WEST ALABAMA PEDIATRICS

Account #. _____ Date _____

Patient's Nickname: _____ Social Security #: _____

Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Sex: M F

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown

Race: African American Asian Caucasian Hispanic Native American Pacific Islander

Language: English Spanish German Other:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Mother Stepmother Guardian
(Circle One)

Name: _____

DOB: _____

Home/Cell Phone: _____

Work Number: _____

Email Address: _____

Employer: _____

Occupation: _____

Social Security #: _____

Driver's License #: _____

Marital Status: _____

Father Stepfather Guardian
(Circle One)

Name: _____

DOB: _____

Home/Cell Phone: _____

Work Number: _____

Email Address: _____

Employer: _____

Occupation: _____

Social Security #:_____

Driver's License #: _____

Marital Status: _____

Select preference for Appointment Reminders: **Text** or **Call**

Can messages be left on your Home/Cell phone #? **Yes** **No**

Patient's cell phone # if age 14 years or older: _____

Emergency Contact Person: _____ Relation: _____ Phone # _____

Primary Insurance

Insurance Company: _____

Contract #: _____

Group #: _____

Effective Date: _____

Policy Holder: _____

Policy Holder DOB: _____

Relationship to Patient: _____

CoPay Amount: _____

Secondary Insurance

Insurance Company: _____

Contract #: _____

Group #: _____

Effective Date: _____

Policy Holder: _____

Policy Holder DOB: _____

Relationship to Patient: _____

CoPay Amount: _____

WEST ALABAMA PEDIATRICS

Insurance and Office Policies

All professional services provided by West Alabama Pediatrics are charged to the patient. We file most major insurance companies. Please contact your insurance company and verify that we participate in your group plan. It is the patient/parents responsibility to make sure we have the correct insurance information on file. We will gladly file your insurance for you. However, patients are responsible for all fees regardless of the insurance coverage.

All co-pays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. In cases of divorce or separation, where each parent is responsible for a portion of the bill, we do not "split" account balances. There will be a $10.00 billing fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover.

You should receive a statement on your account by the first of every month. We expect our patients to pay their account balance in full. Please notify our office manager immediately if you have unusual financial circumstances and need to make special financial arrangements. We are willing to work with you on an arranged payment plan. An account that is delinquent for more than 90 days will be sent to collections, and any costs incurred thereby will be the responsibility of the patient (parent of responsible party). If your account is turned over for collection, we may no longer continue to provide medical care for your child. No well visits or immunizations will be given if you have an outstanding account balance or if you have not made arrangements for your account to be paid in full.

It is the patient's responsibility to know your insurance benefits and whether the physician you see is or is not a preferred provider. Some insurance require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours during normal business hours if you are seeing or have seen another physician. We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance or is considered an emergency.

You have 30 days to add a new baby to your insurance. Please contact your HR department and make sure your baby is added to your policy before the baby's first visit to our office. If we are unable to verify coverage, you will be responsible for paying the office visit in full.

In order to release medical records, we must have a release signed by a parent or guardian on file. There is a fee for copying of medical records that includes $1.00 per page for the first 25 pages and .50 for each page thereafter. In order to release your medical records to another physician for the purpose of changing physicians, we request that the balance of your account be paid in full. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

There is a fee and a 48 hour waiting period on all medical forms, including blue cards (immunization record) not requested at the time of a check-up. A form fee list and price is posted at the front desk.

There is a $10.00 fee associated with after hour's telephone calls. Please read our Telephone Policy to avoid unnecessary costs. There is a $30.00 No Show/Cancellation fee if you do not call and cancel your appointment 24 hours prior to the scheduled appointment time. There is a $30.00 fee on any returned checks.

Agreement to Accept Financial Responsibility,
Insurance Authorization and Assignment of Benefits

I hereby authorize payment directly to West Alabama Pediatrics for the medical services rendered to myself or my dependents. I hereby authorize West Alabama Pediatrics to furnish medical information to my insurance carriers for payment of claims. I understand that the charges occurred at each office visit are for my continued healthcare. I understand that I am financially responsible to the physician for charges not covered by my insurance company. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due it may be turned over to a collection agency, an attorney or small claims court for collection. I agree to pay 28% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

_____I_____I_____

Signature of Parent or Guardian **Relationship to Child** **Date**

Effective 3/17/17

WEST ALABAMA PEDIATRICS

ACKNOWLEDGEMENT & CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

You are receiving healthcare services from WEST ALABAMA PEDIATRICS. You agree that all records concerning your care within WEST ALABAMA PEDIATRICS shall remain the property of WEST ALABAMA PEDIATRICS.

You understand and agree that such information is used for:

(1) **Your treatment** – the provision and coordination of your healthcare which may require disclosure of all or any portion of your medical record information to your attending physician, consulting physician(s) and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient.

(2) **Payment for your services** – billing, claims management, medical data processing, reimbursement and for determining coverage which may necessitate disclosure of such information to any insurance company, third party payor or other entity (or their authorized representatives), including any copies or excerpts of your medical record which are necessary for payment of patient's account.

(3) **Routine healthcare operations** – including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of WEST ALABAMA PEDIATRICS; AND

(4) **Medical research and educational purposes** -- You acknowledge that you have been provided with a WEST ALABAMA PEDIATRICS Notice of Health Information Practices that provides a more complete description of the uses and disclosures of the patient's healthcare information, and that the Notice has been reviewed prior to the signing of this consent. You understand that WEST ALABAMA PEDIATRICS reserves the right to change the Notice and that WEST ALABAMA PEDIATRICS will provide you with a revised Notice when you come to WEST ALABAMA PEDIATRICS.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Restrictions Requested: _____

_____

WEST ALABAMA PEDIATRICS:

_____ Agree ____ Not Agree ____ N/A

Patient Signature: _____

Date:_____

WEST ALABAMA PEDIATRICS
Patient Authorization for Personal Representative

Please print all information, then sign and date form at bottom.

Name of Practice: WEST ALABAMA PEDIATRICS

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

Parent Name: _____ **Date of Birth:** _____

Parent Name: _____ **Date of Birth:** _____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1. Name of Personal Representative: _____
   DOB: _____ Relationship to patient: _____
   Phone #: _____

2. Name of Personal Representative: _____
   DOB: _____ Relationship to patient: _____
   Phone #: _____

3. Name of Personal Representative: _____
   DOB: _____ Relationship to patient: _____
   Phone #: _____

4. Name of Personal Representative: _____
   DOB: _____ Relationship to patient: _____
   Phone #: _____

***Description of information to be disclosed:** I authorize the practice to disclose all of my protected health information to my designated personal representative.

***Expirations or termination of authorization:** This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

***Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

WEST ALABAMA PEDIATRICS
Attn: Privacy Manager
1060 Fairfax Park, Suite C
Tuscaloosa, AL 35406

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Parent Signature: _____ Date: _____

WEST ALABAMA PEDIATRICS

PATIENT'S RIGHTS AND RESPONSIBILITIES

Child's Name: _____ **DOB:** _____

Welcome to the West Alabama Pediatric team!! Join us as active members of your child's health care team by reviewing the Patient/Family Rights and Responsibilities listed below.

Children and their parent(s)/guardian(s) have the **RIGHT** to:

- Be given considerate, respectful, and compassionate care
- Be treated fairly regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment
- Have their cultural and personal values, beliefs, and wishes respected
- Have treatment and other patient information kept private. Only by law may records be released without permission.
- Access care easily and in a timely manner
- Share in developing their plan of care/treatments
- Information about clinical guidelines used in managing their care
- Information about provider(s) work history and training
- Information about practice services
- Complain and have the complaint reviewed without affecting their care. If you have a problem you may talk directly with the practice manager.
- Know about laws that relate to their rights and responsibilities

Children and their parent(s)/guardian(s) have the **RESPONSIBILITY** to:

- Treat those giving them care with dignity and respect
- Give providers accurate and complete information they need in order to provide the best possible care
- Ask their provider questions about any diagnosis and/or treatment
- Help develop and follow the agreed-upon treatment plan for their care, including medications
- Tell their provider about medication changes, including medication given by other providers
- Take responsibility for the consequence of refusing care or not following treatment instructions
- Keep and be on time for all appointments. Patients should call the office as soon as possible if they need to cancel or reschedule an appointment.
- Inform the office about their insurance coverage and any changes to it, or any problems with paying fees
- Openly report concerns about quality of care to the practice manager
- Let the office know about any changes to their contact information (name, address, phone numbers) and to keep an updated "release of information" list
- Refrain from taking pictures/videos/recordings without permission from the staff

Parent's Signature: _____ **Date:** _____

West Alabama Pediatrics

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when using or disclosing this information. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices We are required by law to follow the terms of this Notice. We reserve the right to change the terms of the Notice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as described in this Notice, unless you authorize other use or disclosure in writing. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. We are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the expected date when the request will be fulfilled.

You have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information* - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability* - You may submit a written request for a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

* If you have questions regarding your privacy rights, or would like to submit any type of written request described above, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restriction, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

_____

Effective Date 4/12/18 Publication Date 2018

West Alabama Pediatrics
Newborn History Intake Sheet

Today's Date:_____
Name:_____ Date of Birth:_____ Current Age:_____
Name of Person Completing Form:_____

Child's Birth History:

Birth Weight:_____ Delivery Hospital:_____
Doctor:_____
Length of Pregnancy:_____ weeks Early (<38 wks) Term(38-42 wks) Late (>42 wks)
Type of Delivery: □ Vaginal □ C-Section Reason:_____
Complications of Pregnancy, Labor, or Delivery: □ No □ Yes, List _____
Baby went to: □ Well Baby Nursery □NICU … Length of Stay_____
APGAR Scores: 1 minute_____ 5 minutes_____
Problems in Nursery? □ No □ Yes, List_____
Mother's Age at Delivery:_____ **Previous** Pregnancies:
Full Term:_____
Premature:_____
Miscarriages/Abortions:_____

Child's Diet History:

Current Diet: □ Breastfeeding Frequency:_____
Pumping? Yes/No How many ounces?_____
How often?_____
□ Formula Type:_____
How many ounces?_____
How often?_____

Child's Family History:

Relationship	Age	Medical Problems No	Medical Problems Yes	Describe
Mother	_____	□	□	_____
Father	_____	□	□	_____
Sister(s)	_____	□	□	_____
Brother(s)	_____	□	□	_____

Child's Past Medical History:

	Yes	No	Type	Date/Hospital/Doctor
Surgeries/Procedures:	☐	☐	_____	_____
			_____	_____

Allergies:	Yes	No	Type	Describe Reaction
Medication	☐	☐	_____	_____
Other	☐	☐	_____	_____

Has a Relative of Your Child Ever Had:

(indicate child's: M-mother, F-father, B-brother, S-sister, MGM-maternal grandmother, MGF-maternal grandfather, PGM-paternal grandmother, PGF-paternal grandfather. Also include maternal or paternal aunts, uncles, or cousins.)

	No	Yes	Relationship		No	Yes	Relationship
ADHD	☐	☐	_____	Epilepsy	☐	☐	_____
Alcohol Abuse	☐	☐	_____	Family History of Allergies	☐	☐	_____
Arthritis	☐	☐	_____	Genetic Defects	☐	☐	_____
Asperger's Disorder	☐	☐	_____	Hearing Disorder	☐	☐	_____
Asthma	☐	☐	_____	Kidney Disease	☐	☐	_____
Autism	☐	☐	_____	MI/Heart Attack	☐	☐	_____
Blood Disorder	☐	☐	_____	Mental Retardation	☐	☐	_____
Cancer	☐	☐	_____	Muscular Dystrophy	☐	☐	_____
Celiac Disease	☐	☐	_____	Seizures	☐	☐	_____
Cystic Fibrosis	☐	☐	_____	Sickle Cell Trait	☐	☐	_____
Diabetes	☐	☐	_____	Skin Disease	☐	☐	_____
Digestive System Disorder	☐	☐	_____	Substance Abuse	☐	☐	_____
Down's Syndrome	☐	☐	_____	Thyroid Disease	☐	☐	_____
Eczema	☐	☐	_____	Tuberculosis	☐	☐	_____
Elevated Cholesterol	☐	☐	_____	Vision Disorder	☐	☐	_____

Other:_____

Child's Social History:

City or Area Where Child Lives:_____

Type of Home: ☐ House ☐ Mobile Home ☐ Apartment

City Water? ☐ Yes ☐ No Well Water? ☐ Yes ☐ No

Do you have access to the Internet? ☐ Yes ☐ No

Child Lives With: ☐ Mom & Dad ☐ Mom Only ☐ Dad Only ☐ Other:_____

Parents are: ☐ Married ☐ Divorced ☐ Single

Number of People in Household:_____ Relation to Child:_____

Father's Occupation:_____ Mother's Occupation:_____

Do Household Members Smoke? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No Type:_____ Inside the Home? ☐ Yes ☐ No