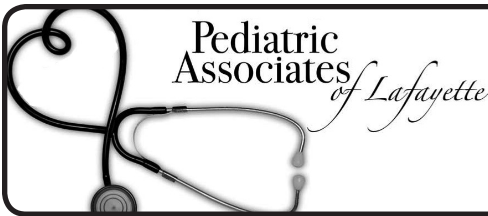

Your information for us

Primary Physician *(Circle one)*: **PADGETT BELL THOMAS OTHER**

Child's Name________________________________ Sex______ DOB______
Last First Middle

Child's Name________________________________ Sex______ DOB______
Last First Middle

Child's Name________________________________ Sex______ DOB______
Last First Middle

Child's Name________________________________ Sex______ DOB______
Last First Middle

Child's Name________________________________ Sex______ DOB______
Last First Middle

Address____
Street No. & Name Box No. City State Zip Code

Primary Phone (_____)____________ cell home *(must have cell as primary if opt for text message)*

RESPONSIBLE PARTY INFORMATION

Mother's Name ________________________________ Marital Status ____________
Last First Middle

Address *(if different from child)* ____________________________

Home Phone (_____) ____________ Cell Phone (_____) ____________

Date of Birth ____________ Social Security No. ____________

Employer____________ Work Phone (_____)____________

Father's Name________________________________ Marital Status ____________
Last First Middle

Address *(if different from child)* ____________________________

Home Phone (_____) ____________ Cell Phone (_____) ____________

Date of Birth ____________ Social Security No. ____________

Employer____________ Work Phone (_____)____________

Primary Insurance Company Name ____________________ ID No. ____________

Group or ID No. ____________ Policy Holder ____________ Policy Holder's DOB ____________

Secondary Insurance Company Name ____________________ ID No. ____________

Group or ID No. ____________ Policy Holder ____________ Policy Holder's DOB ____________

OTHERS WHO MAY BRING CHILD & RECEIVE INFORMATION

Name________________________ Relationship________________

Home Phone (_____)____________Cell Phone (_____)____________Work Phone (_____)____________

I request and consent to the staff of Pediatric Associates of Lafayette, P.C. to provide medical care, tests, procedures and other services and supplies to my child as are considered necessary by my physician, whether accompanied by me or my designee. I authorize Pediatric Associates of Lafayette, P.C. to file claims to my insurance company and to provide information to the insurance carrier for the processing of claims for medical benefits. I request that my insurance company honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

I agree to be responsible for charges for all services and supplies rendered in this office. Pediatric Associates of Lafayette, P.C. will assist me in obtaining insurance benefits when those benefits are assigned to my physician. It is my responsibility to make sure insurance payments are processed and paid promptly to my physician. I understand that if I default on my account, I will be responsible for any pre-judgement and/or post-judgement interest at current legal rate, court costs, collection agency fees and attorney fees. I understand that you may contact me by telephone at any number associated with my account, including wireless telephone numbers. Methods of contact may include pre-recorded/artificial voice messages and/or the use of an automatic dialing device.

2017

______________________________ Signature of Parent / Legal Guardian

____________ Date

12/2015

Pediatric Associates of Lafayette, P.C.

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 required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose 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 to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices 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 within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. 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, telephone), and 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 copy your PHI - This means you may inspect, and obtain a copy of your complete health record. 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 fee for paper or electronic copies as established by professional, state, or federal guidelines.

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 may have the right to request an amendment to your protected health information - This means you may request an amendment of 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 - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

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, please feel free to contact our Privacy Manager. Contact information is provided on the following page 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.

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 and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

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.

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 the PHI, 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 for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; 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. You may file a complaint with us by notifying the Privacy Manager at: Pediatric Associates of Lafayette, P.C., 2300 Ferry St., Lafayette, IN 47904.

We will not retaliate against you for filing a complaint.

Effective Date : September 15, 2015   Publication Date: September 15, 2015

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below I am acknowledging that the office of **Pediatric Associates of Lafayette, P.C.** has provided me with a copy of its Notice of Privacy Practices.

Child's Name: ______________________________

Child's Date of Birth: ______________________________

Parent/Guardian Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

INITIAL MEDICAL DATA SHEET

Todays date ___/____/____

Child's Legal Name: ______________________________

Birthdate:____/____/____

Your name: ______________________________

Pediatric Associates of Lafayette, PC
2300 Ferry St., Lafayette, IN 47904
Jan 04

Child's Medical History:

List hospital stays and reasons: ______________________________

____

Surgeries: ______________________________

Chronic Illnesses: ______________________________

Allergies to foods or medications: ______________________________

Birth weight and birth problems: ______________________________

Previous doctor and medical consults: ______________________________

____

Has your child had chickenpox?____ Other viruses? ______________ __________

List any problems with your child's skills (speech, motor, fine motor, social): __________

____

Family History: Please list parents, grandparents, and siblings, with illnesses and causes of death:

______________ (Mom) ______________ (Mom's Mom) ______________ (Mom's Dad)

______________ (Dad) ______________ (Dad's Mom) ______________ (Dad's Dad)

______________ ______________ ______________ (Siblings)

______________ ______________ ______________

Are any of the following present in the child's immediate family?

__Asthma __Cystic Fibrosis __ Diabetes __Seizures __Kidney disease __ High blood press.
__ ADD/learning prob. __ High cholesterol __ Clotting problems __ Thyroid problems
— Glaucoma __ Cancer___Eczema ___ Liver disease ___ Bowel disease ___Heart disease

Child's current medications :

____

____

____

____

____

____

____

To your knowledge, are your child's vaccinations up to date? ___________

Besides the parents and children listed above, does anyone else live with your child?

____

Are parents: Married? ___Divorced?___ Single?___ Smokers?___ Use alcohol? ___

Daycare/Sitter: ______________________________

School:______________________________

Is there any additional information that you feel should be part of your child's medical record? ______________________________

____

Pediatric Associates of Lafayette, P.C.

THOMAS C. PADGETT, M.D. (765) 448-6158
CATHERINE J. W. BELL, M.D. (765) 448-6420
JAMES L. THOMAS, M.D. (765) 448-6449

RECORDS RELEASE AUTHORIZATION

PLEASE FILL OUT THE FORM COMPLETELY

Patient Name ______________________________ Date: ______________

Date of Birth ______________________ Phone# (____) ____-________

Address ____

City ____________________ State __________ Zip __________

RELEASE FROM:

____
Name of person/facility

____
Address

____
City, State, Zip Code

RELEASE TO:

Pediatric Associates of Lafayette, P.C.
2300 Ferry St.
Lafayette, IN 47904

INFORMATION TO BE RELEASED:

- ALL RECORDS

THE PURPOSE FOR DISCLOSURE

- Transfer of care

I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of (60) days, whichever occurs first, except to the extent that action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, pregnancy, genetic testing, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. I further understand that my protected health information that is used or disclosed under the Authorization may be subject to re-disclosure and no longer protected by the law.

PATIENT/CONSENTING PARTY: ______________________________
Printed Name

Signature: ______________________________
Guardian if Patient is under 18

____
Current Address

____
City, State, Zip Code

Medical records are legal documents, therefore owned by Pediatric Associates of Lafayette, P.C. Charges for copies of these documents shall be in accordance with Indiana code 760 IAC 1-71-3 effctive November 2005, which states as follows:
1. Minimum $20.00 labor charge. (includes pages 1-10) 2. A charge of $.50 per page (for pages 11-50) 3. A charge of $.25 per page (for pages 51 and up) 4. Postage fee applicable. 5. If a person persists that the copies be provided within 2 working days, an additional $10.00 charge will be made.

FAX (765) 447-9423

2300 FERRY STREET LAFAYETTE, INDIANA 47904