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
12 MONTH 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.

- ☐ Look for hidden objects.
- ☐ Imitate new gestures.
- ☐ Say, "Dad" or "Mom" with meaning
- ☐ Use one word other than *Mom*, *Dad*, or personal names.
- ☐ Follow a verbal command that includes a gesture.
- ☐ Take first independent steps.
- ☐ Stand without support.
- ☐ Drop objects in a cup.
- ☐ Pick up small object with 2-finger pincer grasp.
- ☐ Pick up food and eat it.

PATIENT NAME: _____ DATE: _____

Please print.

12 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O 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 that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O 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)?	O No	O Yes	O Unsure
	Has your child 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
	Is your child infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Do you have enough heat, hot water, electricity, and working appliances in your home?	O Yes	O No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others		
Do you have child care or an adult you trust to care for your child?	O Yes	O No
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	O Yes	O No
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	O Yes	O No

CARING FOR YOUR CHILD

If your child is upset, do you help distract him using another activity, book, or toy?	O Yes	O No
Do you use time-outs as a way to manage your child's behavior?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes
Does your family regularly make time for reading, playing, and talking together?	O Yes	O No
Do you eat together as a family?	O Yes	O No
Do you have regular mealtimes and snack times?	O Yes	O No
Do you help your child feel comfortable around new people and new situations?	O Yes	O No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

12 MONTH VISIT

CARING FOR YOUR CHILD (*CONTINUED*)

Does your child watch TV or play on a tablet or smartphone? If yes, how much time each day? ____ hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

FEEDING YOUR CHILD

Does your child try feeding herself using a spoon?	O Yes	O No
Does your child drink from a cup?	O Yes	O No
Do you give your child small, hard foods such as peanuts and popcorn?	O No	O Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	O No	O Yes
Do you include your child in family meals?	O Yes	O No
Have you begun to serve your child cow's milk?	O Yes	O No
Does your child eat vegetables and fruits?	O Yes	O No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	O Yes	O No
Do you let your child decide what and how much to eat?	O Yes	O No

HEALTHY TEETH

Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	O Yes	O No

SAFETY

Car and Home Safety			
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?		O Yes	O No
Are you having any problems using your car safety seat?		O No	O Yes
Do you have a gate at the top and bottom of all stairs in your home?		O Yes	O No
Is the mattress in your child's crib set on the lowest setting to prevent falls?		O Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?		O Yes	O No
Do all your electrical outlets have covers?		O Yes	O No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?		O Yes	O No
Do you keep your child away from the stove, fireplaces, and space heaters?		O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?		O Yes	O No
Water and Sun Safety			
Do you always stay within arm's reach of your child when he is in the bath?		O Yes	O No
Do you have a swimming pool, pond, or lake in or near your home?		O No	O Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?		O Yes	O No
Pets			
Do you own a pet?		O No	O Yes
If so, does your child interact with the pet?	O NA	O No	O 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®

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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).

____ 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. <u>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</u>.

   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.

_____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian