PATIENTS INFORMATION

PATIENTS LEGAL NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH:_____ SEX (CIRCLE ONE) MALE FEMALE SS#_____-_____-_____

RACE: _____PRIMARY LANGUAGE:_____ ETHNICITY (CIRCLE ONE) HISPANIC NON HISPANIC

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE NUMBER: (_____)_____PREFERED PHARMACY:_____

PARENTS/GUARDIANS INFORMATION

FAMILY EMAIL ADDRESS:_____@_____(YOU MAY RECEIVE EMAILS FROM OUR OFFICE.)

PARENT #1 LEGAL NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH:_____ SEX (CIRCLE ONE) MALE FEMALE SS#_____-_____-_____

EMPLOYER:_____ WORK NUMBER: (_____)_____ EXT_____

CELL PHONE NUMBER: (_____)_____

PARENT #2 LEGAL NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH:_____ SEX (CIRCLE ONE) MALE FEMALE SS#_____-_____-_____

EMPLOYER:_____ WORK NUMBER: (_____)_____ EXT_____

CELL PHONE NUMBER: (_____)_____

CHILD LIVES WITH (CIRCLE ONE): MOTHER FATHER BOTH GUARDIAN OTHER_____

MARTIAL STATUS OF PARENTS(CIRCLE ONE): MARRIED DIVORCED OR DIVORCE PENDING SINGLE NEVER MARRIED

GUARDIAN'S LEGAL NAME (FIRST, MIDDLE, LAST):_____

DATE OF BIRTH:_____ SEX (CIRCLE ONE) MALE FEMALE SS#_____-_____-_____

EMPLOYER:_____ WORK NUMBER: (_____)_____ EXT_____

CELL PHONE NUMBER: (_____)_____ RELATIONSHIP TO PATIENT:_____

EMERGENCY CONTACT (OTHER THAN PARENTS):_____

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE NUMBER: (_____)_____PHONE NUMBER: (_____)_____

LIST NAMES AND BIRTHDATES OF OTHER SIBLINGS:_____

_____

PREFERRED METHOD OF COMMUNICATIONS: ____MAIL ____EMAIL ____PHONE CALLS _____PATIENT PORTAL _____ALL ARE ACCEPTABLE

By listing numbers on this form, I give Pediatric Associates of Auburn, and/or our agents permission to contact you by telephone at any telephone number associated with your account, including wireless telephone number, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice message and/or use of automatic dialing device, as applicable.

ALL COPAYS AND PAST DUE BALANCES ARE DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAS BEEN MADE.

PRIMARY INSURANCE (WE WILL NEED TO SCAN A COPY OF THIS CARD)

NAME OF INSURANCE COMPANY:_____

CONTRACT NUMBER: _____GROUP NUMBER:_____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH:_____

EMPLOYER:_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE (WE WILL NEED TO SCAN A COPY OF THIS CARD)

NAME OF INSURANCE COMPANY:_____

CONTRACT NUMBER: _____GROUP NUMBER:_____

POLICY HOLDER'S NAME: _____ DATE OF BIRTH:_____

EMPLOYER:_____ RELATIONSHIP TO PATIENT:_____

I UNDERSTAND THAT PAYMENT OF ALL MEDICAL CARE IS DUE AT THE TIME OF SERVICE. THE PARENT AND/OR LEGAL GUARDIAN WHO SIGNS THIS FORM IS RESPONSIBLE FOR ANY AND ALL CO PAYS, DEDUCTIBLES, CO- INSURANCE, AND/OR UNPAID BALANCES NOT COVERED BY INSURANCE, REGARDLESS OF MARTIAL STATUS. I, THE UNDERSIGNED, ACCEPT THE FEE CHARGED AS A LEGAL AND LAWFUL DEBT AND AGREE TO PAY SAID FEE, INCLUDING ANY/ALL COLLECTION AGENCY FEES, (33.33%), ATTORNEY FEES AND OR COURT COSTS, IF SUCH BE NECESSARY. I HEREBY GRANT PERMISSION TO PEDIATRIC ASSOCIATES OF AUBURN) TO RELEASE AND OBTAIN ANY PERTINENT INFORMATION NEEDED FOR TREATMENT AND/OR PAYMENT; I ALSO AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC ASSOCIATES OF AUBURN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Parent/Guardian's Signature:_____ Date: _____

Name _____ D.O.B. _____

Form Completed by: _____ Relationship to patient _____

Date of Completion _____

Birth History

Birth Weight _____

Was baby born at term, early or late? _____

Was the delivery vaginal or by C-section? _____ _
If C-section why? _____ _

Did your baby have any problems right after birth?
☐No ☐Yes Explain _____ _

Did the mother have any problems or illness during her pregnancy? ☐No ☐Yes _____

Was initial feeding ☐Bottle ☐Breast (for how long?) _____ _

During pregnancy, did mother:
Smoke ☐Yes ☐No Drink Alcohol ☐Yes ☐No
Use presription medications or other drugs ☐Yes ☐No
What _____ When _____ _

Was your baby discharged from the hospital with the mother?
☐Yes ☐No Explain _____ _

General

Do you consider your child to be in good health?	☐Yes	☐ No	Explain _____
Does your child have any serious illness or medical condition?	☐Yes	☐No	Explain _____
Has your child had serious injuries or accidents?	☐Yes	☐No	Explain _____
Has your child had any surgery?	☐Yes	☐ No	Explain _____
Has your child been hospitalized overnight?	☐Yes	☐ No	Explain _____
Is your child allergic to any medications?	☐Yes	☐ No	Explain _____
Is your child currently taking any medications?	☐Yes	☐ No	Explain _____

Past History

Does your child have, or has he/she ever had:

Chicken Pox	☐Yes	☐No
Frequent ear infections	☐Yes	☐No
Problems with ears or hearing	☐Yes	☐No
Nasal allergies	☐Yes	☐No
Problems with eyes or vision	☐Yes	☐No
Asthma, pneumonia, bronchiolitis	☐Yes	☐No
Heart problem or murmur Anemia or	☐Yes	☐No
bleeding problem Blood transfusion	☐Yes	☐No
Frequent abdominal pain	☐Yes	☐No
Constipation requiring doctor visit	☐Yes	☐No
Bladder or kidney infection	☐Yes	☐No

Bed-wetting (after 5 years old)	☐ Yes	☐No
Started menstrual periods? _ -	☐ Yes	☐No
Problems with periods?	☐ Yes	☐No
Chronic or recurrent skin problems	☐Yes	☐No
Frequent headaches	☐Yes	☐No
Seizures or neurologic problems	☐ Yes	☐No
Diabetes	☐ Yes	☐No
Thyroid or endocrine problems	☐ Yes	☐No
Use of alcohol or drugs	☐ Yes	☐No

Any other significant problem?
Explain.

_____
_____

*If you need more space to answer any of the questions, please use the back side of this form.

Pediatric Associates of Auburn
www.auburnpediatric.com
2901 Corporate Park Drive
Opelika, AL. 36801
Phone (334) 203-1766
Fax (334) 203-1784
Email: auburnpediatric@gmail.com

Office Policies

Welcome to Auburn Pediatric Associates! Here are a few guidelines that we would like for you to be aware of:

1. A Parent/Guardian must notify the office of changes in address, telephone number or insurance.
2. Please bring your insurance card to every visit. **You will be responsible for payment of charges from services rendered if we are unable to verify benefits.**
3. Insurance companies require collection of your co-pay or contracted percentage of services at every visit. If you have a deductible that has not been met. you will be required to pay for the visit in full. If your insurance company does not pay for a service, the charges will be the responsibility of the parent/guardian. We recommend that you always question your insurance company regarding your benefits and do not assume that everything done in our office is covered by your insurance carrier.
4. We accept cash, checks. Visa, MasterCard, Discover, and American Express.
5. Financial arrangements will be required for balances which remain unpaid after two statements have been received prior to scheduling an appointment.
6. There is a $30 fee for returned checks.
7. Our office cannot be involved in payment disputes between parents. The person who brings the child to the office will be expected to pay at the time of service.
8. Medical records can be mailed to another physician free of charge upon release of the medical record. Patient copies of the medical record can be obtained for a fee. Copies of the medical record will be provided within 7 business days with a prepayment.
9. Patients are seen **by appointment only.** Each child needing examination by the doctor should have an individual appointment. We are required by insurance companies to collect co-pays or contracted percentages for each child examined.
10. Rescheduling may be necessary if you are more than 10 minutes late for your appointment. We will try to work you in if time allows.
11. Absences from school will only be excused by our office if your child has been seen in the office for the illness.
12. In general, well examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. This also applies to other conditions that require a significant amount of time for the physician to effectively manage the condition (i.e., asthma, ADHD).
13. Patients on medication for ADHD will be seen for medication check-ups every 3 months. Refills for ADHD medications will be provided only if these appointments are kept. Parents/Guardians may call the nurse to request a refill for ADHD medications. These prescriptions will be available for pick-up 24-48 hrs after the request has been made during our regular business hours.
14. Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e., asthma, allergies), as long as the patient is established and has been seen for the condition within the past 6 months. Refills will not be provided after hours or on the weekends. Please allow 24-48 hrs for these refills to be completed.
15. In general, antibiotics will not be prescribed over the phone. If you feel your child may need an antibiotic, he/she will need to be seen.
16. Our nurses are always available during business hours to serve your needs. You can ask to leave a message for any questions that you may have. All messages will be returned on that business day; however, depending on the daily schedule, these calls may not be returned until the end of the day, and they will be returned in order of urgency. If you feel your child needs to be seen you should speak with someone in the front office to schedule an appointment, as the schedule fills quickly.
17. After-hours contact with the physician is intended for urgent medical problems only. Questions about appointments, billing, referrals, refills, or other issues of a non-urgent nature should be placed during normal business hours.
18. In case of an emergency, call 911 or take your child to the nearest hospital emergency room.

By signing below, you acknowledge that you have read and understand the office policies.

Signed:_____ **Date:**_____

Signature of Parent/Guardian

PRIVACY NOTICE

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 2901 Corporate Park Drive
Opelika, AL. 36801
Attn: Dianne Carlton, Privacy Officer
Telephone: 334-203-1766 Fax: 334-203-1784

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3b70,61 Forsyth Street, SW, Atlanta, GA 30303-8909. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The Effective Date of the Privacy Notice is 10-13-2014.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

Alabama One Health Record® Notice of Privacy and Data Practices

Pediatric Associates of Auburn participates in the Alabama One Health Record®, the statewide health information exchange (HIE) designated by the State of Alabama. The HIE is a secure network for health care providers to share your important health information to support treatment and continuity of care. For example, if you are admitted to a One Health Record® participating health care facility not affiliated with *Pediatric Associates of Auburn,* health care providers there will be able to see important health information held in our electronic medical record systems.

Your patient record includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included is your full name, birth date, sex, and last four digits of your social security number. All information contained in the HIE is kept private and used in accordance with applicable state and federal laws and regulations. The information is accessible to participating providers to support treatment and healthcare operations such as mandated disease reporting to the Alabama Department of Public Health.

You do not have to participate in the HIE to receive care. For more information about the Alabama One Health Record® and your choices regarding participation, visit www.onehealthrecord.alabama.gov or call 334-353-4463.

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship

To be completed by Health Care Provider:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s)

_____ _____
Signature of Office Representative Date

TEXT MESSAGE
APPOINTMENT REMINDERS

Pediatric Associates of Auburn is happy to offer text message appointment reminders in the near future. If you are interested in signing up for this service, please complete this form. Please note that standard data fees and/or text messaging rates may apply based on your plan with your mobile phone carrier. Pediatric Associates of Auburn will not be responsible for these fees.

Patient's Name: _____

_____

_____

_____

_____

_____

Cell Phone Number: _(_____)_____

Cell Phone Carrier (circle one)

AT&T Verizon T-Mobile Sprint PCS

Virgin Mobile US Cellular Nextel

OTHER: _____

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I hereby authorize Pediatric Associates of Auburn to (**circle one**) ~~release~~ / **receive** my child's confidential health information in the following manner:

(x) Mail (x) Fax ( ) Hand Carrying ( ) Verbal ( ) Other: _____

To / From: _____
(circle one)

_____

_____

Phone: _____

Fax: _____

for the purpose of: (x) Changing Physicians ( ) Treatment ( )Other _____

Patient's Name: _____ Date of Birth:_ _____

Address: _____

_____

Phone#: _____ Alt.#: _____

My authorization is for the use and disclosure of the following records:

(x) complete medical records (x) mental health records (x) Other ALL RECORDS

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- This authorization is valid for a 60-day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is a valid as the original.

This authorization will expire on: _____

_____
Patient's Signature if age 14 years or older Date

_____
Signature of Parent or Legal Guardian Date

_____
Name of Parent or Personal Representative (Please Print) Relationship to Patient

_____
Witness (non-family member)