messages require the following information: patient's name, date of birth, pharmacy, brief description of your concern, your name, and a contact phone number to call you back. Without this information, we cannot accurately assess your child's needs and develop a plan of care. Most phone messages for providers will be returned at the end of the business day.

NO SHOW POLICY

We define a "no-show" as a missed appointment without the parent, guardian, or patient giving a minimum of a 24-hour notice of cancellation or rescheduling. Additionally, it is not in your child's best interest to miss an appointment and not reschedule it on another day.

For these reasons, we will be enforcing the following:

1. After acceptance into the practice, if the patient misses the initial (1st) New Patient Appointment with the practice without a 24-hours' notice, the patient will receive a notification of discharge and be discharged from the practice 30 days after written notification.
2. After your initial appointment, if 2 appointments are missed within a calendar year without a 24-hour notice, the patient will receive a written warning reminding the patient of our no-show policy.
3. When an appointment is missed for any reason, rescheduling will be done on a first-available basis. (Neither special exceptions nor accommodations will be made when paperwork needs to be filled out for other agencies.)
4. Repeated missed appointments can be deemed medical neglect by a primary care provider and as such may be reported to the Department of Family and Children's Services (DFCS) and the appointment rescheduled. If patient misses the rescheduled appointment, then patient will receive a notification of discharge and be discharged from the practice.

72 HOURS PRIOR TO APPOINTMENTS, A REMINDER CALL WILL BE MADE IN THE EVENING. PLEASE ENSURE THAT WE ALWAYS HAVE YOUR CURRENT PHONE NUMBER.

Patient Name _____ Date of Birth _____

Responsible Party Name and Signature _____ Today's Date _____

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ZERO TOLERANCE POLICY

All of our staff are trained and dedicated to serve you with courtesy and respect at all times. In return, we ask that you and anyone that you bring with you to the Practice treat our Providers, Administrative and clinical staff with the same courtesy and respect.

We have a ZERO TOLERANCE approach to any behavior such as verbal, aggressive, and violent abuse towards our staff or other patients. We respectfully advise you that abuse and/or violence will not be tolerated.

If a patient or anyone accompanied with the patient to the Practice, is abusive, aggressive, or violent towards our staff and/or other patients the police will be called and may result in you being removed from our office and dismissed from the practice.

Patient Name Date of Birth

Responsible Party Name and Signature Today's Date