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
10 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

PATIENT NAME: _____ DATE: _____

Please print.

10 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	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

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child felt excluded or not a part of any group of friends?	O No	O Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	O No	O 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?	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
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	O No	O Yes
Harm From the Internet		
Do you know about your child's Internet use?	O Yes	O No
Do you have rules for the Internet?	O Yes	O No
Have you installed an Internet safety filter on computers, tablets, and smartphones?	O Yes	O No
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Does your child have the chance to help others at home, at school, or in your community?	O Yes	O No
Connectedness With Family and Peers		
Do your family members get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No
Does your child have chores or responsibilities at home?	O Yes	O No
Does your child have friends at school or in your neighborhood?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

10 YEAR VISIT

YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	O No	O Yes
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you help your child control his anger, deal with worries, and solve problems?	O Yes	O No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	O Yes	O No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	O Yes	O No
Have you discussed privacy and body safety with your child?	O Yes	O No
Have you and your child talked about sex?	O Yes	O No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	O Yes	O No

SCHOOL

Do you have concerns about your child's school experience?	O No	O Yes
Has your child missed more than 2 days of school in any month?	O No	O Yes
Does your child have any difficulties at school or get extra help in any subjects?	O No	O Yes
Does your child participate in activities outside of school?	O Yes	O No

STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	O Yes	O No
Does your child brush and floss his teeth every day?	O Yes	O No
Does your child use a mouth guard when playing contact sports?	O Yes	O No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	O No	O Yes
Nutrition		
Do you have any concerns about your child's weight?	O No	O Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Do you eat family meals together?	O Yes	O No
Do you hear your child talking about how he looks or dieting?	O No	O Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	O Yes	O No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	O No	O Yes
Does your child have trouble going to sleep or does she wake up during the night?	O No	O Yes
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?	O No	O Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No

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 she rides in a vehicle?	O Yes	O No
Does everyone in the vehicle always use a lap and shoulder seat belt?	O Yes	O No
Safety During Physical Activity		
Does your child always wear a helmet to protect his head when biking, skating, or doing other outdoor activities?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

10 YEAR VISIT

SAFETY (*CONTINUED*)

Outdoor Safety		
Does your child know how to swim?	O Yes	O No
Does your child know to always have an adult watching her in the water and never to swim alone?	O Yes	O No
Does your child always use sunscreen when playing outside?	O Yes	O No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	O Yes	O No
Does your child know how to get help in an emergency if you are not there?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No
Have you talked with your child about gun safety?	O Yes	O 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.

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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 _____