



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 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.

| <b>Check only ONE (1) box. My child...</b>  |                       |    |
|---|-----------------------|----|
| (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

## 8 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 items that are true for your child.

- Shows the ability to get along with others and control his emotions
- Chooses to eat healthy foods and participate in physical activity every day
- Forms caring, supportive relationships with family members, other adults, and peers

## 8 YEAR VISIT

### RISK ASSESSMENT

|                     |  |                           |                           |                              |
|---------------------|--|---------------------------|---------------------------|------------------------------|
| <b>Anemia</b>       | 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 |
|                     | Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?  | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                     | If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?   | <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 |
| <b>Dyslipidemia</b> | 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 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 |
| <b>Oral health</b>  | Does your child's primary water source contain fluoride?   | <input type="radio"/> Yes | <input type="radio"/> No  | <input type="radio"/> Unsure |
| <b>Tuberculosis</b> | 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

|  |                           |                           |
|--|---------------------------|---------------------------|
| <b>Neighborhood and Family Violence</b>  |                           |                           |
| 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 |
| Have you talked with your child about how to get help and who to call if there is an emergency?                    | <input type="radio"/> Yes | <input type="radio"/> No  |
| Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?         | <input type="radio"/> No  | <input type="radio"/> Yes |
| <b>Food Security</b>   |                           |                           |
| 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 |
| <b>Alcohol and Drugs</b>   |                           |                           |
| Is there anyone in your child's life whose alcohol or drug use concerns you?                                       | <input type="radio"/> No  | <input type="radio"/> Yes |
| <b>Harm From the Internet</b>  |                           |                           |
| Do you supervise your child's Internet use?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you have rules about Internet use?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you use safety filters on computers, tablets, and smartphones?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| <b>Emotional Security and Self-esteem</b>  |                           |                           |
| 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  |
| <b>Connectedness With Family and Peers</b>   |                           |                           |
| 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  |

## 8 YEAR VISIT

### YOUR CHILD'S DEVELOPMENT

|  |                           |                           |
|--|---------------------------|---------------------------|
| 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 he is doing a good job?                                | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child frequently have worries?   | <input type="radio"/> No  | <input type="radio"/> Yes |
| Does your child have problems dealing with anger or frustration?                       | <input type="radio"/> No  | <input type="radio"/> Yes |
| Do you help your child control her anger, deal with worries, and solve problems?       | <input type="radio"/> Yes | <input type="radio"/> No  |
| Have you talked with your child about how his body will change during puberty?         | <input type="radio"/> Yes | <input type="radio"/> No  |

### SCHOOL

|  |                           |                           |
|--|---------------------------|---------------------------|
| Is your child doing well in school?                                | <input type="radio"/> Yes | <input type="radio"/> No  |
| Has your child missed more than 2 days of school in any month?     | <input type="radio"/> No  | <input type="radio"/> Yes |
| Does your child have any difficulties at school or get extra help? | <input type="radio"/> No  | <input type="radio"/> Yes |
| Does your child like school?                                       | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child have friends at school?                            | <input type="radio"/> Yes | <input type="radio"/> No  |
| Is your child involved in after-school activities?                 | <input type="radio"/> Yes | <input type="radio"/> No  |

### STAYING HEALTHY

|  |                           |                           |
|--|---------------------------|---------------------------|
| <b>Healthy Teeth</b>   |                           |                           |
| 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  |
| Does your child use a mouth guard when playing contact sports?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| <b>Nutrition</b>   |                           |                           |
| Do you have any concerns about your child's weight or eating habits?   | <input type="radio"/> No  | <input type="radio"/> Yes |
| 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 or eat 3 servings of dairy foods, such as milk, cheese, or yogurt, a day?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you eat meals together as a family?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| 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  |
| <b>Physical Activity</b>   |                           |                           |
| 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, playing video games, 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 |

Please print.

## 8 YEAR VISIT

### SAFETY

| Car Safety   |                           |                           |
|--|---------------------------|---------------------------|
| Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt 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 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?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| 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  |
| Harm From Adults   |                           |                           |
| Do you know your child's friends and their families?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child know how to get help in an emergency if you aren't there?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| 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 \_\_\_\_\_