PARKSIDE PEDIATRICS

New Patient Information Form

Date

PATIENT INFORMATION

Patient's Last Name | ☐ Male ☐ Female | Patient's First Name | Preferred Name | Middle Initial

Date of Birth | SSN# | Primary Language

Email Address | Race/Ethnicity | Is patient of Hispanic Origin? ☐ YES ☐ NO

MOM'S INFORMATION

Mom's Last Name | Mom's First Name | Middle Initial

Address | ☐ This is the primary contact number for this patient. | City & State | Zip Code

Mom's Cell Phone | Mom's Date of Birth | Mom's SSN#

DAD'S INFORMATION

Dad's Last Name | Dad's First Name | Middle Initial

Address *if different than Mom's address. | ☐ This is the primary contact number for this patient. | City & State | Zip Code

Dad's Cell Phone | Dad's Date of Birth | Dad's SSN#

EMERGENCY CONTACT

Please Choose an Emergency Contact: ☐ Mom ☐ Dad ☐ Other

Name | Phone | Relation to Patient

SIBLINGS

Last Name | First Name | ☐ Male ☐ Female | Last Name | First Name | ☐ Male ☐ Female

Last Name | First Name | ☐ Male ☐ Female | Last Name | First Name | ☐ Male ☐ Female

INSURANCE INFORMATION *Please present your insurance card to the front desk staff member.*

Name of Insurance Company | Name of Subscriber | Middle Initial

Group Number | Subscriber Number | Insured Date of Birth *If different than parent.*

PREFERRED PHARMACY

Name of Pharmacy | Location/Address | Phone

HOW DID YOU HEAR ABOUT PARKSIDE?

PARKSIDE PEDIATRICS

New Patient Medical History

____
Date

PATIENT INFORMATION

Patient's Name ______________________________ Date of Birth ______________

MEDICAL INFORMATION

During pregnancy, Did Mom have any medical conditions? ☐No ☐Yes Explain ______________
Or use tobacco, drugs, or alcohol? ☐No ☐Yes Explain ______________
Immediately after birth, did your child have any problems? ☐No ☐Yes Explain ______________
Were they admitted to the NICU? ☐No ☐Yes Explain ______________
Did mom breastfeed? ☐No ☐Yes For how long? ______________
What was your child's birth weight ______lbs. ______ oz. Born at term? ☐Yes ☐Early ☐Late Delivery? ☐Vaginal ☐Cesarean
In which hospital or birthing center was your child born? ______________

Do you consider your child to be in good health? ☐No ☐Yes Explain ______________
Besides birth, has your child ever been hospitalized? ☐No ☐Yes Explain ______________
Has your child ever had:
- A blood transfusion ☐No ☐Yes Explain ______________
- Convulsions or seizures ☐No ☐Yes Explain ______________
- Heart problems/murmur ☐No ☐Yes Explain ______________
- Surgeries ☐No ☐Yes Explain ______________
- Serious illnesses ☐No ☐Yes Explain ______________
- Major injuries ☐No ☐Yes Explain ______________

Does your child have any:
- Food Allergies ☐No ☐Yes Explain ______________
- Drug Allergies ☐No ☐Yes Explain ______________

Are you concerned about your child's development:
- Physical ☐No ☐Yes Explain ______________
- Mental ☐No ☐Yes Explain ______________
- Social/emotional ☐No ☐Yes Explain ______________

Are you concerned about your child's attention span? ☐No ☐Yes Explain ______________
Girls Only: Has your daughter started her menstrual cycle? ☐No ☐Yes At what age ______________
Has she experienced problems? ☐No ☐Yes Explain ______________

Does your child attend school? ☐No ☐Yes Where ______________
If so, How is their behavior in school? ☐ Excellent ☐Average ☐Not good Explain ______________
How are their grades? ☐ Excellent ☐Average ☐Failing Explain ______________
On average, how many hours/day does your child spend in front of a screen? *TV, Computer, Video Games* ______________ hour(s)/day
Do you have concerns about your child's weight? ☐No ☐Yes Explain ______________
Does your child routinely exercise or engage in physical activity? ☐No ☐Yes Explain ______________
Has your child experienced ongoing constipation? ☐No ☐Yes Explain ______________
Has your child had any unusual feeding/dietary problems? ☐No ☐Yes Explain ______________

Has your child experienced any of the following? If yes, please explain below.

Frequent ear infections	☐No	☐Yes	Wheezing/Asthma	☐No	☐Yes	Diabetes	☐No	☐Yes
Other problems with ears or hearing	☐No	☐Yes	Bronchitis/Pneumonia	☐No	☐Yes	Fevers	☐No	☐Yes
Chronic or recurrent skin problems	☐No	☐Yes	Lung/breathing issues	☐No	☐Yes	Headaches	☐No	☐Yes
Nasal Allergies	☐No	☐Yes	Abdominal Pain	☐No	☐Yes	Chicken Pox	☐No	☐Yes
Problems with eyes/vision	☐No	☐Yes	Bladder or kidney infections	☐No	☐Yes	Bedwetting *5+ yrs*	☐No	☐Yes

Explain: ______________

____

____

Please explain any other medical or social history that you consider important: ______________

____

____

List any medications that your child is currently taking: ______________

For office use only: Scanned ______________ Entered ______________

PARKSIDE PEDIATRICS

Patient Privacy Form

____
Date

PATIENT INFORMATION

____
Patient's Name   Date of Birth

SHARING INFORMATION

Please CHECK the information below that you authorize Parkside Pediatrics to give out for the above patient, and list who has permission to receive this information other than the patient's parents/legal guardians.

☐ Results of lab tests / x-rays   ☐ Appointment information   ☐ Billing information   ☐ Medical Information

____   ______________________
Name of person that has permission to receive the above patient information   Relationship to patient

____   ______________________
Name of person that has permission to receive the above patient information   Relationship to patient

BRINGING PATIENT TO THE DOCTOR

List anyone who has permission to bring the above patient to the doctor other than the patient's parents/legal guardians.

____   ______________________
Name of person   Relationship to patient

____   ______________________
Name of person   Relationship to patient

COMMUNICATION

I authorize Parkside Pediatrics to leave a message regarding: *Check ONLY ONE*

☐ All Information including appointments, general information, updates, billing, etc.

☐ Appointment Information ONLY

On my voicemail on the: *Check ALL that apply.*   ☐ Primary Contact Number   ☐ Secondary Contact Numbers

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Parkside Pediatrics 211 Batesville Rd, Simpsonville, SC 29681. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to: Parkside Pediatrics 525 Verdae Blvd. Ste 200 Greenville, SC 29607. I understand that I have the right to refuse to sign this authorization.

I have read and received a copy of the Notice of Privacy Practices for Parkside Pediatrics.

______________________________   ____________________   ______________
Signature   Date   Relationship to patient

PARKSIDE PEDIATRICS

Privacy Notice to Patients

HIPAA POLICY STATEMENT

Parkside Pediatrics P.A.'s Privacy Notice to Patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED BY PARKSIDE PEDIATRICS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Effective Date: May 15, 2006
Under the HIPAA Privacy regulations, Parkside Pediatrics and all similar health care providers are required by federal law to maintain the privacy of your child's protected health information (PHI) and will abide by the terms in the Privacy Notice. Please be advised that Parkside Pediatrics may use your child's PHI in rendering treatment to your child. For example, we are permitted to use your child's PHI in providing your child with medical care/treatment when your child visits our office or when we treat your child in a hospital or nursing facility. Under federal law, we may disclose your child's PHI to you or we can disclose your child's PHI to third parties for treatment. For example, if we refer your child to a specialist, we will forward your child's medical information to such specialists. We can disclose your child's PHI for payment purposes. For example, we will disclose your child's PHI to your insurance provider, your employer, Medicare, Medicaid, or other parties responsible for providing your child with health insurance coverage in order for Parkside Pediatrics to be reimbursed for our services rendered to your child. We will also use or disclose your child's PHI for health care operations. For example, we may use your child's PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your child's PHI, when required by the Secretary of the US Department of Health & Human Services. Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your child's PHI without your authorization. Our practice may use or disclose your child's PHI in accordance with the specific requirements of the HIPAA rules without Parkside Pediatrics needing to obtain your authorization if the information is:

1. required by law
2. required for public health purposes
3. required disclosures about victims of abuse, neglect or domestic violence
4. required by a health oversight agency for oversight activities authorized by law
5. required in the course of any judicial or administrative proceeding
6. required for a law enforcement purpose to a law enforcement official
7. required by a coroner or medical examiner
8. required by an organ procurement organization for research, and,
9. necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Parkside Pediatrics is permitted to disclose your child's PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission. We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail or phone, our office personnel will note your request in your chart. In the event our practice wishes to disclose your child's PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Parkside Pediatrics decided to release your child's PHI for reasons other than treatment, payment, or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your child's PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Parkside Pediatrics a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures. Please be further advised that you have the ability to access, obtain a copy, inspect and request amendment to your child's medical information that we maintain. Additionally, if you desire, Parkside Pediatrics can provide you with an accounting of all disclosures for treatment, payment or healthcare operations and pursuant to authorization. If you have a dispute with our practice regarding the use of your child's PHI or a disclosure by Parkside Pediatrics and believe that your child's primary rights have been violated, please contact Parkside Pediatrics to file a complaint or you may contact the Secretary of Health and Human Services. We welcome feedback from our patients through our website contact us form or via email at info@parksidepediatrics.com. Please understand that Parkside Pediatrics will not retaliate against you in any way for filing a complaint. Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your child's PHI to carry out treatment, payment or healthcare operations or disclosures by Parkside Pediatrics of your child's PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested designation or restriction. If you request a copy of your child's PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means. Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact Parkside Peditric's Privacy Contact. Parkside Pediatrics reserves the right to amend this notice as revised. Notices will be posted on our website (www.parksidepediatrics.com) and in our offices and provided to you upon your request. Thank you and if you have any questions, please contact Parkside Pediatrics at 864-272-0388.

PARKSIDE PEDIATRICS

Payment Policy

PAYMENT POLICY

Proof of Insurance:
All patients must complete our patient information forms before seeing the provider. We must obtain a copy of your current, valid insurance card for proof of insurance. If you fail to provide us with the correct insurance information at the time of service, you may be responsible for the balance of your claim.

Co-payments and balance dues:
All co-payments and balance dues must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Claims submission:
We will submit your claims to your insurance provider and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Monthly billing statement:
After your insurance company pays Parkside Pediatrics, you will receive a monthly billing statement, which indicates your balance due and/or deductibles due. These amounts are payable to Parkside Pediatrics. The balance amount is to be paid in full within 10 days of receipt of the monthly billing statement. If you have questions about your account please call 864-272-0388.

Insurance:
We participate in most insurance plans. If you are not insured by a plan we do business with or do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Parkside Pediatrics **does not** file claims with any **secondary** insurance companies.

Coverage change:
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If we cannot verify active coverage; the balance will automatically be billed to you.

Non-payment:
Partial payments will not be accepted unless otherwise negotiated with the billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. You will be responsible for any collection or legal cost associated with collecting your account. If this is to occur, you will be notified that you have 30 days to find alternative medical care. During that 30 day period, our providers will only be able to treat you on an emergency basis.

Missed appointment:
In order to achieve the best appointment availability for our patients, we have a policy for missed appointments. There will be a $15 charge added to the account for the first missed appointment, a $25 charge for the second, and a $35 for the third. Three missed appointments within a 12 month period will result in eligibility for discharge from the practice for the family. We understand the potential for unforeseen circumstances that can arise that may cause a late or missed appointment. If this happens, please call us as soon as possible so we can change your appointment status accordingly and make it available for another patient.

Cancellations:
Our policy is to charge $25 for previously scheduled appointments that are canceled less than 24 hours prior to their scheduled date/time. These charges will be your responsibility and billed directly to you, and not your insurance company. Please help us serve you better by keeping your regularly scheduled appointments.

Non-covered services:
Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. Since all insurance plans are different, please contact your insurance company or HR department for detaled information about what is covered or not covered including well child visit maximums, after-hours fees and immunizations, etc. You will be billed and responsible for all non-covered services.

Newborn Insurance:
In order for Parkside Pediatrics to file insurance for your newborn, a parent must add them to the insurance policy within 30 days of the date of birth. Once added, please notify our billing department in order to have the patient's charges filed in a timely manner. If insurance is not determined after the 30 days from birth, the patient's account will be considered self-pay and the responsible party will be billed for the balance.

Forms of payment:
Parkside Pediatrics accepts payments by cash, check, money orders, Visa, MasterCard, and debit cards bearing these logos. Payment is expected at time of service.