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.
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 _____

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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