Southern Sprouts PEDIATRICS

PATIENT REGISTRATION FORM

☐ NEW PATIENT – NEW FAMILY ☐ NEW PATIENT – ESTABLISHED FAMILY ☐ FOSTER CHILD

☐ AMANDA COLE, CPNP ☐ HEATHER RACHAL, CPNP

PATIENT INFORMATION

PATIENT'S FULL LEGAL NAME (LAST, FIRST, MIDDLE)			PREFERRED NAME
SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PATIENT LIVES WITH ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER _____

PARENT/GUARDIAN INFORMATION

PRIMARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			CITY		STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER			
SECONDARY PARENT / GUARDIAN'S NAME (LAST, FIRST, MIDDLE)		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			CITY		STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE	EMPLOYER			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		
SECONDARY INSURANCE COMPANY NAME	POLICY EFFECTIVE DATE	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME (LAST, FIRST, MIDDLE)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
RELATIONSHIP TO PATIENT	EMPLOYER		

OTHER CHILDREN IN FAMILY

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF SOUTHERN SPROUTS PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF SOUTHERN SPROUTS PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO
NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	IS THIS CHILD A PATIENT OF SOUTHERN SPROUTS PEDIATRICS? ☐ YES, CURRENT PATIENT ☐ YES, FORMER PATIENT ☐ NO

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR INFORMATION RELEASE

- I hereby assign and authorize payment of insurance benefits otherwise payable directly to Southern Sprouts Pediatrics for my child's office services which are not paid by me at the time of service.
- I hereby authorize Southern Sprouts Pediatrics to provide treatment for my child and to release any and all information pertaining to office services rendered to him/her by said practice, including any previous diagnosis and treatment rendered to him/her by physicians, hospitals, and/or other medical facilities/personnel.
- I understand that I am ultimately responsible for payment of any and all charges for treatment rendered to my child, and if this assigned claim is rejected, modified, or not paid within a reasonable amount of time after it has been filed, it will be my responsibility to pay any unpaid charges in full.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

INITIAL HISTORY QUESTIONNAIRE

PATIENT'S NAME	SEX	DATE OF BIRTH
FORM COMPLETED BY	**RELATIONSHIP TO PATIENT**	**DATE COMPLETED**

HOUSEHOLD

Please list all of those living in child's home

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	HEALTH PROBLEMS

Please list all siblings not living in child's home

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	HEALTH PROBLEMS

If child does not live with both biological parents, what is the living situation? ☐ Joint custody ☐ Single custody ☐ Lives with adoptive parents ☐ Lives with foster family

BIRTH HISTORY

Were there any prenatal or neonatal complications? ☐ Yes ☐ No
If yes, explain _____

Did mother have any illnesses during pregnancy? ☐ Yes ☐ No
If yes, explain _____

During pregnancy, did mother Use tobacco? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use medications or drugs? ☐ Yes ☐ No
If yes, list date and what was used _____

Baby was born ☐ Term ☐ Late ☐ Early _____weeks Birth Weight _____lbs _____oz Delivery was ☐ Vaginal ☐ Cesarean

Was a NICU stay required? ☐ Yes ☐ No If yes, why? _____ If cesarean, why? _____

Initial feeding ☐ Bottle ☐ Breast Did baby go home with mother from hospital? ☐ Yes ☐ No If no, why? _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No If no, why? _____

Is your child currently taking any medications? ☐ Yes ☐ No Medication/dosage _____

Is your child allergic to any medications or foods? ☐ Yes ☐ No If yes, list all _____

HOSPITILIZATION	DATE	SURGERY	DATE	SERIOUS ILLNESS	DATE	SERIOUS INJURY	DATE

DEVELOPMENT AND BEHAVIOR

Are you concerned about your child's physical development? ☐ Yes ☐ No If yes, why? _____

Are you concerned about your child's mental/emotional development? ☐ Yes ☐ No If yes, why? _____

Are you concerned about your child's attention span? ☐ Yes ☐ No If yes, why? _____

IF YOUR CHILD IS IN SCHOOL

How is his/her behavior in school? _____

Has he/she failed or repeated a grade? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

INITIAL HISTORY QUESTIONNAIRE (continued)

FAMILY HISTORY

Do any family members have a history of

Anemia	☐ Yes ☐ No	Who _____	Explain _____
Asthma	☐ Yes ☐ No	Who _____	Explain _____
Bedwetting (after age 10)	☐ Yes ☐ No	Who _____	Explain _____
Bleeding disorder	☐ Yes ☐ No	Who _____	Explain _____
Cancer (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
Deafness	☐ Yes ☐ No	Who _____	Explain _____
Developmental disability	☐ Yes ☐ No	Who _____	Explain _____
Diabetes (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
Epilepsy or convulsions	☐ Yes ☐ No	Who _____	Explain _____
Heart disease (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
High blood pressure (before age 50)	☐ Yes ☐ No	Who _____	Explain _____
High cholesterol	☐ Yes ☐ No	Who _____	Explain _____
Immune problems, HIV, or AIDS	☐ Yes ☐ No	Who _____	Explain _____
Kidney disease	☐ Yes ☐ No	Who _____	Explain _____
Liver disease	☐ Yes ☐ No	Who _____	Explain _____
Mental illness	☐ Yes ☐ No	Who _____	Explain _____
Nasal allergies	☐ Yes ☐ No	Who _____	Explain _____
Tuberculosis	☐ Yes ☐ No	Who _____	Explain _____
Alcohol abuse	☐ Yes ☐ No	Who _____	Explain _____
Drug abuse	☐ Yes ☐ No	Who _____	Explain _____

Additional family history _____

PAST HISTORY

Has your child ever had

Chickenpox	☐ Yes ☐ No	Explain _____
Frequent ear infections	☐ Yes ☐ No	Explain _____
Problems with ears or hearing	☐ Yes ☐ No	Explain _____
Nasal allergies	☐ Yes ☐ No	Explain _____
Problems with eyes or vision	☐ Yes ☐ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes ☐ No	Explain _____
Anemia or bleeding problem	☐ Yes ☐ No	Explain _____
Blood transfusion	☐ Yes ☐ No	Explain _____
Frequent abdominal pain	☐ Yes ☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes ☐ No	Explain _____
Bladder or kidney infections	☐ Yes ☐ No	Explain _____
Bedwetting (after age 5)	☐ Yes ☐ No	Explain _____
Chronic or recurrent skin problems (e.g. acne, eczema)	☐ Yes ☐ No	Explain _____
Frequent headaches	☐ Yes ☐ No	Explain _____
Convulsions or other neurologic problems	☐ Yes ☐ No	Explain _____
Thyroid or other endocrine problems	☐ Yes ☐ No	Explain _____
Diabetes	☐ Yes ☐ No	Explain _____
Developmental delay	☐ Yes ☐ No	Explain _____
ADD/ADHD, anxiety, mood problems, or depression	☐ Yes ☐ No	Explain _____
Use of alcohol or drugs	☐ Yes ☐ No	Explain _____
(For girls) Has had first menstrual period	☐ Yes ☐ No	Age at first menstrual period _____
(For girls) Problems with menstrual periods	☐ Yes ☐ No	Explain _____

Any other significant problems _____

VACCINATION POLICY & ACKNOWLEDGEMENT

Patient's Name _____ DOB _____

- Southern Sprouts Pediatrics believes in the effectiveness of vaccines to prevent serious illness and to save lives.
- Southern Sprouts Pediatrics firmly believes in the safety of our vaccines.
- Southern Sprouts Pediatrics firmly believes that all children and young adults should receive all of the recommended vaccines put forth by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- Southern Sprouts Pediatrics firmly believes, based on all available literature, evidence, and current research, that vaccines do not cause autism or other developmental disabilities.
- Southern Sprouts Pediatrics firmly believes that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.
- We, at Southern Sprouts Pediatrics, recognize that the choice to vaccinate may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the recommended vaccine schedule is the most beneficial for your child. However, should you have doubts, please discuss these with your health care provider in advance of your visit. In some cases, we will be open to altering the recommended schedule to accommodate parental concerns or reservations. Any altering of the recommended schedule or delayed vaccines will have to be mutually agreed upon by the provider and parent.
- **Please be advised, however, that some vaccines can not be broken up into separate components due to the use of combination vaccines and delaying vaccines goes against expert recommendations and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Southern Sprouts Pediatrics. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.
- Finally, if you should absolutely refuse to vaccinate your child despite all of our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such provider. Please recognize that by not vaccinating your child, you are putting your child at unnecessary risk for life-threatening illness and disability, or even death.
- As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.
- I have been informed of Southern Sprouts Pediatrics' vaccination policy and understand that if I do not comply to the above policy, my child will be discharged from Southern Sprouts Pediatrics and will no longer receive medical care from any of the providers.

_____ _____ _____

Parent/Guardian Signature Printed Name Date

Telehealth Policy Acknowledgment Form

Patient Name _____ Date of Birth _____

- I understand that my provider at Southern Sprouts Pediatrics may recommend I engage in a telehealth appointment that may be conducted using videoconferencing, video images, still (high quality photo) images, or telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

- I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or myself can discontinue the telehealth appointment at any time if connections are not adequate for the situation.

- I understand that my healthcare provider may share information with other individuals for scheduling and billing purposes. I also understand that all information provided is confidential.

- I understand that chronic conditions and management can often be done over telehealth (ex. ADHD medication checks, asthma medication checks). Other consults related to mental health, development, simple rashes, and behavior can also be done via telemedicine.

- I understand that some parts of the exam including physical tests (ex. flu, strep, urinalysis) require in person physical exams. I understand that antibiotics typically will NOT be prescribed via telehealth visits. I also understand that well checks cannot be done via telehealth.

- In an emergency situation, I understand that it is my responsibility to take the advice of the healthcare provider to obtain further evaluation either in the clinic or at the emergency department upon the termination of the telehealth conversation.

- I understand that many insurance companies are now covering provider telephone advice calls and telemedicine visits. However, I also understand that it is my responsibility to contact the insurance company prior to telehealth conversations regarding billing and coverage for virtual visits.

- I understand that billing for telehealth consultations are still placed in a schedule for your provider during specific office hours. Telehealth visits will be billed to your insurance and copays will be collected when appropriate.

By signing this document, I acknowledge that I have read all terms and conditions, especially the risks and benefits of the telehealth appointment.
I also acknowledge that I have had my question regarding payment, procedures and treatment explained and I hereby consent to the participation in a telehealth consultation appointment under the terms described.

_____ _____

Parent/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Patient's Name _____ DOB _____

I, _____, being the parent/guardian of the above named patient acknowledge that I was provided with a copy of Southern Sprouts Pediatrics' Notice of Privacy Practices.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date

I, _____, being the parent/guardian of the above name patient hereby authorize the following people are allowed to accompany my child to his/her healthcare visits and authorize them to be his/her healthcare management.

_____	_____
Authorized Chaperone's Name	Relationship to Patient
_____	_____
Authorized Chaperone's Name	Relationship to Patient
_____	_____
Authorized Chaperone's Name	Relationship to Patient
_____	_____
Authorized Chaperone's Name	Relationship to Patient

_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

Southern Sprouts
PEDIATRICS

AMANDA COLE, APRN, CPNP-AC/PC
HEATHER RACHAL, APRN, CPNP-AC/PC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name _____ Date of Birth _____

MEDICAL INFORMATION TO BE RELEASED BY

_____
Practice/Provider Name

_____ _____
Office Number Fax Number

I authorize the release of the following medical information

☐ Complete Medical Record ☐ Diagnostic Imagining ☐ Laboratory/Pathology Reports ☐ Hospital Records
☐ Immunizations ☐ Medical History, Consultation/Evaluation Records ☐ Other _____

Reason for request

☐ Changing Physicians ☐ Personal ☐ Continuing Medical Care ☐ Other (Specify) _____

MEDICAL INFORMATION TO BE RELEASED TO

Southern Sprouts Pediatrics
Attention: Medical Records
P.O. Box 13211
Alexandria, Louisiana 71315

I hereby consent to the release of the specified information relating to diagnosis, testing, or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named organization. I understand that I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

_____ _____
Patient or Representative's Signature Printed Name

_____ _____
Relationship to Patient Date