SUMTER PEDIATRICS LLC

Patient Information Date: _____

Name: _____ ___/___/___ □Male □Female Race:_____
Last First Date of Birth
SS#: _____ Insurance:_____ ID#: _____

Name: _____ ___/___/___ □Male □Female Race:_____
Last First Date of Birth
SS#: _____ Insurance:_____ ID#: _____

Name: _____ ___/___/___ □Male □Female Race:_____
Last First Date of Birth
SS#: _____ Insurance:_____ ID#: _____

Name: _____ ___/___/___ □Male □Female Race:_____
Last First Date of Birth
SS#: _____ Insurance:_____ ID#: _____

Parent/Legal Guardian Information

Name:_____
Last First Middle
Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____ Birth Date: ____/____/_____
Relationship to child: _____ Social Security # ____/____/_____
Employer: _____ Work Phone: _____
E-mail Address:_____

Spouse/Other Legal Guardian Information

Name:_____
Last First Middle
Address: _____ Home Phone: _____
City: _____ Cell Phone: _____
State: _____ Zip: _____ Birth Date: ____/____/_____
Relationship to child: _____ Social Security # ____/____/_____
Employer: _____ Work Phone: _____
E-mail Address:_____

Emergency Contact: _____ Phone #: _____

Signature Parent/Guardian _____ Date _____

Please turn the page over for more questions

SUMTER PEDIATRICS LLC

Consent to Treat

We follow the guidelines of the American Academy of Pediatrics in the treatment recommended for your child. I authorize any physician or clinical staff member of Sumter Pediatrics to provide medical treatment for my child/children. This includes hospitalizations, injections, anesthesia, immunizations, referrals and emergency treatment. ***Immunizations will be administered as recommended*** by the American Academy of Pediatrics and the Centers for Disease Control (CDC). If you do not wish for your child to receive immunizations, you must discuss this with the physician.

Financial Policy

We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES. It is your responsibility to:

Bring your insurance card and photo I.D. at every visit.

Pay your Co-Payment and/or any deductibles at each visit. Payment can be made by cash, check or credit card. We accept VISA and MasterCard. We do not bill for Co-Payments.

Pay in full for any medical care or services that are not covered by your insurance plan.

2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service.

3. Your insurance plan may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be required to pay at the time of service until the PCP has been changed to one of our physicians.

4. ***Secondary Insurance:*** We will file secondary insurance.

5. ***You are financially responsible for all charges incurred in your child's care and treatment if not covered by the insurance plan. Not all services may be covered by your plan.***

6. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is located on your insurance card.

7. Failure to meet your financial obligations with this office could lead to dismissal from the practice. Any outstanding balances may be sent to an outside collection agency.

8. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Registration Form. We will scan your insurance card, ID, and Registration Form into your child's electronic medical chart.

9. In cases of divorce and/or separation, the legal guardian will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

Signature of Understanding and Consent for all children on you listed on the front page: I have read, understand and consent to the above policies of Sumter Pediatrics.

Signature of Parent/Guardian _____ **Date** _____

Please turn the page over for more questions

PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING OF SUMTER PEDIATRICS, LLC NOTICE OF PRIVACY PRACTICES

In 1996, Federal law was passed regarding the Privacy Regulations created from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This was created as a direct result of the electronic filing and exchange of health information while protecting a patient's privacy.

Parent's Name: _____ SSN: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

I understand the patient's health information is private and confidential. I understand that Sumter Pediatrics LLC works diligently to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that Sumter Pediatrics LLC may use and disclose the patient's personal health information to help to provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Sumter Pediatrics LLC has a detailed document called "Notice of Privacy Practices". This document contains more detailed information about the policies and practices protecting the patient's privacy. I understand I have the right to read the "Notice" before signing this acknowledgement. I understand Sumter Pediatrics LLC will change and amend the Notice as it deems necessary without individual notification. I understand the most recent amended notice will be available for review for parents/guarantors.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include but are not limited to access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communications or alternative action.

Sumter Pediatrics LLC has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written authorizations, reasonable time frames for requesting information, charges for non-routine needs, etc. I will assist Sumter Pediatrics LLC by following these procedures if I chose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature indicates I have been given the chance to review a current copy of Sumter Pediatrics LLC "Notice of Privacy Practices".

_____

Signature Relationship to patient Date

SUMTER PEDIATRICS

I _____ AUTHORIZE
PARENT/GUARDIAN

1. _____
2. _____
3. _____

TO BRING MY CHILDREN: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

FOR TREATMENT FOR: SICK, VACCINES, HEALTH CHECKS, MEDICINE REFILLS.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

SUMTER PEDIATRICS

I _____ AUTHORIZE
PARENT/GUARDIAN

4. _____
5. _____
6. _____

TO BRING MY CHILDREN: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

FOR TREATMENT FOR: SICK, VACCINES, HEALTH CHECKS, MEDICINE REFILLS.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Sumter Pediatrics

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

Address: _____City:_____State:_____Zip:_____

Phone:_____

Purpose of Requested Use or Disclosure ***(tell us how you will use releasing records)***

___ Transfer of Care ___ Per my request ___ Insurance ___ Other:_____

Authorization - I hereby authorize *(Tell us who will be releasing records)*

_____
Name of hospital, physician, Healthcare Facility

_____
Address City State Zip

_____
Phone Fax

To Release health information to:

Sumter Pediatrics LLC Phone: 229-814-1174

340 US Hwy 19S Fax: 229-814-1274

Leesburg, GA 31763

Information to be disclosed for the following date range: _____ to _____

__ Clinical Notes(Inpatient and Outpatient)

__ Outside Records (Specify Provider Name or Medical Group):_____

__ Radiology Report(s) Specify: __ X-ray __Ultrasound ___CT Scan __MRI

__ Laboratory Test(s) __ Billing Records __ Other:_____

Special Authorization - Specifically authorize release of the following information:

__HIV test results_____(initial) __Substance abuse_____(initial)

__Behavioral Health_____(initial) __Psychiatry_____(initial)

Expiration: This authorization shall become effective immediately and shall remain in effect for one year from the date signed unless a different date is specified here: _____

I understand the following:

1. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
2. The information released in response to this authorization may be re-disclosed to other parties.
3. My/patient's treatment or payment for my/patient's treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

SIGNATURE: _____
Signature of Patient/Legal Representative Date

PRINT NAME:_____

If signed by anyone other than the patient, print name and relationship below:

Name:_____ Relationship:_____
Legal Representative

Patient Name: _____ DOB: _____

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Admin. use only	Mom 1	Dad 2	Sister 3	Brother 4	Mom's Mom 5	Mom's Dad 6	Dad's Mom 7	Dad's Dad 8	Mom's Sister 12	Mom's Brother 13	Dad's Sister 14	Dad's Brother 15
Alcoholism	33												
Anemia	1												
Asthma	5												
Autism	128												
Autoimmune Disorder	34												
Birth Defect/Congenital Anomaly	36												
Bleeding Problem	7												
Cancer, Breast	8												
Cancer: Please Specify Type _____													
Cancer: Please Specify Type _____													
Depression	14												
Diabetes	81												
Eczema (Atopic Dermatitis)	17												
Food Allergy	39												
Genetic Disorder	19												
Hay Fever (Allergic Rhinitis)	20												
Hearing Disorder	21												
Heart Attack/Coronary Artery Disease	13												
High Cholesterol (Hyperlipidemia)	22												
High Blood Pressure (Hypertension)	23												
Immune Disorder	24												
Inflammatory Bowel Disease (Crohns/UC)	59												
Kidney Disease	25												
Mental Retardation or Learning Disability	40												
Migraine Headaches	71												
Psychiatric/Mental Illness	75												
Scoliosis	76												
Stroke	28												
Substance Abuse	43												
Thyroid Disorders	30												
Tobacco Use	30.5												
Tuberculosis	31												
Death before age 56 or reasons not listed above													
Other:													
Other:													

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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