Mama Doc Pediatrics

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I have received a copy of this Office's Notice of Privacy Practices

Patient's Name:_____ DOB:_____

Signature of Parent/Guardian:_____ Date:_____

Please list the names of anyone who may bring the patient in for office visits and who the office staff may release information to on your behalf. If they are not on this list, no information will be released regarding your care or condition.

Name	Relationship to patient	Phone

Please list the names of anyone who you **DON'T** want any information release to

_____ _____

_____ _____

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to accept notice

_____ Individual refused to sign acknowledgement

_____ Individual was unable to sign

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other:_____

Signature of Employee:_____ Date:_____

Patient Name:_____ **DOB:**_____ **Sex:** ☐ M ☐ F

Mailing Address:_____ **Primary Phone:**_____

_____ _____ _____ **Home/Day Phone:**_____

City **State** **Zip** **Mobile Phone:**_____

County:_____ **Home email:**_____

Social Security #:_____

Ethnicity: ☐ Non Hispanic or Latino ☐ Hispanic ☐ Refuse to answer **Language:**_____

Race: ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Refuse to answer

Primary Insurance

Name of Insurance Company:_____

Who carries the policy? _____ DOB:_____

Relationship to the patient:_____ SS #:_____

Secondary Insurance

Name of Insurance Company:_____

Who carries the policy? _____ DOB:_____

Relationship to the patient:_____ SS #:_____

****Primary Guardian 1**** Name:_____

Custody: ☐ Joint (shared custody with other parent) ☐ Sole (Exclusive) (not shared w/ other parent)

DOB:_____ Relationship to patient:_____ SS #:_____

Address if different from patient:_____

Preferred mode of contact: ☐ Home phone ☐ mobile phone ☐ email ☐ other _____

Occupation:_____ Does the child live with this guardian? ☐ Yes ☐ No

****Guardian 2**** Name:_____

Custody: ☐ Joint (shared custody with other parent) ☐ Sole (Exclusive) (not shared w/ other parent)

DOB:_____ Relationship to patient:_____ SS #:_____

Address if different from patient:_____

Preferred mode of contact: ☐ Home phone ☐ mobile phone ☐ email ☐ other _____

Occupation:_____ Does the child live with this guardian? ☐ Yes ☐ No

Preferred Pharmacy:_____ **Phone:**_____

THE UNDERSIGNED HEREBY GRANTS MAMA DOC PEDIATRICS AUTHORIZATION FOR REASONABLE AND PROPER TREATMENTS AND PROCEDURES BY TODAY'S STANDARDS THAT ARE DEEMED NECESSARY FOR THE ABOVE NAME CHILD. I GIVE PERMISSION FOR MAMA DOC PEDIATRICS TO RELEASE NEEDED INFORMATION FOR INSURANCE AND QUALITY REVIEW PURPOSES. A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED FOR INSURANCE PURPOSES. I AUTHORIZE PAYMENT DIRECTLY BY MY INSURANCE COMPANY TO MAMA DOC PEDIATRICS/ELIZABETH PENN. I UNDERSTAND THAT I AM RESPONISBLE FOR CHARGES NOT COVERED BY THIS ASSIGNMENT. THIS ASSIGNMENT AND RELEASE OF ANY MEDICAL INFO IN ALL RESPECTS IS APPLICABLE FOR MY CHILD'S PHYSICIAN, AS WELL AS ANY PA'S AND OR NURSE PRACTIONER WHO MAY BE INVOLVED IN MY CHILD'S CARE.I ALSO UNDERSTAND THAT SUCH TREATMENTS AND PROCEDURES MAY BE PERFORMED BY A PHYSICIAN OR APPROPRIATELY TRAINED EMPLOYESS OF MAMA DOC PEDIATRICS. UNLESS OTHERWISE REQUESTED, MEDICAL, NURSING, AND OTHER PERSONNEL IN TRAINING AND THEIR INSTRUCTORS MAY BE PRESENT AT AND PARTICIPATE IN SUCH TREATMENT AND PROCEDURES.

******I CERTIFY THAT I UNDERSTAND THAT **ALL CO-PAYS AND APPLICABLE DEDUCTIBES WILL BE PAID AT THE TIME OF SERVICE.********

Signature of Parent or Guardian:_____

Attention **Mama Doc Pediatrics** Patients and Families:

Please be advised that we are not able to accommodate a significant number of no shows for scheduled appointments. Due to the high demand for appointments and limited time slots, we will not be able to care for families who have a total of three or more no shows for scheduled appointments.

This policy was instituted in order to open more slots for sick patients and well child checks. We ask that you provide at least 24 hours notice when cancelling an appointment.

Due to such high demand for appointments, if you miss appointments or do not cancel at least 24 hours in advance you will be charged as follows:
$50.00 for missed well checks
$25.00 for missed sick, rechecks, or call ins
This amount will be billed to you directly, not your insurance company. It must be paid before the patient is seen again.

Thank you for your consideration and assistance in providing our patients with timely care.

Our policy is that if you are more than 15 min late for an appointment, you will be asked to reschedule. The only exceptions is emergencies and it will be at the discretion of the provider.

After Hours Answering Service

The after hours calls are answered by Nurse One. When you call the office number you will hear a recording about office hours, etc. You may experience a brief wait period before a nurse or receptionist answers the call. Upon answering the call, the on-call nurse is notified. If the nurse is immediately available the call will be directly connected. If the nurse is not available you will receive a call back within 30 minutes. If you are unable to wait until you receive a call back, please go to your local emergency room.

After hours phone number: (912) 871-5437

I acknowledge that I understand and have received a copy of these policies.

_____
Patient/Patient's Name

_____ _____
Parent/Guardian's Signature Date

Office Copy

Mama Doc

PEDIATRICS

In House Diagnostic Test Policy

It is your responsibility to notify us if your insurance requires you to use a preferred lab for diagnostic tests. We will be happy to give you an order and you can take it to your preferred lab. If you fail to notify us prior to testing or choose to have it done in our office to get immediate results and insurance denies, you will be responsible for the billed amount.

Acute Care Visit Policy

At Mama Doc Pediatrics, we will always do our best to see your child for acute care visits as quickly as possible. In order to best care for your child, we must be the child's primary care provider. Due to potential safety issues for your child's health, if we are not your primary care provider, we are unable to see your child for acute care visits only. If you would like to transfer your child's care to us, we are happy to request records (with a signed release of health information form) from your previous pediatrician. Transfer of records will need to be completed at your child's first visit with us. We appreciate your understanding and allowing us to give your child the best care possible.

Vaccination Policy

At Mama Doc Pediatrics we require that all patients follow and comply with the current Centers for Disease Control recommendations for childhood vaccinations. The only exception to this requirement is a medical contraindication of vaccination for an individual patient. At date of this policy, we do allow for refusal of the seasonal influenza vaccine. If a patient or caretaker of the patient refuses vaccination of any or all recommended vaccines (except influenza) at the recommended age, we will allow for a thirty day grace period from date of certified letter to the family. In order to continue as a patient at Mama Doc Pediatrics, the patient must receive the refused vaccine within the thirty day grace period. If the family does not comply with these requirements, we will discharge the patient and any siblings from the practice.

We respect your right as a parent to refuse vaccinations; however, due to the risks of infection and transmission of vaccine preventable illnesses, we cannot risk exposing our patients to these illnesses.

Mama Doc Pediatrics
November 1, 2015

I understand that I must follow the CDC recommendations for childhood vaccines or my child will be discharged from the practice.

I acknowledge the in house diagnostic test policy, the acute care visit policy and the vaccination policy.

_____ _____

Child's Name DOB

_____ _____

Parent/Guardian's Signature Date

Mama Doc Pediatrics

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

At Mama Doc Pediatrics we respect the privacy and confidentiality of your health information. This notice of privacy describes how we may obtain, use and disclose your health information, and your rights concerning your health information created and/or maintained at our practice, including any information that we receive from other health care providers or facilities. Your health information includes individually identifiable information that relates to your past, present or future health treatment or payment for health care services.

OUR RESPONSIBILITIES TO YOU
We are required by law to maintain the privacy of your health information, to provide you with the notice of our legal duties and privacy practices with respect to your health information, and to comply with the terms of our notice currently in effect.

PATIENT PRIVACY
At Mama Doc Pediatrics your privacy is a priority. We follow strict federal and state guidelines to maintain the confidentiality of your medical (protected health) information.

PROTECTED HEALTH INFORMATION
Protected health information (PHI) is any information about your past, present, or future health care, or payment for that care that could be used to identify you. Members of our workforce and our business associates may only access the minimum amount of protected health information that they need to complete their assigned tasks.

USE AND DISCLOSURE OF PHI
When you visit Mama Doc Pediatrics, we use and disclose your protected health information to treat you, to obtain payment for services, and to conduct normal business known as health operations. We may also share information with a contracted business associate who must meet our privacy requirements. Examples of how we use and disclose your information include.

- Treatment- we document each visit. This may include your test results, diagnoses, medications, and your response to medications or other therapies. This allows your doctors, nurses and other clinical staff to provide the best care to meet your needs
- Payment- we document the services and supplies you receive at each visit so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require its approval
- Health Care Operations- medical information is used to improve the services we provide, to train staff and students, for business management, performance improvements, and customer service.

  We may also use information to:
  - -recommend treatment alternatives
  - -tell you about health benefits and services
  - -communicate with other healthcare facility members or business associates for treatment, payment or healthcare operations
  - -send appointment reminders
  - -communicate with family or friends involved in our care with your permission
  - -include you on the inpatient list for callers or visitors if you are admitted.
  - -let clergy know if you are being admitted

There are limited times when we are permitted or required to disclose medical information without your signed permission. These situations are listed below:

-for public health activities such as tracking diseases or medical devices
-to protect victims of abuse or neglect
-for federal and state health oversite activities such as fraud investigations
-for judicial or administrative proceedings
-if required by law or for law enforcement
-to coroners, medical examiners and funeral director
-for organ donations
-to workers compensation if you are injured at work
-a correctional institution if you are an inmate
-for research following strict review to ensure protection of information
-to avert serious threat to public health or safety
-for specialized government functions such as national security and intelligence

Quality Improvement Purposes
We may disclose health information about you to another healthcare facility that was also involved in your care if requested for purposes of that facility's internal quality improvement activities, such as evaluating patient outcomes. We will limit such disclosure to only that information which is minimally necessary for the other facility to perform its quality improvement functions. Other uses and disclosures, not previously described, may only be done with your signed authorization, in writing, at any time.

OUR RESPONSIBILITIES
Mama Doc Pediatrics is required by law to maintain the privacy practices, and make the new practices effective for all the information we maintain. Revised notices will be posted in our practice.

YOUR RIGHTS
You have the right to: request that we restrict how we use or disclose your medical information (we are not required to abide by your request). Request that we use a specific telephone number or address to communicate with you. Inspect and copy your medical information. Receive an accounting of how your medical information was disclosed (excludes disclosures for treatment, payment, health care operations and some required disclosures (fees may apply). Obtain a paper copy of this notice if you received it electronically. Register a complaint.

If you would like to exercise your right or if you feel your privacy rights have been violated contact the Privacy Officer at Mama Doc Pediatrics (912) 871-5437.

All complaints will be investigated and you will not suffer retaliation for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C.

A detailed Privacy Notice is available upon request.

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Patient Copy

Initial History Questionnaire

FORM COMPLETED BY _____ DATE COMPLETED _____

Name _____

ID NUMBER _____

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.)

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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