PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
1 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening is also part of this visit.** 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 BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

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

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

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

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your baby is able to do.

- ☐ Look at you.
- ☐ Follow you with her eyes.
- ☐ Comfort himself by doing things such as bringing his hands to his mouth.
- ☐ Start to get fussy when she is bored.
- ☐ Calm when he is picked up or spoken to.
- ☐ Look briefly at objects.
- ☐ Make short sounds such as "ooh" and "ah."
- ☐ Become alert when she hears unexpected sounds.
- ☐ Become quiet or turn when he hears your voice.
- ☐ Show signs she is sensitive to her surroundings (such as crying or startling) or need extra support to handle daily activities.
- ☐ Use different cries for hunger and tiredness.
- ☐ Move both arms and legs together.
- ☐ Hold his chin up when he is on his stomach.
- ☐ Open her fingers a little when at rest.

PATIENT NAME: _____ DATE: _____

Please print.

1 MONTH VISIT

RISK ASSESSMENT

Tuberculosis	Was your baby 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 baby 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 baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security			
Is permanent housing a worry for you?		O No	O Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?		O Yes	O No
Does your home have enough heat, hot water, and electricity?		O Yes	O No
Do you have health insurance for yourself?		O Yes	O No
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
Do you need help in finding community support services, such as WIC or food stamps?		O No	O Yes
Have you had any problems with mold or dampness in your home?		O No	O Yes
If your home has a basement, has it been checked for radon?	O NA	O Yes	O No
Do you use pesticides inside or outside your home?		O No	O Yes
Intimate Partner Violence			
Do you always feel safe in your home?		O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?		O No	O Yes
Maternal Alcohol and Substance Use			
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
Family Support			
Do you feel comfortable returning to work or school after the baby's birth?		O Yes	O No
Have you made arrangements for child care?		O Yes	O No

MOTHER'S HEALTH AND FAMILY RELATIONSHIPS

Have you had a post-birth checkup?		O Yes	O No
Does your partner or do other family members help care for the baby and help around the house?		O Yes	O No
If you have older children, are they getting along with the baby?	O NA	O Yes	O No

CARING FOR YOUR BABY

Is your baby sleeping well?	O Yes	O No
Does your baby use a pacifier?	O Yes	O No
Can you tell what your baby wants by how she cries?	O Yes	O No
Are you able to calm your baby?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	O No	O Yes
Do you put your baby on his tummy for short periods of time when he is awake and with you?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

1 MONTH VISIT

CARING FOR YOUR BABY (*CONTINUED*)

Medical Home After-hours Support		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you know when to call your baby's doctor?	O Yes	O No
General Information		
Does your baby feed well?	O Yes	O No
Do you give your baby any supplements, herbs, special teas, or vitamins?	O No	O Yes
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	O No	O Yes
Are you able to burp your baby?	O Yes	O No
If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No
Are you continuing to take prenatal vitamins?	O Yes	O No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes
Are you giving your baby vitamin D drops?	O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	O Yes	O No
Safe Sleep		
Does your baby sleep on his back?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No
Does your baby sleep in your room?	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.

NEWBORN PACKET

Please complete the following documents and bring them with you to your first appointment. Any documents NOT completed will need to be completed **prior to being seen**. Having these documents completed can significantly decrease your wait time at your first appointment. For your convenience, we have provided you a checklist of items that will need to be brought with you to your first appointment.

CHILD

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First name	MI	Contact Number

I have received a copy of the following notices/policies from Southern Pediatric Clinic

Please check all that apply:

_____ Notice of Privacy Practices
_____ Insurance Information Requirements & Financial Policy
_____ No Show Policy
_____ Vaccination Policy

I have completed the following:

_____ Financial Consent
_____ Patient Information Form
_____ Patient Medical History
_____ Patient Consent for Use & Disclosure of PHI & Statement of Persons Allowed to Accompany Patient to Office Visits

Signature of Parent/Guardian or Patient Date

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

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

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.

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

Southern Pediatric Clinic, LLC
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Patient Information Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex M / F

Address _____ Zip Code _____ Social Security # _____

Name & birthdates of child's brothers and/or sisters (include last name if different)

Has your child ever been seen at our practice? ☐ NO ☐ YES When? _____

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ YES ☐ NO

If yes, which brothers or sisters? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's previous doctor _____

Name of parents' family doctor _____

Name of mother's obstetrician/gynecologist _____

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: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____

Relationship _____ Address _____ Home Phone _____

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						

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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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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

Patient Health Questionnaire-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Total point score: _____

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

Source:
Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110