



**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

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POLICY HOLDER'S NAME	DOB	SSN	COPAY
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PRIMARY INSURANCE CO.	POLICY NUMBER	GROUP NUMBER
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**SECONDARY INSURANCE**

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POLICY HOLDER'S NAME	DOB	SSN	COPAY
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SECONDARY INSURANCE CO.	POLICY NUMBER	GROUP NUMBER
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**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.

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SIGNATURE OF PARENT OF LEGAL GUARDIAN	PRINT NAME	DATE
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# 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.

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## 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.

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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

<b>2 and 4 months</b>	<b>*Pedarix, HIB, Prevnar, and Rotateq</b>
<b>6 months</b>	<b>*Pedarix, Prevnar and Rotateq</b>
<b>12 months</b>	<b>HIB, Prevnar and Hepatitis A</b>
<b>15 months</b>	<b>MMR , Varivax</b>
<b>18 months</b>	<b>DTaP, Hepatitis A</b>
<b>4- 5 years</b>	<b>*Kinrix, MMR and Varivax</b>
<b>11-12 years</b>	<b>Tdap ,Meningitis A and HPV</b>
<b>16-18 years</b>	<b>Meningitis A, Meningitis B</b>

**\*Pedarix 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Limited Patient Authorization for Disclosure of Protected Health Information

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

Patients Name

Date Of Birth

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**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.

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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 \_\_\_\_\_

\_\_\_\_\_