SOUTHERN PEDIATRIC CLINIC

WELCOME TO OUR PRACTICE

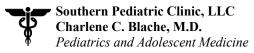
BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT

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 PARENT/GUARDIAN	First Name	MI	Date of Birth
Last Name	First name	MI	Contact Number
I have received a copy	of the following notices/policie	es from Southern Pedia	atric Clinic
Please check all that a	pply:		
	Notice of Privacy Practices Insurance Information Req No Show Policy Vaccination Policy		Policy
I have completed the f	following:		
	Financial Consent		
	Patient Information Form		
	Patient Medical History Patient Consent for Use & Allowed to Accompany Pa		statement of Persons



Financial Consent

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. 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		r Name	Primary Insurance	Primary Insurance Policy Number		
М	F					
Primary Policy Sex / Date of Birth			ex / Da	te of Birth	Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

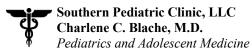
Office Staff Initials



Patient Information Form

		Toda	ay's Date
Child's Name		Birthdate	Sex M / F
Address	Zip Code	Social Se	ecurity #
Name & birthdates of child's brothers and/or	sisters (include last name if dif	ferent)	
Has your child ever been seen at our practice? Have any of your child's brothers and/or siste If yes, which brothers or sisters?			
If your child (or children) has not been seen by Name of child's previous doctor		eferring you to our office? teting Ads	Facebook / Instagram)
MOTHER'S NAME WHO IS LEGAL GU	ARDIAN		Birthdate
Social Security # Max			
Address			
Employer			
FATHER'S NAME WHO IS LEGAL GU	ARDIAN		Birthdate
Social Security # Mai			
Address			
Employer			
MEDICAL INSURANCE INFORMATIO	N: PROVIDE A COPY OF E	ACH INSURANCE CARD)
Primary Policy Holder Name	Primary Insurance	e Sec	ondary Ins./Medicaid
EMERGENCY CONTACT OTHER THA	N PARENT Name		
Relationship Addres		Home Ph	ione
I authorize <u>Dr. Blache</u> to release any medical in and requ <u>Clinic, LLC staff and/or Dr. Blache</u> to use the	est the insurance company to mak	-	•
Parent/Guardian Printed Name	Sig	nature	Date

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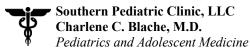


PATIENT

Patient Medical History

T (N	F . (1)	NT			M		
Last Name		Name	4	1. 4 41.	MI		Date of Birth
	1. Please answer the following questions about your child's birth.						
City and hospital where							weight?
Was baby born vaginally					•	•	
Was baby breech? \Box no \Box	🗆 yes 🛛 Di	d baby hav	e a hip probler	$n? \square no \square$	yes		
Were there any complica	ations at birth?	□ no □ yes					
Did baby have any probl	lems after birth	? □ no □ ye	_				
2. Please answer the f	following aues	tions abou					
Who takes care of yo			e your ennu s	social mist			
Who lives at home w		i the thire.	·				
		71 9					
Does child attend day							
Does anyone smoke i							
3. Please list all medie	cations that yo	ur child is	currently tak	ing			
4. Does your child ha	•		-				
5. Does your child ha							
	blood disorders		□ eczema		oneumonia	□ ot	her:
6	bronchiolitis/R		□ febrile seiz		osychiatric disorder		
	chronic ear infe developmental		□ heart condi		arinary tract infection vision/eye problems	ns	
•	-		□ kidney prol		v 1	. —	
6. If your child has ev	ver been hospi	talized or l	had surgery, p	lease list a	ipproximate dates	and reasons	•
7. If your child has ev	ver been injure	ed please li	st injuries, ap	proximate	dates and any trea	atment give	n.
8. Is there a <u>family</u> hi	istory of any of	f the follow	ving? Check a	ll that app			
	Mom	Dad	Brother	Sister	Mom's parent		Dad's parents/siblings
					(please spe	ecify)	(please specify)
\Box asthma							
□ allergies							
□ eczema							
□ diabetes							
□ obesity □ high cholesterol							
□ hypertension							
\Box heart disease							
□ ADHD/ADD							
							<u> </u>
□ developmental delay							
□ mental disorder							
□ anemia/blood disorder							
□ thyroid disorder							
□ other							

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

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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