Infirmary Pediatrics
Mobile | INFIRMARY HEALTH

Dear Parents,

Thank you for choosing Infirmary Pediatrics for your child's medical care. Our Physicians and Staff look forward to developing and maintaining a relationship with your entire family! Our office hours are Monday through Friday, 7:30am to 5pm, also Saturday from 8am to 12pm for sick child appointments. If you should have an urgent medical question after hours please call the office and a Pediatric Registered Nurse will return your call. For true medical emergencies, please call 911.

If your child is sick, please try to call as soon and as early as possible in the day so that we may schedule your appointment. For sports physicals/well child checks please call 1 to 2 weeks in advance. We value the time we have set aside to see and treat your child, if you are not able to keep an appointment, we require a 2-hour notice of cancellation. There is a charge of $25 for missed appointments. If you are more than 15 minutes late for your appointment, we will do our best to accommodate you. However on certain days, it might be necessary to reschedule your appointment.

Prescription refills require 24 hours and we do not call in prescriptions after hours. All paperwork including but not limited to, blue cards, school physical forms, family medical leave, and daycare forms take 3 to 4 business days to properly complete and there will be a fee if not brought with you on the day of the visit.

As a patient with Infirmary Pediatrics, you consent to our immunization schedule as recommended by the American Academy of Pediatrics. If you would like a schedule of immunizations we would be happy to provide you with one. Additionally, information sheets will be provided to you about each immunization at the time your child receives them.

Only parents or legal guardians are allowed to consent to medical treatment unless another individual is granted permission and listed on the Patient Registration form.

It is your responsibility to provide us with your child's current address, telephone number and medical insurance information. You will be asked to verify this information at each office visit. We do not mediate when there is a divorce or separation between a child's parents. Any balances will be both parents financial responsibility.

Urgent Care Centers should be treated as an alternative when your primary care doctor's office is not open. Before taking your child to one of these centers, please call us first for available appointments. Please note that if you choose to have care provided at one of these centers during office hours, a referral may not be provided for visit.

Please feel free to call us with any questions or concerns you may have.

Follow us on Facebook!

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The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, and family centered, coordinated, compassionate, and culturally effective. These characteristics define the "medical home." In contrast to care provided in a medical home, care provided through emergency departments, walk-in clinics, and other urgent-care facilities, though sometimes necessary, is more costly and often less effective.

Urgent Care Centers should be treated as an alternative when your primary care doctor's office is not open. Before taking your child to one of these centers or to another physician's office, please call us first for available appointments. Please note that if you choose to have care provided at one of these locations during our regular office hours, we will be unable to give any telephone advice regarding that visit and a referral will not be provided. There will be a $14 fee for using our after hour's triage service for these types of calls. Also, if you choose to use any hospital other than Mobile Infirmary or USA Children's and Women, we will be unable to provide care for you during your stay there.

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Please be aware we charge for **ALL FORMS** if not received at the time and date of your appointment. These charges will vary depending upon the complexity of the form and are determined by your child's physician as stated in our office policies. Also, please be aware that the form requested may take up to 48 hours to complete. We thank you for your cooperation and understanding.

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CLINIC VACCINE POLICY

The vaccines that we provide are safe and very effective in preventing serious illnesses and death.

All infants, children and adolescents should receive all vaccines according to the schedule published yearly by the American Academy of Pediatrics and the Centers for Disease Control.

Based on current literature and multiple studies, vaccines do not cause autism, developmental disabilities or immune diseases.

We realize that you will hear stories about vaccines. Our mission is to educate you and answer any questions you have regarding vaccines and the current vaccine schedule. CDC Vaccine Information Sheets are given for each vaccine given. Please discuss any concerns you may have with us.

"Alternative schedules" and "breaking up vaccines" do not follow the Immunization Schedule.

We have an obligation to provide the best medical care possible; the Vaccine Schedule is consistent with that goal. Vaccines protect children and teens from life-threatening illnesses, such as meningitis and whooping cough, as well as rubella that can disable children for life.

Families who chose not to follow the current Vaccine Schedule are not the best fit for this office and will need to find pediatric care elsewhere.

_____
PATIENT NAME

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

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INFIRMARY PEDIATRICS
PATIENT INFORMATION

Date _____

Chart # _____

Childs Full Name _____
First Middle Last Name Called

Address _____ Apt# _____ City _____ State _____ Zip _____

SSN# _____ Birthdate _____ Sex _____

***Father/Guardian** _____ Home _____ Cell _____

Address _____ City _____ State/Zip _____

Employer _____ Occupation _____ Work# _____

Birthdate _____ SS# _____ Marital Status: M S W D

***Mother/Guardian** _____ Home _____ Cell _____

Address _____ City _____ State/Zip _____

Employer _____ Occupation _____ Work# _____

Birthdate _____ SS# _____ Marital Status: M S W D

***Step Parent** _____ Home _____ Cell _____

Referred by: _____ Primary Email Address: _____

Please list other household members (if applicable):

Name	sex	DOB	Relation

INSURANCE

PRIMARY Health Insurance Company _____ Policy Holder Name _____

Contract # _____ group# _____ effective date _____

SECONDARY Health Insurance Company _____ Policy Holder Name _____

Contract # _____ group# _____ effective date _____

GUARANTOR INFORMATION

Name of Person Responsible for this account _____ relation to patient _____

Address _____ home # _____

Employer _____ work # _____

Driver's Licence # _____ cell# _____

(PLEASE COMPLETE BOTH SIDES OF THIS FORM)

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IMC-Patient Responsibility Consent Form

_____ ____/____/____

Patient Last Name Patient First Name Date of Birth

Assignment of Benefits

I request that payment of authorized Medicare and/or Medicaid benefits to be made on my behalf for services in or by the Clinic, shall be made to the Clinic, and I specifically assign such benefits to the Clinic. If applicable, I hereby assign and authorize payment directly to the Clinic of all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Release of Information

I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services.

Financial Responsibility

I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible, the Clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Telephone and Alternative Communication Consent

I understand the Clinic or its agents may use pre-recorded/artificial voice messages and or/auto-dialing devices to remind me about appointments or notify me of other information and I expressly consent to the Clinic or its agents use of any number associated with my account including any wireless number. I also authorize the Clinic or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded or artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize the Clinic to communicate with me using any email address I provide to the Clinic.

No Show Appointments

I understand when I make an appointment, time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify the Clinic no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand the Clinic has the right to charge me a no-show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Minors

I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Authorization to Treat

I voluntarily consent to medical treatment and diagnostic procedures provided by the clinic. I am aware that the practice of medicine & surgery is not an exact science. I acknowledge that no guarantees have been made as to the results of treatments and/or examinations.

_____ ____/____/____

Patient (or Responsible Party) Signature Date

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(Please Print)

Patients name_____

DOB_____

Please list any family members or significant others whom may bring the child into the office for medical treatment (include step-parent):

1._____relationship_____

2._____relationship_____

3._____relationship_____

Please list any family members or significant others whom we may inform about your child's general medical condition, their diagnosis, and to whom we may release prescriptions (include step-parent):

1_____relationship_____phone#_____

2._____relationship_____phone#_____

3_____relationship_____phone#_____

Please list the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information:

Primary_____Secondary_____

Can confidential messages (e.g. appointment reminders) be left on your home answering machine or other provided voice mail: (please circle) **YES** **NO**

If you do not have a voice mail, can confidential messages be left with an individual at your home: (Please circle) **YES** **NO**

Signature of Parent/legal guardian_____

Date_____

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Infirmary Pediatrics

**** Office Policies ****

Please read the following information carefully and Sign the back:

1) **Missed Appointments:**
   a. Our office works on a scheduled appointment basis. It is important that you keep your child's scheduled appointment; and be on time for those appointments. If you do not show up (or arrive late) it causes conflicts for other children who also need to see the doctor.
   b. If you are unable to keep your child's scheduled appointment, please contact our office—preferably within 2 hours—to cancel or reschedule for a more convenient time.
   c. On occasion, circumstances may arise that can cause you to arrive late for your child's appointment. If you are late, you may have to wait until another appointment time becomes available. We will try to accommodate you the best way we can. However, it may be necessary to reschedule your child's appointment for a later date.
   d. IF YOU MISS THREE (3) APPOINTMENTS, YOUR CHILD/CHILDREN MAY BE DISMISSED FROM OUR PRACTICE.

2) **Office Visit Co-Payments:**
   a. All office visit co-payments and applicable deductibles are DUE AT THE TIME OF YOUR CHILD'S OFFICE VISIT. We accept cash, personal check, VISA, and MasterCard for payment.
   b. If you do not have your co-payment or deductible at the time of service, then you may be asked to reschedule your child's appointment.
   c. We do not accept post-dated personal checks.
   d. You will be charged a $30.00 fee if your check is returned to us because of insufficient funds.

3) **Divorce / Separation of Parents:**
   a. We do not mediate which parent is responsible for your child's account balance when there is a divorce or separation between a child's parents. Please note that a child support/divorce order is *between the parents*. Therefore, IF EITHER PARENT FAILS TO PAY THE BALANCE ON YOUR CHILD'S ACCOUNT THEN YOUR CHILD/CHILDREN MAY BE DISMISSED FROM OUR PRACTICE.

4) **Providing Us With Correct Information:**
   a. It is your responsibility to provide us with your child's correct address, current telephone number and current medical insurance information.
   b. You will be asked for verification of this information each time you bring your child to our office. You will be responsible to pay for the services in full if your insurance is deemed to be inactive at the time of service.
   c. It is expected that you notify us either in writing or by telephone if your child's address, telephone number or medical insurance information changes.

6) **Transferring of Medical Records:**
   a. If at any time you choose to transfer your child's medical records to another Pediatrician's office or Family Practice doctor's office, then we will no longer consider ourselves your child's doctor.

7) **Forms**
   a. There will be a charge for Blue Cards and School Forms if not received at the time of the visit.

8) Designating Who May Bring Your Child/Children to Our Office For Treatment:

a. You must provide us with the name(s) of any person who you give permission to bring your child to our office for medical treatment in the event that you (Parent/Legal Guardian) are not able to bring them yourself
b. Children 13 years old and younger cannot legally be seen by the physician without the Parent/Legal Guardian or designated representative present.

9) Prescription Refills

a. We do not call in prescription refills after office hours. Please contact our office during normal business hours for a refill on a prescription

10)A.D.H.D.

a. All children diagnosed with A.D.H.D. require an office visit every 3 months. A.D.H.D. medication refills will only be given during an office visit. Do not lose the written prescription you are given, as we will not be able to write another one for your child.

I have received a copy and understand the Urgent Care Policy.

I have received a copy of and understand the Vaccine Policy.

I have read and understand the office policies listed; and I agree to comply accordingly.

_____ _____

Signature of Responsible Party (Parent/Legal Guardian) *Date*

12/22/2015

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Acknowledgement of Receipt of Privacy Practices (HIPAA)

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call (251) 435-5437.

_____ _____/_____/_____
Patient Name (please print) Date

_____
Signature

If the patient is unable to sign, please indicate the reason why:

_____ Admitted directly to treatment area
_____ Left AMA or without being seen
_____ Unresponsive
_____ Not competent (POA signed)
_____ Refused to sign
_____ Patient is a minor (Guardian signed)

Please list anyone with whom we can speak with about your account:

	Name	Relationship	Medical?	Billing?
1.	_____	_____	□Y □N	□Y □N
2.	_____	_____	□Y □N	□Y □N
3.	_____	_____	□Y □N	□Y □N
4.	_____	_____	□Y □N	□Y □N

☐ I do not wish to have my health care discussed with anyone.

FOR OFFICE USE ONLY

_____ _____/_____/_____
Facility Representative Date

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Patient: _____

At Infirmary Pediatrics we strive to make your healthcare experience remarkable. Often when you come in for a routine examination (annual well visit, wellness check, sports physical), you may have new problems that need to be addressed, or a condition that requires additional attention at your visit. Insurance companies now recommend that when this occurs, this should be documented and billed as two separate visits on the same day.

This is billed separately because there will be additional services performed, and additional documentation at your visit. The additional services are not considered part of your preventative service benefit, therefore the office visit charges may be applied towards your deductible and a co-payment, if applicable, will be due.

Additional Services that may not be covered under your wellness exam are:

- Assessment of chronic or ongoing diagnosed conditions (diabetes, ADD/ADHD)
- Acute injury
- Acute illness such as cough, fever, sore throat, ear pain, congestion, rash, etc...
- New conditions/diagnoses
- Additional labs unrelated to your wellness exam

Please make us aware if you would like to come back for separate visit to discuss any of the additional problems or concerns that you may have.

If you have any questions in regards to this, please let us know and we will be glad to help.

_____

Parent/Guardian Date

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Use and disclosure of Protect Health Information (PHI)
Authorization Form - Release of Information(ROI)

Patient Name: _____ Date of Birth: _____

By signing this Authorization Form, I understand I am giving authorization to Infirmary Pediatrics, medical record custodian, to release my protected health information including Medical, Psychiatric, Alcohol, HIV, Drug Abuse, Reproductive Healthcare and/or Financial Information contained in my records. I authorize Infirmary Pediatrics to:

[ ] Disclose (release) to: or [ ] Obtain (request) from:

Name of Person or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of release: ☐ Continuity of Care ☐ Change of PCP ☐ Insurance Claim
☐ Personal Use ☐ Legal Use
☐ Other _____

Personal Health Information to be disclosed/or obtained:

☐ All Medical Records ☐ Immunization Records
☐ Lab Reports ☐ Progress Notes
☐ Operative Notes ☐ Radiology Reports
☐ Pathology Reports ☐ Other _____

Comments: _____

Medium to be Used: ☐ Paper, ☐ MyChart, ☐ CD/DVD, ☐ Email: _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to Infirmary Pediatrics.

This authorization will expire 1 year from the date of signing below unless specified otherwise. Date of expiration if different: _____

I understand that Infirmary Pediatrics will not condition treatment or payment on whether you sign this authorization unless this authorization is for the provision of research-related treatment or for the creation of health information for disclosure to a third party.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Authorized Representative Date Relationship

Records given to patient/representative on Date: _____ By Signature: _____

When selecting email as the medium to receive information you are accepting potential security risk associated with unencrypted email. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45 CFR 160.