PEDIATRIC CARE CENTER
Patient Information Form

HOW DID YOU HEAR ABOUT US? ❒ Online ❒ Health/School Event ❒ Referral/Word of Mouth

PATIENT INFORMATION

Child's Name (Last Name, First Name, Middle Name)_____

Date of Birth (Month/Day/Year)_____/_____/_____ ❒ Male ❒ Female SSN#_____

Child's Street Address (City, State, Zip):_____

Child lives with: ❒ Mother ❒ Father ❒ Guardian/Other:_____ Phone Number:_____

Email:_____ Preferred Pharmacy Name:_____ Cross Streets:_____

Race (Please select appropriate group):
❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American
❒ Native Hawaiian or Other Pacific Islander ❒ White or Caucasian ❒ Other

Ethnicity (Please select appropriate group):
❒ Latino/Hispanic
❒ Other

PATIENT/GUARDIAN INFORMATION

Mother/Guardian's Name:_____ **Father/Guardian's Name:**_____

DOB:_____ Primary Phone:_____ DOB:_____ Primary Phone:_____

Address:_____ Address:_____

Employer:_____ Work Phone:_____ Employer:_____ Work Phone:_____

EMERGENCY CONTACT - In case of emergency, who should we contact?

Name:_____ Relationship:_____ Phone:_____

Mother Social Security #:_____ **Father Social Security #:**_____

INSURANCE INFORMATION

Is the patient covered by insurance? ❒ Yes ❒ No

Name of Person Responsible for Paying the Bill ❒ Mother ❒ Father ❒ Other_____

Street Address: ❒ Same as Child ❒ Other (Address, City, State, Zip):_____

Primary Phone Number:_____ Cell Phone Number:_____

PRIMARY INSURANCE **Policy id #:**_____

Policy Holder's Name ❒ Child ❒ Mother ❒ Father ❒ Other:_____ Insurance Name:_____

Policy Holder's Social Security # (if other than child): _____ Policy Holder's Date of Birth:_____

SECONDARY INSURANCE **Policy id #:**_____

Policy Holder's Name ❒ Child ❒ Mother ❒ Father ❒ Other:_____ Insurance Name:_____

Policy Holder's Social Security # (if other than child): _____ Policy Holder's Date of Birth:_____

I certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility and duty to inform Pediatric Care Center should any information contained on this form change in the future.

_____ _____ _____

Printed Name of Parent/Legal Guardian Signature Date

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NO SHOW POLICY ACKNOWLEDGEMENT

While we understand that situations do arise that may prevent you from making your child's appointment, advance notifications allows us the opportunity to offer the appointment time to other patients in need of medical care. When patient families do not show for their appointments, other patients waiting to be scheduled are unable to receive an appointment.

In order to improve access to care for all patients, failure to cancel or reschedule an appointment by 3pm the day prior to your appointment and/or failure to present at the time of the appointment, will result in a "No-show" fee up to $50.00. Multiple no-shows may result in the need to transfer your care to another provider.

❒ I have read and understand the No-Show Policy and acknowledge that I will be held accountable as specified above.

PREFERRED METHOD OF COMMUNICATION

My preferred method of communication regarding patient's medical information is:

❒ Home Phone ❒ Work Phone ❒ Cell Phone

Please check the appropriate box:

❒ Leave a message with detailed information

❒ Leave a message with a call back number

DELEGATION OF CONSENT

We understand that on occasion, the need may arise for someone other than the parent/legal guardian indicated on file to bring in the child for medical care. Below, please indicate those to whom authorization may be given when you are unavailable.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I authorize the above individuals to consent to any and all medical care/treatment for this child by a Pediatric Care Center healthcare provider. This delegation is valid until I have withdrawn this consent.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Parent/Legal Guardian Date

PEDIATRIC CARE CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information abut you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of your patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. **WHO WILL FOLLOW THIS NOTICE:** This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medial chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that are currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications: You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan: You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, Pediatric Care Center, you may contact the Office Manager at 228-762-9595 or 4105 Hospital Road, Suite 104, Pascagoula, MS 39581. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

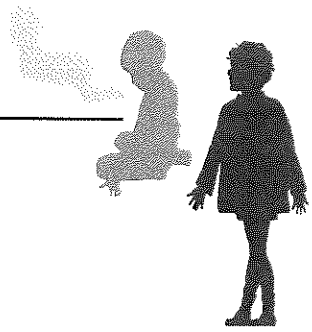
If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signature	Date	Witness	Date

PEDIATRIC CARE CENTER

4105 Hospital Road, Suite 104 Pascagoula, Mississippi 39581
228/762-9595 228/762-9494 Fax



PERMISSION TO VERBALLY DISCUSS PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____

Patient SSN:_____

Name	Telephone Number	Relationship to Patient
Name	Telephone Number	Relationship to Patient
Name	Telephone Number	Relationship to Patient

By signing below, you hereby consent for this Practice to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form. You should read the Notice of Privacy Practices for PHI attached to this form before signing the Consent. The terms of the notice may change from time to time, and you may always get a revised copy of it by asking the Privacy Officer for this Practice. You have the right to request that the Practice restrict how PHI is used or disclosed to carry out treatment, payment or health care operations. The Practice is not required to agree to requested restrictions, however; if the Practice agrees to your requested restrictions, the restriction is binding on it. Information about you is protected under federal law, and you have the right to revoke this Consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed pursuant to this COnsent may be subject to re-disclousre by the recipient and may no longer be protected under federal law.

Patient/Responsible Party Signature	Responsible Party Relationship
Patient Printed Name	Date