# GULF SHORES PEDIATRICS, PC

PATIENT INFORMATION

**PLEASE PRINT**

**Patient Name** _____ **Sex**: M / F

**Date of Birth** _____ **SS#**_____

**Race**: Hispanic/Black/Caucasian/Other_____ **Primary Language**: English/Spanish/Other_____

With whom does the child live? _____

**Parent(s) OR Guardian(s) Information**

**Name** _____**DOB**_____**Tel**_____

Relationship: Mother Father Grandparent Other _____
EMAIL _____
Mailing Address:_____
City_____ State_____ Zip Code_____
Employer/Occupation_____ SSN _____

**Name** _____**DOB** _____**Tel** _____

Relationship: Mother Father Grandparent Other _____
EMAIL _____
Mailing Address:_____
City_____ State_____ Zip Code_____
Employer/Occupation_____ SSN _____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME AND PHONE NUMBER OF A PERSON WHO DOES NOT LIVE WITH YOU

Name _____ Phone _____

Please list all children in the family that are less than 18 years old.

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

*******I agree to schedule and make all Well Child Visits due*****_____(Initial)**
*******Please note more than 2 NO SHOWS may result in dismissal from the Practice*****_____(Initial)**

Parent Signature: _____ Date: _____

OFFICE USE ONLY:

_____ _____ _____
Witness Medical Record # Date

# Pediatric History

Date _____ Child's Last Name _____ First _____
Sex: M F Date of Birth _____ Age _____ Pharmacy _____
***Medication Allergies**: Please list the substances and the reaction. If no known allergies, please write "no known allergies"

_____

***Immunizations**: Is your child up to date? Y / N Has your child ever had any reaction to any immunization? If so, which vaccine and what was the reaction? If none, please write "none".

_____

***Delivery and Birth History**
Delivery was : ___On time ___ Premature ___Late ___Normal Complications _____
Did your newborn have: ___ Birth Defects ___Infection ___Breathing Problems ___ Jaundice
***Current and Past Medical History**
Please describe if your child has any of the following ( write N/A if there is nothing to report)
Chronic (long-term) diseases/illnesses? _____
1.Developmental Delays? If so, what kind of delay(s) and how is it being treated (by which therapist or dr)

_____

2.Previous hospitalizations? If so, please describe for what reason, when and for how long

_____

3.Previous fractures (broken bones)? If so, describe which bone, how it happened and when

_____

4.Does your child see any specialists? If so, please give the name, specialty and the reason

_____

5.Previous Surgeries?

_____

6.List all prescriptions, over the counter, vitamins or herbal medications your child takes. Please include the dosage and how/when it is taken

_____

Does your child smoke? ____Yes since the age of ____ ___No ___Unknown
**Family History**
Please give the following information about your child's blood relatives
Biological father's name _____ Age _____ If deceased what age & how _____
Biological mother's name _____ Age _____ If deceased what age & how _____
Biological brothers/sisters
Names _____ Age _____ Medical problems _____
_____ Age _____ Medical problems _____
_____ Age _____ Medical problems _____
Have any children in your family died? If yes, please explain how _____
Are there any smokers in your home? ___Yes How many people? ___ / ___No / ___Unknown

Please check the conditions that any of the child's blood relatives have, and state their relationship to the child as well as whose side they come from.

| **Condition** | **Relationship to child** | **N/A** | **Condition** | **Relationship to child** | **N/A** |
|---|---|---|---|---|---|
| Allergies | _____ | ___ | Eczema | _____ | ___ |
| Arthritis | _____ | ___ | Epilepsy/Seizures | _____ | ___ |
| Asthma | _____ | ___ | Eye or ear disorders | _____ | ___ |
| Blood Disorders | _____ | ___ | Genetic Defects | _____ | ___ |
| Birth Defects | _____ | ___ | HIV/AIDS | _____ | ___ |
| Bone/joint disorders | _____ | ___ | Mental disease | _____ | ___ |
| Cancer | _____ | ___ | Muscle disorder | _____ | ___ |
| Diabetes | _____ | ___ | Sickle cell anemia | _____ | ___ |

# Social Status for Patients

DATE: _____

NAME OF CHILD**:** _____ DOB**:** _____
NAME OF CHILD: _____ DOB: _____
NAME OF CHILD: _____ DOB: _____
NAME OF CHILD: _____ DOB: _____

1. Parents marital status: Married Divorced Separated or Single
2. Home Situation: (whom does the child live with)_____
3. Additional Siblings:_____
4. Does the patient's additional siblings live in the home? Yes or No
5. Childcare? Yes or No
6. Daycare or Sitter? _____
7. Animal Exposure in the household? Yes or No
   What kind of animal? _____
8. Are there any smokers in the home? ___Yes, how many? ___ ___ No/ ___ Unknown
9. Smoke Detectors in household? Yes or No
10. Seat Belt/Car Seat routine? Yes or No

Parent Signature: _____

# GULF SHORES PEDIATRICS P.C.

## CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I authorize the examination and treatment of Patient Name(s):1) _____
2) _____ 3) _____ 4)_____ 5)_____
by members of Gulf Shores Pediatrics. I understand the examination and follow up may include the use of medications, lab tests and other non-invasive diagnostic procedures.
I understand that should more specialized tests and procedures be required, these will be explained by the Physician or his/her designee and my consent will be obtained.

**In the event that I am unable to attend subsequent visits with my child, I authorize Gulf Shores Pediatrics to treat my child if he/she is brought to the clinic by:**

Name: _____ Relationship: _____ Phone number: _____
Name: _____ Relationship: _____ Phone number: _____
Name: _____ Relationship: _____ Phone number: _____

***I understand that such treatment does not include any invasive procedures.***
I hereby authorize Gulf Shores Pediatrics, P.C. to release any medical information or medical records regarding my child's medical treatment or condition, including drug/alcohol use/abuse, psychiatric evaluations/treatment, and/or AIDS testing for AIDS (HIV) to appropriate consulting medical personnel without necessity of obtaining further permission from me, except as required by law. When required by law, a separate authorization/consent will be provided to me with regard to releasing data or information of this nature. If I do not authorize the release of this information, I understand the continuity of care could be affected. I agree to assume all responsibility of my refusal to exchange this information and also not to hold my physician(s), of Gulf Shores Pediatrics, P.C. responsible for any adverse results from my refusal to release this information.
I authorize the release of information for processing Health Insurance Claims. If I do not consent to the release of information, I understand that I am personally responsible or cause the Responsible party to be liable for all or any part of my bills for treatment and/or Consultation by Gulf Shores Pediatrics, P.C.
Gulf Shores Pediatrics, P.C. recognizes that medical record information received/released by this clinic is protected by State and Federal confidentiality laws. Any further disclosure of this information is prohibited.

Parent/Patient: _____ Relationship to Patient: _____ Date: _____

Witness: _____ Medical Record #: _____ Date: _____

# GULF SHORES PEDIATRICS, P.C.

## PATIENT CONTACT INFORMATION SHEET

One form may be used for all children in the family **under age 14;** however, all children **14 years of age or older** must sign a separate form to allow their information to be disclosed to the contacts listed below.

Date: _____>>>>>> Is this an update to a previous **Patient Contact Information Sheet?** Yes or No (circle one)

Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____
Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____
Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____
Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____

Any physician, staff, employee or representative of Gulf Shores Pediatrics, P.C. has my permission to discuss and/or disclose information regarding my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information in order to facilitate and coordinate my care, treatment and payment with the following persons:

Contact Name: _____ Relationship to patient: _____ Phone Number: _____
Contact Name: _____ Relationship to patient: _____ Phone Number: _____
Contact Name: _____ Relationship to patient: _____ Phone Number: _____
Contact Name: _____ Relationship to patient: _____ Phone Number: _____

Any physician, staff, employee or representative of Gulf Shores Pediatrics, P.C. has my permission to discuss and/or disclose protected health information regarding "Blue Form" immunization records and doctor visit excuses for school absence when required by the patient's school. This information may be disclosed to the school by mail, fax, or patient receipt and delivery and will not require any other special authorization beyond this form.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. If I do not sign this form it is **invalid** and may not be used for contact information. I can revoke it by writing the Gulf Shores Pediatrics, P.C. Attn: Privacy Officer, 232 Office Park Drive, Gulf Shores, AL 36542 or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s). I have been offered a copy of the Gulf Shores Pediatrics, P.C. Notice of Privacy Practices and am aware of my responsibilities as well as Gulf Shores Pediatrics, P.C. legal requirements and limitations as contained in the Notice of Privacy Practices.

I acknowledge that I have received notification of the privacy practices of Gulf Shores Pediatrics, P.C
I understand that it is my responsibility to read the Notice of Privacy Practices fully.
I was offered a written copy of the Notice of Privacy Practices on the date signed.

If the signee is not the parent or legal guardian, signee agrees to forward this information to the parent of legal guardian.

**If the patient is 13 years of age or younger, the person who brings the patient must sign HERE:**

Signature: _____ Print Name: _____ Relationship to Patient: _____

**Patients 14 years of age or older must sign this form below.**
Signature: _____ Print Name: _____ Relationship to Patient: _____

**If any of the above information changes, please complete a new Patient Contact Information Sheet.**

# FINANCIAL POLICY

I understand that it is my responsibility as the guarantor of this child to provide current and correct insurance information on the date of service that care will be provided. I agree to accept the financial responsibilities for any procedure my insurance deems as a non-covered charge.

We participate with most major insurance companies; we will bill all charges to your insurance company as a courtesy to you. If we are unable to verify your insurance benefits prior to the appointment, the guardian will be considered self-pay for the full cost of the visit. Any service that your insurance company deems as "non-covered" you will be responsible for the balance.

Payment of all copays and out of pocket expenses are expected at the time of service. Copayments must be made prior to seeing the provider each visit. This is required in the agreement that you have made with your insurance company. Full payment is due at the time of service for all self-pay visits unless other mutually agreed upon arrangements are made with our staff prior to the visit. Any bills over thirty days old will need to be paid with the next statement or before the next appointment.

Well Child Exams may be considered as preventative care with your insurance company as they may have restrictions and/or limitations on these services. It is your responsibility to find out how your insurance company will cover these services. You will be responsible for balances unpaid by your insurance company.

We reserve the right to assess collection fees on unpaid balances. Accounts placed into collections are subject to dismissal from our practice.

Gulf Shores Pediatrics has a strict **No Show/Cancellation Policy.** Upon the second no show appointment in a full calendar year, a consultation via the phone will take place between administration and the parents of the child take place. Upon the third no show the **family** will be dismissed from the practice.

Our office strives to provide an environment of excellence and professionalism in the best possible manner. Therefore, in order to ensure that everyone feels comfortable, we expect everyone to be mindful of their conduct. Any inappropriate language, loud conversations, and/or disrespectful demeanor towards our staff or other people visiting our office will **not** be tolerated.

**Please refrain from contacting our office or staff via social media**. The use of social media is not HIPAA compliant, and we will not answer messages that are received through social media to the practice or staff.

I may revoke consent in writing except to the extent of the practice that has already been performed upon my prior consent. If I do not sign this consent, Gulf Shores Pediatrics may decline to provide treatment to my child.

I have been made aware of Gulf Shores Pediatrics Notice of Privacy Practices. I understand that I may receive a complete copy at my request.

_____ _____ _____ _____

CHILD'S NAME DOB CHILD'S NAME DOB

_____ _____ _____ _____

CHILD'S NAME DOB CHILD'S NAME DOB

_____ _____ _____

Signature of Parent/Legal Guardian Printed name of Parent/Legal Guardian Date

# VACCINE STATEMENT/POLICY

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientist and physicians.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under-immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years. Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable. We making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do.

Please be advised that delaying or “breaking up the vaccines” to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness or even death and goes against our medical advice as providers at Gulf Shores Pediatrics, PC.

If you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views. We do not keep a list of such providers nor would we recommend any such physicians.

Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death. As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

WRITE PATIENT NAME(S)/DATE OF BIRTH BELOW:

1 _____ 3 _____

2 _____ 4 _____

PARENT/GUARDIAN SIGNATURE:_____ Date: _____

# Insurance and Non-Covered Services Form

## Insurance Plans

- It is your responsibility to keep us updated with your correct insurance information. If your insurance policy changes, we ask that you provide us with a copy of the insurance card at the time of service.
- If the insurance card/plan you present is incorrect or we are unable to verify the benefits, you will be responsible for payment of the visit at the time of service.
- If we are your primary care provider, make sure our name/phone number appears on your most up to date card. If your insurance has not been informed that we are your primary care provider, you may be financially responsible for your current visit.
- If the patient's insurance plan allows a certain number of visits per year or services and those visits have been exceeded. You will be responsible for payment.
- It is your responsibility to understand your plan benefits. Not all plans cover Well Child Visits, Vision/Hearing Screenings, Routine Lab Screenings or Physicals. If these services are not covered, you will be responsible for payment.
-

## Financial Responsibility

- According to your insurance plan, you are responsible for all co-pays, deductibles and coinsurances.
- Co-pays are due at the time of service. A $10 service fee will be charged in addition to your co-pay if not paid at the time of service.
- Self-pay patients are expected to pay for all services at the time of the visit. This includes patients with out of network insurance plans. Our office will be happy to provide the necessary documentation for you to file the claim for reimbursement with your insurance company.
- Patient balances are billed monthly. We ask that you pay your statement balance after receiving your first statement to prevent a late fee of 20% being added to any balance older than 60 days.
- If previous arrangements have not been made with our office, any account balances over 90 days will be forwarded to our collection agency and all collections expenses will become your responsibility. Your child will be dismissed from the office at this time.
- For scheduled appointments, any outstanding balances must be paid prior to the visit or you will be asked to reschedule.
- We accept Cash, Check and all major Credit Cards
- A $30 fee will be charged for any checks returned for insufficient funds and checks will no longer be allowed as payment on your account.

**Patient Name:_____ DOB:_____**

**Patient Name:_____ DOB:_____**

**Patient Name:_____ DOB:_____**

**Patient Name:_____ DOB:_____**

**Parent Signature:_____ Date:_____**

# Telemedicine Consent Form

**CONSENT FOR USE OF DISCLOSURE OF PROETECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS**

I understand the purpose for this service is to seek medical advice and guidance for the care of my child who does not have an emergency condition. I also understand that at any time I feel I cannot wait for a visit or feel my child's conditions has become an emergency then I will call 911 and/or seek emergent care.

I understand that telemedicine is the video communication or telecommunication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell in assessing my child's condition.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment but there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment.
- Delay in care resulting from communication service or equipment failure.
- Inadequate visual resolution resulting in incomplete assessment.
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse result.

In addition to these risks, I understand that the remote provider evaluating my child does not have the opportunity to meet with my child in-person and must rely on information provided by me and/or my child. I understand and acknowledge that the remote provider cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me, my child or others.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges related to my child's telemedicine visit, I understand that my telemedicine visit may not be covered by my insurance plan.

My child and I have had the opportunity to review this information prior to any form of payment being collected. By signing this form, I indicate that I have chosen to proceed with the telemedicine visit for my child.

I understand that the remote provider is a provider of Gulf Shores Pediatrics. Gulf Shores Pediatrics will maintain a record of this telemedicine visit and I may obtain a copy of that record as provided in the Notice of Privacy Practices.

I consent to the healthcare provider I am connected with to providing healthcare services to my child via telemedicine. As long as this consent has not been revoked by me in writing, it remains in effect. The physician may provide healthcare services to my child via telemedicine pursuant to this consent without the need for me to sign another consent form.

By signing below, you recognize that the protected health information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

**Patient Name: _____ DOB: _____**
**Patient Name: _____ DOB: _____**
**Patient Name: _____ DOB: _____**

**Parent/Guardian Signature: _____**

# CREDIT CARD AUTHORIZATION

**PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE.**
**IT WILL BE SENT SECURELY TO OUR OFFICE.**
Thank you for choosing Gulf Shores Pediatrics as your child's medical provider. We are committed to providing you with exceptional service. Each year, insurance companies are shifting more costs to families. We are adding a new service to help families manage these health care expenses.

We have added a new feature, you can now put a credit card on file to pay your Gulf Shores Pediatrics balance automatically after all insurance payments and adjustments have been made. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card on file when they inform us of your responsibility. Circumstances when your card would be charged include but are not limited to uncollected copay, coinsurance, deductible, and non-covered services and/or denial of services.

- Once your insurance has processed your claims, an Explanation of Benefits (EOB) will be available to both you and our office showing the amount of your responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility, please contact your insurance carrier immediately.

- When we receive the EOB, we will apply any payment/adjustment information to your account. At that time, any remaining balance owe4d by you will be charged to your credit card on file and a receipt will be emailed to you for your records.

If the credit card on file becomes invalid, please notify Gulf Shores Pediatrics immediately. If for some reason we are not notified of any changes and the credit card on file is declined, we will attempt to reach you to update the information. If we are unable to reach you, a surcharge of $25 may be applied to your account. This information will need to be updated prior to scheduling any future appointments.

Should there be an adjustment regarding a claim, we will promptly reimburse you the portion that is due back to you.

To streamline our billing and payment system and to provide a seamless, convenient way for families to pay their bills, effective 07/01/2020, any account that has a history of collections status will be required to keep a credit card on file.

**PATIENTS**

| | |
|---|---|
| PATIENT: | DOB: mm/dd/yyyy |
| PATIENT: | DOB: mm/dd/yyyy |
| PATIENT: | DOB: mm/dd/yyyy |
| PATIENT: | DOB: mm/dd/yyyy |

**CREDIT CARD ON FILE AUTHORIZATION**

By signing below, I agree to Gulf Shores Pediatrics' credit card on file policy and I authorize Gulf Shores Pediatrics to keep my signature and valid credit/debit card number securely and confidentially encrypted on file.
**SIGNATURE:**
**NAME ON CARD:**
**CARD NUMBER:**
**EXPIRATION DATE:**
**CVV: ZIPCODE:**