mobile pediatric
CLINIC

1835 Old Shell Road
Mobile, AL 36607
P: (251)-706-8170
F: (251)-706-8098

6321 Piccadilly Square Drive
Mobile, AL 36609
P: (251)-342-8900
F: (251)-342-2333

www.mobilepeds.com

Patient Demographics

Age: Gender:

Patient Full Name: _____

Nickname: _____ Email: _____

DOB: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

Mother's Name: _____ DOB: _____

Employer: _____ Phone: _____

Cell Phone: _____ Social Security Number: _____

Father's Name: _____ DOB: _____

Employer: _____ Phone: _____

Cell Phone: _____ Social Security Number: _____

Legal Guardian (if different than parent): _____

(Please note: Legal Guardian must present certified court documents showing legal guardianship)

Child Lives With: _____

Insurance: *Carrier* _____ *Insured ID#* _____

Group Number _____ *Name of Insured* _____ *D.O.B* _____

Emergency Contact (other than parent or guardian): _____

Relationship to the patient _____ Phone _____

Pharmacy: Where would you like your prescriptions sent? _____

Person(s) that you authorize to accompany and give consent for treatment to the child (other than the parents)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I certify the above information is complete, accurate and up to date. I agree to update any changes to the above information as it becomes available to me.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____

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CLINIC OFFICE POLICY

Thank you for choosing Mobile Pediatric Clinic as your healthcare provider. The following is a summary of our Financial Policy. We require that you read and sign our policy prior to treatment. A copy of our full financial policy is available upon request. Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit.

All visits are by appointment only. The following policies assure that we maintain a superior standard of care for all our patients.

INSURANCE – Mobile Pediatric Clinic will bill all participating insurance companies as a courtesy to our patients. Insurance companies offer many different plan coverages to their insurance. Mobile Pediatric Clinic does not have access to your individual insurance plan benefits. It is the patient's responsibility to understand what is covered and not covered by your individual plan. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note that your insurance policy is a contact between you and your insurance company, therefore, it is your responsibility to verify all charges are paid whether by you or your insurance company.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE – All co-payments, coinsurance, and deductibles are due at the time of service unless other arrangements have been made in advance. These fees are a contract between you and your insurance company and cannot be waived. If you do not have insurance, are unable to provide proof of current insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your visit. Any balances that you may have incurred from your prior or present dates of service will be collected when you visit our office. Please also be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services. For your convenience, we accept cash, check, Visa/Mastercard, American Express and Discover. There is a $25 service charge for returned checks. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. Please contact our business department for assistance. Failure to resolve any past due accounts including returned checks will result in referral to a collection agency. You will be responsible for any fees associated with the costs of collections in addition to the amount owed on the account. Any family whose account is forwarded to a collection agency may be discharged from our practice

MISSED APPOINTMENTS/LATE CANCELLATIONS – Missed appointments are very disruptive to our office and deprive others from an appointment. We encourage our patients to arrive at the office on time or a few minutes prior to their scheduled appointment. If you are late (under the discretion of the provider) for your Well Visit or consult appointment, we reserve the right to reschedule your appointment. If you are late (under the discretion of the provider) for your Sick Visit, you will forfeit your scheduled appointment time and will be rescheduled for the next available open appointment time. Well Visits, ADHD and ADD reviews, Sports Physicals and Consults require NO LESS than 24 hour notice of cancellation. Same Day Sick Visits require no less than 3 hour notice. Patients who no-show for a double visit will be restricted from scheduling double appointments in the future. In the event of 3 No Shows per family within a 365 day period, you may be dismissed from our practice. Excessive abuse of this policy will result in dismissal from the practice for your child(ren).

MEDICAL RECORDS/FORMS - Our practice charges for additional paperwork outside of the completion of the medical record. Upon request, you will receive a standard well-child form and/or blue/immunization record annually free of charge at the time of your annual visit. There is a $10 fee to complete forms (camp, school, sport, WIC form or prescriptions, etc.) outside of your well visit appointment. There is a $5 fee for a blue card//immunization record outside of the well visit. We can provide Family Medical Leave Act (FMLA) forms for a fee of $25.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION – I authorize the release of any medical or other information necessary to process my child's insurance claim. This includes the release of medical information to other doctors, insurance companies, referrals or continuing medical care. I authorize payment of medical benefits to Mobile Pediatric Clinic for services rendered and agree to abide by the financial policies of these clinics.

I acknowledge that I have read and understand the policies stated above. I agree to pay any monies due at the time of service and provide accurate information to Mobile Pediatric Clinic to allow for timely filing and prompt payment of my claims. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collections.

_____ _____

Child's Name ***Parent/Guardian Name* (Please print)**

_____ _____

Date ***Parent/Guardian Signature***

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Patient Consent For Use & Disclosure of Protected Health Information

I hereby give my consent for Mobile Pediatric Clinic (MPC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Mobile Pediatric Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the notice and Privacy Practices prior to signing this consent. MPC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mobile Pediatric Clinic, Privacy Officer, P. O. Box 91899, Mobile, AL 36691, or by requesting a copy in the office.

With this consent, MPC may call my home or any alternative telephone numbers provided. Unless otherwise specified, this also authorizes MPC to leave a message on voicemail or in person in reference to any items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent MPC may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With this consent, MPC may email to my home or alternative location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements.

By signing this form, I am consenting to Mobile Pediatric Clinic's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing at any time except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, Mobile Pediatric Clinic may decline to provide treatment to me.

_____ _____

Child's Name Date

_____ _____

Printed Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

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Clinic Vaccine Policy

We believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We believe in the safety of the vaccines we provide.

We believe that all children and adolescents should receive all the recommended vaccines according to the schedule published by the Centers for Disease Control and American Academy of Pediatrics.

We believe, based on all the available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities. We also believe that vaccinating children and adolescents may be the single most important health-promoting intervention we provide as your pediatrician.

We would like to emphasize the importance of vaccinating your child. We recognize that you may hear rumors or myths about vaccines. We are here to educate and inform you on each individual vaccine as well as the current vaccination schedule. Vaccine information sheets are provided for each vaccine. Should you have any questions please discuss them with your provider.

Please be advised, that “alternative schedules” or “breaking up the vaccines” goes against our recommendations. This can put your child at risk for serious illness or death. An Alabama Certificate of Immunization will not be given until your child is up to date on vaccines according to the American Academy of Pediatrics vaccine schedule.

Should you refuse to vaccinate your child or choose an alternative schedule, we will ask that you find another health care provider.

_____ _____

Parent/Guardian Signature Date

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Authorization for Release of Medical Information

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Date of Request: _____

☐ I authorize Mobile Pediatric Clinic to **release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

OR

☐ I authorize Mobile Pediatric Clinic **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

PURPOSE FOR THIS REQUEST: (check one) ☐ Transfer of Care ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

TYPE OF RECORDS REQUESTED: (check one)

☐ Immunization History ☐ Administrated by MPC ☐ Include records submitted to MPC
☐ All Medical Records related to a specific illness or injury _____
Specific illness/ injury Date of treatment
☐ Treatment Summary (Includes history/ physical, laboratory tests & x-ray reports, operative reports, pathology)
☐ Specific Treatment (select one or more, as applicable)
☐ Procedure Report ☐ History & Physical ☐ X-Ray Reports ☐ Lab Results
☐ Entire copy of the medical record.

AUTHORIZATION VALID FOR: (check one)
☐ This request only.
☐ One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request and for medical records of any **future** treatment of the type described above until: _____ (insert date)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information state above could be redisclosed.
- Release of HIV- related information, mental health related care, or substance abuse diagnosis and treatment information may require additional authorization

Signature of Patient or Representative _____ Date: _____

Relationship to Patient (If requester is not the patient) _____

Patient Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI: You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy: Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site. Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints: If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Mobile Pediatric Clinic. If you have questions and would like additional information, you may contact your office.

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.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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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