Southside Pediatrics, LLC
1322 AL 77
Southside, Alabama 35907
Ph. 256-344-7070 Fax: 877-349-8474

Patient Information

Patient Full Name _____

PreferredName _____ DOB_____ Sex_____

Primary Phone _____ Secondary Phone _____

EmailAddress _____

Address _____

City / State / Zip _____

Ethnicity (circle): Hispanic or Non-Hispanic Race: _____ SSN: _____

Primary Provider- Please circle one

Lindsay Davis CPNP-PC Savannah Goodlett FNP-C Dr. M. Hallenbeck

Parent Information

Mothers First and Last Name _____ Phone Number _____

Fathers First and Last Name _____ Phone Number _____

Insurance Information

Primary Insurance Company_____ Group # _____ Policy # _____

Policy Holder's Name_____Policy Holder's DOB _____

Secondary Insurance Company_____ Group # _____ Policy # _____

Policy Holder's Name_____Policy Holder's DOB _____

Emergency Information

Person to notify in case of emergency Relationship to patient

_____

Phone #

_____

Parent/Guardian Signature

_____

Parent/Guardian Name (Printed)

_____

Patient Medical History Form

Provider your child was seeing previously:

_____

ALLERGIES- Please list the patients drug, food, or other allergies:

☐ No known drug allergies ☐List Drug Allergies:
☐No food or other allergies ☐List Allergies:

MEDICATIONS- Please list the patients medications and supplements:

Medication Name	Dose	Medication Name	Dose
1.		2.	
3.		4.	
5.		6.	
7.		8.	

PAST MEDICAL HISTORY- Please list the **patient's** medical conditions:

1.	2.
3.	4.
5.	6.
7.	8.

PAST SURGICAL/HOSPITALIZATION HISTORY- List the **patient's** surgeries and/or hospitalizations with approximate dates:

Operation/Hospitalization	Date	Operation/Hospitalization	Date
1.		2.	
3.		4.	
5.		6.	
7.		8.	

Immunizations (check one): up to date _____ delayed _____ I have elected not to immunize my child _____
Reason for delay or for declining immunizations _____

Birth History
Pregnancy or birth complications? _____ Full term or preterm? _____ Twins? _____

Family History

Please only include the child's Mother, Father, Siblings, and Grandparents
Please indicate if grandparents are maternal or paternal

HISTORY	Y/N	FAMILY MEMBER	DETAILS
Heart Disease			
Sudden Death before 50 years of age			
High Blood Pressure			
Heart Failure			
Cancer			
Kidney Disease			
Asthma or Allergies			
Reaction to Anesthesia (surgery)			
Diabetes			
Anxiety, Depression, ADHD			
Blood Clotting Disorder			
Genetic Disorder			
Any history not listed:			

Consent for Treatment

CONSENT FOR TREATMENT- I give consent to the Southside Pediatric Clinic for examination and treatment, including drugs, medicine, performance of operations, or other studies that may be done by the attending physician, nurse practitioner, medical assistant, or staff, as needed (indicated for my care.)

AUTHORIZATION OF BENEFITS- I authorize Southside Pediatric Clinic, LLC to furnish any medical information requested by insurance companies including Medicare with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job injury.

ASSIGNMENT OF BENEFITS- I hereby authorize payment directly to Southside Pediatric Clinic for benefits otherwise payable to me including major medical insurance and Medicare also payment for surgical benefits, but not to exceed the Southside Pediatric Clinic charges for these services. I understand that I am financially responsible to Southside Pediatric Clinic for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Southside Pediatric Clinic I hereby guarantee the payment of all accounts for services rendered for me and all the family members I am responsible for. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee and court costs.

ACKNOWLEDGEMENT- I have received the currently effective Notice of Privacy Practices. This also serves as a PHI document release should I request treatment be sent to other medical facilities in the future. Southside Pediatrics, LLC will only call the phone numbers provided by you unless you give instructions to remove contact information from your file. No emails or text messages will be sent from our office. This consent/authorization remains in effect until revoked in writing.

VACCINES- I understand that Southside Pediatrics recommends following the CDC Guidelines for Childhood Immunizations. I understand that I have the option to decline vaccinations at each appointment, after an informed discussion with the provider. I understand that any diseases contracted due to lack of vaccination/ my child's under-immunized status, is my responsibility. I understand that vaccines may cause common side-effects or adverse reactions and it is my responsibility to discuss these concerns with a provider. I understand that regardless of vaccination status, there may be instances where I am asked to wait in my car, or there may be a time- delay in my visit, considering the immunocompromised patients of our practice. I understand that Southside Pediatrics offers care to vaccinated and unvaccinated patients and while Southside Pediatrics operates as safely as they deem possible and to the best of their ethical ability to provide care for all children, they cannot guarantee my child will not be exposed to communicable diseases within the practice.

I give my permission for Southside Pediatric Clinic to treat my child, _____(Please Print), according to the provider's judgement, upholding to the best of their ability, the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity, as deemed appropriate. I understand that I have the right to detailed informed consent and may request this at any time. I understand that if I am concerned about the severity of an illness I have the ability to have my child evaluated for a second opinion within Southside Pediatrics or at another facility. For alarming conditions and emergencies, it is my responsibility to have my child evaluated in the emergency department of a hospital.

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature_____Date_____

Authorization for Treatment in Absence of Parent or Guardian

I, _____ (Please Print), do hereby consent and authorize Southside Pediatric Clinic, LLC and its providers and staff to examine and /or treat my child_____ (Please Print) in my absence. I affirm that I have Legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who had the legal right and exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and /or treatments. I hereby consent to any medical treatment, including diagnosis, procedures, examinations, and medications, deemed appropriate by Southside Pediatrics, LLC and providers, understanding that this includes the authority to perform any necessary medical interventions in case of emergency, as per Alabama state law.

I give the providers and staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. Listed below are people who can bring my child in my absence for well child and/or sick visits, as well as getting vaccines. If we are unable to contact the guardian, the people listed below are authorized to be contacted by the provider's staff and to make decisions regarding the child's care.

NOTICES ON MINOR CONSENT

Ala. Code §§22-8-4; 22-8-7

Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary.

Ala. Code § 22-8-6

Any minor may give effective consent for any legally authorized medical, health or mental health services to determine the presence of, or to treat, pregnancy, venereal disease, drug dependency, alcohol toxicity or any reportable disease, and the consent of no other person shall be deemed necessary.

Name	Relationship to Patient	Phone Number

Parent/Guardian Signature_____ Date_____

No Show/Missed Appointment Policy

We at Southside Pediatric understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the office number 256-344-7070.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

Parent/Guardian Name:_____

Parent/Guardian Signature:_____

Southside PEDIATRICS

Authorization to Use and Disclose Protected Health Information

Patient's Name:_____ Date of Birth: _____-_____-_____
Address: _____
Parent/Legal Guardian Name: _____
Daytime Phone #:_____

I authorize Southside Pediatric Clinic LLC to **request/release** my child's protected health information (PHI) from/to the listed organization below:

Person / Organization information: (TO BE FILLED OUT BY MEDICAL OFFICE)

Name: _____
Address: _____
City, State, Zip: _____
Phone #:_____ Fax #: _____

Specific Information Requested:

Dates of treatment: from: _____to: _____

____ History & Physical ____ Labs
____ Immunization Records ____ Radiology Reports
____ Progress Notes ____ Pathology Report
____ ADHD Evaluation ____ Allergy Records
____ Entire Record ____ Sports Physical Evaluation
____ Other, specify_____

By initialing next to a category listed below, I specifically authorize Southside Pediatric to use and/or disclose my highly confidential information. **Initial each category that Southside Pediatrics, LLC is authorized to release.**

_____Mental Health / Psychiatric / Psychological Records
_____Alcohol and/or Drug Abuse Records
_____Information about sexually transmitted diseases
_____HIV/AIDS related testing (whether the results were positive or negative)

The purpose for the use/disclosure of the information is:

_____Patient/Personal Representative request _____Legal
_____Physician care _____Insurance
_____Other, specify: _____

Unless otherwise revoked, this Authorization will expire: **One (1) year from signature date**

I understand that once Southside Pediatrics, LLC discloses my PHI to the recipient, Southside Pediatrics cannot guarantee that the recipient will not disclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state Privacy law governing the use and disclosure of my PHI.

I understand that according to state and federal law I may be charged a reasonable fee by the releasing facility for the photocopying of the requested records. I understand that Southside Pediatrics may directly or indirectly receive remuneration from a third party in connection with the use or disclosure of my PHI.

I understand that I may refuse to sign or may revoke (at any time) this Authorization and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Southside Pediatrics; except, however if my treatment at Southside Pediatrics is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Southside Pediatrics may refuse to treat me if I do not sign this Authorization.

I understand that if I revoke this Authorization, I must send a written notice of revocation to the Custodian of Records at the address listed below. The revocation will be effective immediately upon Southside Pediatric's receipt of my written notice. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I may contact the HIM/Custodian of Records at the address and phone/fax listed below

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly, and voluntarily authorize Southside Pediatrics to use or disclose my PHI in the manner described above.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, Relationship to Patient Signature of Witness Date · Please fill out the authorization completely. If sections are blank or incomplete, we may not be able to process your request. . When submitting your request for medical records, please enclose a copy of your Photo ID.
Drivers License ___ Work Photo ID___ SS Card ___ Other Photo ID___ Notarized signature ____ Other___ · If the records are for a patient whom you have Power of Attorney, please enclose a copy of the POA. . If the records are for a deceased patient, please provide a copy of the Executor of Estate or Death Certificate.

Completed Authorizations and any required paperwork can be mailed to:

Southside Pediatrics, LLC
1322 AL-77
Southside, Al 35907
256-344-7070
877-349-8474

Disclosure of Protected Health Information

Phone Communication:

According to our office policy, lab results and billing information may be provided to the patient and/or the guardian by telephone communication. Do we have permission to leave messages on your voicemail? Y/N

Do we have permission to discuss lab results with the following listed phone numbers? Y/N

Please provide the telephone numbers in which lab results may be provided:

Phone: _____ Phone: _____ Phone: _____

Release of Paper Documents:

If you would like to provide permission to disclose protected health information via paper documentation to include; medical records, immunizations (blue forms) and Dr's excuses, to anyone other than the guardian on file please specify below their name and relationship to your child. By signing below you provide permission to the staff of Southside Pediatric to disclose your child's PHI and fully understand that this disclosure is subject to any and all medical records pertaining to your child.

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Please note that in accordance with the HIPAA guidelines and in order to assure complete confidentiality of your child's PHI, disclosure of PHI will not be provided from the staff by email, mail or fax. Release of PHI via fax is permitted only in the event your child's medical records are requested by another treating physician, and only if the proper "authorization for release of information is received". All requests for PHI information to be released upon request to the parent, guardian, or anyone listed above must be picked up from Southside Pediatric, and only if the proper "authorization for release of information is received".

Patient/Guardian Signature_____ Date_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Evaluation and treatment, Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), Obtaining payment from third party payers (e.g., my insurance company and billing company), and the day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact Southside Pediatrics at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protective health information is used and disclosed to carry out treatment, payment, and health care operations, but that Southside Pediatrics and providers are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____.

Print Patient Name _____.

Signature _____Relationship to Patient _____.

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care Insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of every individual requirement for each plan.

It is the responsibility of each patient to know the details of his/her insurance plan, in addition to any lapses in insurance coverage. Any changes that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that may not be covered by your plan; we may bill you directly for those charges. If current Insurance coverage cannot be verified prior to each appointment, payment for those charges will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions regarding your laboratory bill, please contact the lab or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Southside Pediatrics offers care for uninsured patients and this payment is required at the time service is rendered.

If an account is not paid in full within 90 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a $35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds.

I hereby authorize the practice to release all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company and billing company; and hereby authorize payment of the insurance benefits directly to Southside Pediatrics for any services rendered that are not paid for directly by myself. I authorize Alabama Billing and Credentialing Solutions, LLC to access my information and to contact me, as necessary, for the collection of payment on my account until resolution of the balance.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- Patient Financial Responsibility including collections
- Confidentiality and Privacy of Medical Records

Parent/Guardian Signature _____ Date _____
Parent/Guardian Printed Name _____ Date _____