

New Patient Demographics Form

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		Birthdate		
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	Mobile Phone	Phone	Email: Mobile Phone Work Phone Birthdate Mobile Phone Work	Email: Mobile Phone Phone Birthdate Birthdate Email: Work

EMERGENCY CONTACT OTHER THAN PARENT

_____ Relationship ______ Mobile Phone Number: ___

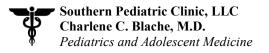
Name: Physical Address:

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
	— [1]— — — — — — — — — — — — — — — — — —	



PATIENT

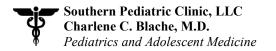
 \Box other

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

Patient Medical History

Last Name	First	Name			MI		Date of Birth
1. Please answer the fo	llowing ques	tions about	your child's	birth.			
City and hospital where c	hild was born	•				Birth	weight?
Was baby born vaginally	or by C- secti	on?	Was	baby prema	ture? □ no □ yes	How many	weeks?
Was baby breech? \Box no \Box					es	•	
Were there any complicat							
Did baby have any proble		•					
2. Please answer the fo		•		social histor	***		
Who takes care of you	•••		your child s	social mistor	·y.		
Who lives at home wit		i the time:					
Does child attend dayc		Thoras					
•			-				
Does anyone smoke in			-	•			
3. Please list all medica	ations that yo	our child is	currently tak	ing			
4. Does your child hav	-		_				
5. Does your child hav			0			+	
	lood disorder ronchiolitis/R		□ eczema □ febrile seiz		eumonia ychiatric disorder	□ otł	ier:
U	hronic ear inf		\Box heart condi	1	inary tract infection	ns	
	evelopmental		\Box kidney prol		sion/eye problems		
6. If your child has eve	1		<i>v</i> 1		• •	nd reasons	
o. If your child has eve	i been nospi	unzeu or n	au sui sei y, p	neuse nst up	proximate dates i	inu i cusons	•
7 If your shild has and					Ja4aa and ann 4	4	
7. If your child has eve	er been injur	eu please in	st injuries, ap	proximate o	lates and any trea	itment giver	1.
8. Is there a <u>family</u> his	tory of any o	f the follow	ing? Check a	ll that annly	& indicate which	n mamhar h	ad/bas the condition
o. Is there a <u>family</u> his			-		Mom's parents		Dad's parents/siblings
	Mom	Dad	Brother	Sister	(please spe	0	(please specify)
□ asthma							
□ allergies							
□ eczema							
□ diabetes							
□ obesity							
□ high cholesterol							
 high cholesterol hypertension 							
 high cholesterol hypertension heart disease 							
 high cholesterol hypertension heart disease ADHD/ADD 							
 high cholesterol hypertension heart disease ADHD/ADD seizures 							
 high cholesterol hypertension heart disease ADHD/ADD seizures developmental delay 							
 high cholesterol hypertension heart disease ADHD/ADD seizures developmental delay mental disorder 							
 high cholesterol hypertension heart disease ADHD/ADD seizures developmental delay mental disorder anemia/blood disorder 							
 high cholesterol hypertension heart disease ADHD/ADD seizures developmental delay mental disorder 							

Parent/Guardian Printed Name Signature Date



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PLEASE SIGN THIS FORM NOW, SO YOU WOULD NOT HAVE TO COME IN TO SIGN A RELEASE OF

RECORDS FORM IF THAT BECOMES NECESSARY OVER THE NEXT 12 MONTHS.

PLEASE COMPLETE WHERE THERE ARE ASTERISKS (*)

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

*Patient's Name: ______ * DOB: _____

Date

FOR OFFICE USE ONLY

Southern Pediatric Clinic, LLC

Charlene Blache, M.D. 406-M Northside Drive Valdosta, GA 31602

Information Requested

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

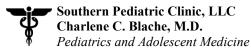
Purpose of Request

Changing Doctors Changing Insurance

____ Moving Other (specify):

More convenient location

**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			

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

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.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

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. Video recording or pictures during vaccines is PROHIBITED. Violators of this policy may be asked to leave and are subject to dismissal depending on circumstances.
- 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.
- 11. Verbal, abusive, aggressive, and violent abuse towards staff and or other patients will not be tolerated and may result in you being removed from the office and dismissed from the practice.

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.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian