Vidalia Pediatric Clinic
303 Harris Industrial Blvd, Ste 3
Vidalia, GA 30474
Phone: (912) 537-9355

All information **MUST** be filled out in order for services to be provided. Thank you.

Patient Information

Date: _____

_____

First Name *Middle Name* *Last Name*

Physical Address: _____
Street City State Zip

Mailing Address: _____
(If Different from Above) Street City State Zip

Date of Birth: _____ *Social Security Num*:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Sex: □ Male □ Female *Race*: □African American □Asian □Caucasian □Hispanic □Indian □ Native American

Insurance Type: □Medicaid □Wellcare □Amerigroup □Peachstate □Other: _____

Can we text cell phone for appointment reminders: □ Yes □ No

Parent Email Address:_____

List of Child's Siblings (if any): _____

Mothers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Fathers Name: _____

Address: _____
Street City State Zip

Social Security: _____ *Home Number*: _____

Date of Birth: _____ *Cell Number*: _____

Emergency Contact: _____
Name Number Relationship

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Release Form for Individuals in Care of Patient

Parent/Guardian Name: _____

Patient's Name: _____ Patient's Date of Birth: _____

I give Vidalia Pediatric Clinic permission to speak with the following people regarding my child's health status; including diagnosis, treatment options and plans, and payments for health services. I give Vidalia Pediatric Clinic permission to treat my child in my absence when brought by the following people.

This consent is valid until such time as I provide Vidalia Pediatric Clinic written revocation of it.

Vidalia Pediatric Clinic may speak with:

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Name: _____
Contact #: _____
Relationship: _____

Parent Signature: _____
Date: _____

Authorization to Release Medical Records

Patient Name _____DOB: _____

Mother's Name:_____ If Newborn:
Address_____ Baby Boy □
Phone Number _____ Baby Girl □

Previous Provider	Name:_____ Address: _____ Phone: _____Fax: _____
Requestor	Name: **Vidalia Pediatric Clinic** Address: **303 Harris Industrial Blvd, Suite 3** **Vidalia, GA 30474** Phone: **(912) 537-9355** Fax: **(912) 373-8096** Delivery Preference: _X_ US Mail ___ Email _X_ Fax
Information To Be Released	□ Newborn Records □ Any and all records

 With the exception of psychotherapy notes, all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by initialing here:_____
 I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.
 This authorization will automatically expire one year from the date of my signature, or _____ (period of time, for example 2 days, or 3 weeks, or 5 months) from my signature, if specified here. The expiration period noted here may exceed one year only in certain situations as specified in Georgia.
 I understand there may be a retrieval and copy charge associated with the release.
 I understand that once information is released pursuant to this authorization, Vidalia Pediatric Clinic cannot prevent the re-disclosure of the information to another third party.
 I understand this authorization must be filled out completely, signed and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.
 Except for research-related treatment, Vidalia Pediatric Clinic will not condition treatment on my signing this authorization.

_____ _____
Signature of patient / Authorized Person Date

_____ _____
Authorized person's authority to sign Date
(Parent, guardian, power of attorney, etc.)

_____ _____
Witness Date

If you have any questions, please call the receptionist at (912) 537-9355.

Birth Hx: Birth weight: _____ Gestation age: _____ C-section / vaginal delivery

Surgical history: _____

Social history:
Lives with: _____

Smoke exposure: (circle) No exposure / occasional exposure / frequent exposure

Smoke detectors in home: Yes / No

Number of siblings: ___ Brothers _____ Sisters

Family History:

Medical Condition	Family Member (check if yes)
Asthma	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Autoimmune (specify) Lupus Rheumatoid Arthritis (JRA) Sjogren's Syndrome	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Cancer (specify)	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Diabetes Type 1 (juvenile onset) Type 2	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
High Blood Pressure	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Heart attack/stroke	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____

Crohn's Disease Celiac Disease Diverticulitis Ulcerative colitis Multiple sclerosis Dementia / Alzheimer	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
High cholesterol / or Lipids	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Migraines	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Seizures (specify) Epilepsy Febrile seizures Convulsions	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Sickle cell or other anemia	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Thyroid problems	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Psychiatric disorders (specify) Anxiety Depression Mental illness (Bipolar, Schizophrenia, etc.)	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____
Other: Genetic disorder Eating disorder Autism Neurofibromatosis Other: _____	☐ Mother ☐ Maternal grandmother/grandfather ☐ Father ☐ Paternal grandmother/grandfather ☐ Siblings ☐ Other (specify) _____

Consent For Treatment and Financial Responsibility

I, _____, parent and/or legal guardian of _____, born on _____/_____/_____ do hereby consent to any and all medical care deemed necessary by the clinical staff of Vidalia Pediatric Clinic. I understand that Vidalia Pediatric Clinic utilizes the services of Doctors, Nurse Practitioners, Physician Assistants, Nurses, and Medical Assistants to provide treatment.

I understand that Vidalia Pediatric Clinic partners with local colleges to provide students a place to gain medical experience. Your physician has agreed to permit such students to observe and participate in your child's care, under the supervision of the Provider.

ASSIGNMENT OF BENEFITS-

I hereby authorize and assign all payments and/or insurance benefits for medical services and procedures rendered to the patient, directly to Vidalia Pediatric Clinic. I hereby authorize Vidalia Pediatric Clinic to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

FINANCIAL RESPONSIBILITY-

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Vidalia Pediatric Clinic. I am responsible for any and all copays, co-insurance, and/or deductibles at the time of service.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE-

I understand that it is my responsibility to provide Vidalia Pediatric Clinic with all medical insurance information. I will notify Vidalia Pediatric Clinic immediately upon any change in my insurance.

Third Party Laboratories

I understand that Vidalia Pediatric Clinic utilizes the services of third-party laboratories in certain treatment situations. I agree that Vidalia Pediatric Clinic will not be responsible for any patient balance resulting from these services. If you are concerned with the financial responsibility of third-party laboratory charges, please discuss different options with your Provider prior to testing.

_____ _____

Parent and/or Legal Guardian Date

One-on-One Discussion Acknowledgement

At Vidalia Pediatric Clinic, we believe allowing your child the space and freedom to connect with their provider privately is one of the best things for your teen's health. Given all of your involvement over the years, this moment may come as a shock. You might even feel confused or excluded by the request to step out of the room. We believe that as kids get older and undergo both physical and emotional changes, they may start to feel uncomfortable discussing certain topics in front of their parents. Things such as hygiene or sexual activity may feel too embarrassing to talk about. In other cases, they may fear judgment, punishment, or physical harm from their parents. This one-on-one time provides teens an opportunity to speak openly and honestly about their health without fear of perceived repercussions. Likewise, this time teaches teens how to advocate for their own health and well-being as they move into adulthood, while forming trusting relationships with their providers. Though this will not happen at every visit, or with every patient, we want parents to be informed about our process.

What topics will my teen discuss with their provider?

This is your child's opportunity to discuss anything they want, including topics they may have been too uncomfortable to discuss with you in the room. Your provider may ask your child about their school, goals, friendships and romantic relationships, sexual identity, orientation, and activity, mental health, or substance use. Other topics might include hygiene, body image, peer pressure, nutrition, exercise, family life, or safety. If you have a specific concern about your child's health, you can also ask their provider to discuss it during their private time as well. Your child's provider will review how certain behaviors can affect your teen's health, and in turn, encourage positive choices. We encourage parents to have ongoing conversations with their teen about all of these topics, and can help facilitate starting the conversation.

Is their conversation confidential?

State privacy laws allow teenagers to receive some health care services on their own. Because adolescents can legally consent for certain kinds of treatment, health care providers have to keep information related to those services confidential. "Confidential" means we will only share this information if a teenager consents. We will also share pertinent information if your teen or someone else is in danger. We can contact you about most of the services your child receives. However, we need your teenager's permission to discuss certain services provided, such as sexual health and substance abuse. We encourage teens to discuss their health concerns with their parents, and provide guidance on how they might start these sensitive conversations. We ask

that parents and caregivers support this policy and help your teens learn to care for their own health needs as they mature into adults.

If needed, in order for the Provider or a member of our staff to contact your child to follow up on any confidential information shared during the one-on-discussion, please list your child's cell phone number below. In addition, please sign to acknowledge that you are aware of our one-on-one discussion process.

Thank you for trusting us with your child's care!

_____	_____
Parent/Guardian	Date
_____	_____
Patient/Teenager	Patient (child's) Cell #

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you, or your child, may be used and disclosed and how you can get access to this information. If you have any questions about this notice, please contact our office at 912-537-9355.

OUR OBLIGATIONS-

We are required by law to:

- Maintain the privacy of Protected Health Information (PHI)
- Give this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, and future health or condition, the provision of health care to you, or the payment for healthcare provided to you. In general, we may not use or share any more PHI than is necessary to accomplish our purpose.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION-

Described as follows are the way we use and disclose health information that identifies you (Health Information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our Practice Administrator:

- **Treatment**: We may use and disclose PHI in order to provide treatment and other treatment-related healthcare services. Examples may include, Doctors, Nurses, Technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information.
- **Payment**: We may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan to obtain approval for the healthcare services we have provided. We also may share PHI with billing companies that process our healthcare claims.
- **Healthcare Operations**: We may use and disclose PHI for Healthcare operation purposes.

These uses and disclosures are necessary to make sure that all of patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We may also share information with our accountants, attorneys, and others in order to make sure we are complying with the laws that affect us.

OTHER USES OF PHI-

- **Reports required by law**: We may report PHI when the law requires us to give information to government agencies and law enforcement about victims of abuse, neglect, or domestic violence, when dealing with gunshot and other wounds, or when required in a legal proceeding.
- **Public Health**: We may report PHI about births, deaths, and other diseases to government officials in charge of collecting that. We also may provide PHI relating to death to coroners, medical examiners, and funeral directors' information
- **Health Oversight**: We may report PHI to assist the government when it investigates or inspects a healthcare provider or organization.
- **Organ Donation**: We may notify organ banks to assist them in organ, eye, or tissue donation and transplants.
- **Research**: We may use PHI in order to conduct medical research.
- **To Avoid Harm**: We may report PHI to law enforcement in order to avoid serious threats to the health or safety of a person or the public.
- **Other government functions**: We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.

● Workers' compensation: We may report PHI in order to comply with workers compensation laws. Appointment reminders and health related benefits or services. We may use health information to give you appointment reminders, or give you information about treatment choices or other healthcare services or benefits we offer.

● Inmates or individuals in custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be made necessary if: 1. For the institution to provide you with healthcare. 2. To protect your health and safety of others. 3. For the safety and security of the correctional institution.

YOUR RIGHTS-

You have the following rights regarding health information we have about you:

● Your rights to request limits on our use of PHI: You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required to or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.

● Right to Request Confidential Communication: You have the right to request that we communicate with you about the medical matters in a certain way for a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

● Your Right to View and Receive a Copy of your PHI: You may view or obtain a copy of your PHI (except mental health notes). Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance.

● Your Rights to a List of Reports we have made: You have the right to get a list of the parties to whom we have reported your PHI. The list will not include reports for treatment, payment, or healthcare operation, reports you have previously authorized, reports made directly to you or to your family, Reports made for national security purposes, reports to corrections or law enforcement personnel, or reports made before April 14, 2003.

● We Will Respond to Your Request within 60 Days: We will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person receiving the report, the type of information reported, and the reason for the report.

● We Will not Charge you for the List: If you make more than one request in the same year, however, we may charge you a fee for each additional request. For a list, you must make a request in writing to the Practice administrator.

● Your Right to Correct or Update your PHI: If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be made to the Practice Administrator. We will respond within 60 days of your request. We may deny your request if the PHI is 1) Correct and complete 2) Not created by us 3) Not allowed to be shared with you 4) Not in our records. If we deny your request, we will inform you of the reason for the denial. You may file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI. If we agree to honor your request, we will change your PHI, inform you of the change, and tell others that need to know about the change to your PHI.

● Your Right to a Paper Copy of this Notice: You can ask us for a copy of this notice at any time.

● Person to Contact for Information about this Notice or to File a complaint about our Privacy Practices: If you have any questions about this notice, please contact our office at 912-537-9355. If you wish to file a complaint about our privacy practices feel that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, please contact out Practice Administrator. You may also send a written complaint to the secretary, US Department of Health and Human Services, 2003 Independence Avenue, SW Washington DC 20201. Your complaint will not alter or affect the care we provide to you.

_____ _____

Patient / Authorized Parent or Guardian Date