PEDIATRIC ASSOCIATES OF MADISON

21 Hughes Rd., Suite 2 ● Madison, Alabama 35758 ● 256-772-2037 ● Fax 256-772-9523

www.pedsofmadison.com

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Date: _____ **PATIENT REGISTRATION** **Chart #_____**

PLEASE PRINT – FILL OUT ALL AREAS

PATIENT INFORMATION

CHILD'S NAME(OLDEST TO YOUNGEST) BIRTHDATE SSN SEX CELL PHONE# (14 YRS & OLDER)

1._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

2._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

3._____

Race: □ Asian □ African American □ White Other: _____ **Ethnicity:** □ Hispanic □ Non-Hispanic

4._____

Race: □ Asian □ African American □ White Other:_____ **Ethnicity:** □ Hispanic □ Non-Hispanic

PATIENT ADDRESS

_____

STREET CITY, STATE ZIP CODE

***PRIMARY CONTACT AND APPOINTMENT REMINDER PHONE # _____**

PARENT INFORMATION

***CELL PHONE CARRIER _____**

_____

DAD'S NAME DAD □ STEP DAD □

_____

ADDRESS

_____

DAD'S CELL PHONE #

_____

DOB SOCIAL SECURITY #

_____

EMPLOYER

_____

WORK PHONE NUMBER

_____

E-MAIL ADDRESS - May we add you to our email list? ___yes ___no

_____

MOM'S NAME MOM □ STEP MOM □

_____

ADDRESS

_____

MOM'S CELL PHONE #

_____

DOB SOCIAL SECURITY #

_____

EMPLOYER

_____

WORK PHONE NUMBER

_____

E-MAIL ADDRESS - May we add you to our email list? ___yes ___no

EMERGENCY CONTACT (FRIEND OR RELATIVE)

_____

NAME RELATIONSHIP HOME PHONE CELL PHONE

REFERRED BY: _____

CONTINUE ON BACK >>>>>>>>>

INSURANCE INFORMATION

PRIMARY INSURANCE

POLICY HOLDER'S NAME | DOB | SSN | COPAY

PRIMARY INSURANCE CO. | POLICY NUMBER | GROUP NUMBER

SECONDARY INSURANCE

POLICY HOLDER'S NAME | DOB | SSN | COPAY

SECONDARY INSURANCE CO. | POLICY NUMBER | GROUP NUMBER

PLEASE READ AND SIGN AUTHORIZATION AND ASSIGNMENT

*ALL COPAYS OR CO-INSURANCE ARE DUE AT THE TIME OF SERVICE.

I (We), the undersigned, hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. In the event of non-payment the account will accrue a monthly finance fee of $20 and may be turned over for collections and will result in dismissal from the practice.

I acknowledge and agree that Pediatric Associates of Madison, P.C., and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Pediatric Associates of Madison, P.C., if I have given up ownership or control of any such telephone number.

CONSENT FOR TREATMENT

I authorize the doctors of Pediatric Associates of Madison, P.C., to treat my minor children listed above as they deem medically necessary. I authorize emergency medical treatment for the above-named child(ren) in the event that he/she is brought into this practice by any person other than myself.

SIGNATURE OF PARENT OF LEGAL GUARDIAN | PRINT NAME | DATE

NOTIFICATION OF POSSIBLE NON-COVERED SERVICES

There are recommended screening tests which may be performed at a well checkup that are necessary for the maintenance of good health. These tests may or may not be covered by your medical insurance. If your medical insurance is Healthcare Reform Compliant it should cover the following services. It will be the patient's responsibility to pay for any non-covered services. If you have any questions about whether or not a particular service is covered by your medical insurance, please contact your insurance company.

_____

Chart Number

Possible Non-Covered Service(s)	**Amount**
Complete Blood Count (CBC)- every 2 years	$17.00
Cholesterol Screening – 9-11 years old	Sent to outside Lab
Eye Screening- with a spot vision screener	$20.00
Hearing Screen	$32.00
M-Chat Autism Questionnaire- 18 months old	$15.00
Glucose	$6.00
Urinalysis	$10.00

FORMS/SERVICE FEE

Fees will be charged for the following forms if not requested at the time of an office visit:

- Blue Card - $5
- Camp & Sports Physicals Forms - $10
- School Medication Authorization Forms - $5
- FMLA or Disability Forms - $15
- Letters requested by patients - $5

(ALL FORM FEES WILL BE DUE AT THE TIME OF PICKUP.)
Rush Form Fee:
If a form is needed in less than 24 hrs. the form fee will be doubled.

SERVICES

- Nurse/Lab visits which are non-physician visits - $15
  (Weight checks, immunization updates, allergy shots, and labs.)
- No-Show Appointments - $50
- Minimum $25 charge for any after-hours physician call not related to an office visit

I (We), the undersigned have read and hereby agree to pay all amounts and charges hereafter incurred by me or members of my family for services rendered by this office. In the event of non-payment, either by insurance or by me. The account may be turned over for collections and may result in dismissal from the practice.

_____

Guardian Signature Date

IMMUNIZATION POLICY

It is the policy of all Pediatric Associates of Madison physicians that your child(ren) receive all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP).

Immunization Schedule

2 and 4 months	***Pediarix, HIB, Prevnar, and Rotateq**
6 months	***Pediarix, Prevnar and Rotateq**
12 months	**HIB, Prevnar and Hepatitis A**
15 months	**MMR , Varivax**
18 months	**DTaP, Hepatitis A**
4- 5 years	***Kinrix, MMR and Varivax**
11-12 years	**TdaP ,Meningitis A and HPV**
16-18 years	**Meningitis A, Meningitis B**

***Pediarix includes DTaP, IPV, Hepatitis B**
***Kinrix includes DTaP, IPV**

I acknowledge the receipt of the immunization policy of Pediatric Associates of Madison, and I agree to comply with this vaccine schedule.

_____ _____

Parent/Guardian **Date**

Name _____ DOB _____ Today's Date _____

BIRTH HISTORY: (please circle all that apply)

vaginal caesarean Pre-term _____weeks full term

weight _____ breast bottle

Complications: _____

FAMILY HISTORY: (please circle all that apply)

Diabetes Bleeding Problems Cancer

Heart Disease Mental Illness High Cholesterol

Seizures / Epilepsy Allergies

Maternal Height _____ Paternal Height _____

PAST MEDICAL HISTORY: (please circle all that apply)

Chickenpox Pneumonia Wheezing

Seizure / Loss of consciousness Eczema Vision problems

Broken bones Bedwetting Kidney / bladder problems

Development / Behavior problems

SURGICAL HISTORY: (please list all previous procedures)

_____

_____

SOCIAL HISTORY: (please circle all that apply)

Patient lives with:

Mother Father Siblings _____

Other: _____

Pets smoke exposure Attends daycare / school

Guns in home

DAILY MEDICATIONS / HERBS / SUPPLEMENTS: (if so, please list)

_____

_____

_____

Pediatric Associates of Madison

21 HUGHES RD. SUITE 2 MADISON, AL 35758
(256)772-2037 FAX (256) 772-9523

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Each Patient Must Have a Separate Release Form

PLEASE PRINT CLEARLY **DATE:**_____

Patient Name: _____ Date of Birth: _____

Please Check One:
Send Records to □ **Obtain Records From** □

Person/ Organization:_____

Street Address: _____

City: _____ State:_____ Zip: _____

Phone No:_____ Fax No:_____

Information to be sent or received: (check all that apply)

_____Immunizations
_____Problem List
_____Growth Charts
_____Other /Specify: _____

Purpose of Disclosure:

_____ Leaving Practice _____Specialist Referral
_____ Personal Use _____ Insurance Purposes
_____ Relocating/Transfer

A $10 RETRIEVAL FEE AND A FEE OF .50 PER PAGE WILL BE CHARGED FOR ANY RECORDS THAT HAS TO BE RETRIEVED FROM STORAGE.

I hereby Release and Authorize Pediatric Associates of Madison, P.C. to Release the Medical Records of the dependent listed (or self 18 or over) including diagnosis, treatment, prognosis, and recommendation, as well as other data pertinent to patient's treatment to the following location listed above. I hereby state that I am the child's parent or court appointed legal guardian and have the legal right to make and/or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I understand that is authorization will expire twelve months from the date signed.

_____ _____
Signature Date

Relationship to child: _____

NOTE: We ask that we be allowed 10 to 14 working days to process a release of medical information.

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patients Name **Date Of Birth**

_____

_____

_____

_____

Entity Requested to Release Information: Pediatric Associates Of Madison

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.
Who will be authorized to receive information (the individual(s) who is to receive your PHI)**:**

_____**Relation**_____

_____**Relation**_____

_____**Relation**_____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:
___office notes ____lab results, pathology reports ___x-rays
___financial history report (previous 3 years only).

In **Accordance to Alabama State Law**, when a minor reaches the age of fourteen, we cannot discuss the child's private medical information with a parent without the child present or without written consent from the child. The exception is as follows: if a child seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what services their insurance company has been billed for. If the child does not wish for the policy holder to be given that information, they must pay cash up front for that visit.

This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year:_____

You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

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

_____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

New Baby Information

Mother

Name_____

DOB _____

Cell _____

Email _____

Father

Name _____

DOB _____

Cell _____

Email _____

Pregnancy History

Obstetrician _____

Delivery Hospital _____

Previous miscarriages _____Yes _____No

Plans to Feed: ____Breast ____Bottle

Previous Breast Surgery ____Yes _____No

Previous Problems Breastfeeding ___Yes ___No

Problems during this pregnancy? Have you been referred to a high-risk OB? Any abnormalities on an ultrasound?

_____

_____

_____

Family History (include yourselves, parents, current children, and your siblings)

	Maternal Side	Paternal Side
Food Allergies	_____	_____
Asthma	_____	_____
Congenital Heart Disease	_____	_____
Other Birth Defects	_____	_____
Severe Newborn Jaundice	_____	_____
Frequent urinary tract infections	_____	_____
Strabismus (lazy eye)/Astigmatism	_____	_____
Sudden Infant Death Syndrome	_____	_____
Congenital Hip Dysplasia	_____	_____
Seizures	_____	_____
Bleeding/Clotting Problems	_____	_____