Patient Registration Form

Patient's Name: _____ Male Female

Age: _____ Date of Birth (month/day/year): _____/_____/_____

Social Security Number: _____ Preferred Name: _____

Language(s): _____ Race: _____ Ethnicity: Hispanic or Latino? Yes No

School: _____ Grade: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

Parent/Guardian Information

Name: _____ Address: _____

City: _____ Zip: _____

Preferred Contact Number: _____

Consent to call? Yes No Consent to text? Yes No

E-mail Address (for portal access): _____

How did you hear about us? _____

Insurance Information

Guarantor Information (Person responsible for bill if insurance doesn't pay)-

Name: _____ Date of Birth: _____/_____/_____
Address (if different from patient): _____
Phone Number (if different from patient): _____
Relationship to Patient: _____

Please provide an alternate phone number in case of emergency:

Name of relative: _____
Relationship to patient: _____ Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Bayou Pediatrics. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Parent/Guardian Signature: _____ Date: _____

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

1st period (females) _____

Was your child breastfed ☐ No ☐Yes, how long? _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Review of Systems (*Check all that apply*)

Constitutional
☐ Fever, chills ☐ Fatigue
☐ Unexplained weight loss/gain
☐ Excessive thirst

Ear, Nose, and Throat
☐ Loud voice, hearing problem
☐ Mouth-breathing, snoring
☐ Ear pain
☐ Frequent runny nose

Respiratory
☐ Cough, short of breath
☐ Chest tightness, wheeze

Musculoskeletal
☐ Muscle pain, weakness
☐ Joint pain, swelling
☐ Bone pain

Other (eye,skin,blood)
☐ Blurry vision ☐ Squinting
☐ "Crossed" eyes ☐ Itchy eyes
☐ Rashes ☐ Abnormal moles
☐ Abnormal bruising, bleeding

Gastrointestinal
☐ Nausea, vomiting, diarrhea
☐ Constipation, blood in stool
☐ Abdominal pain

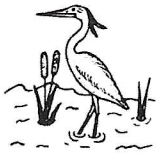
Cardiovascular
☐ Chest pain, palpitations
☐ Tires easily with exertion
☐ Fainting

Genitourinary
☐ Frequent or painful urination
☐ Bedwetting, frequent accidents
☐ Vaginal or penile discharge

Neurologic
☐ Headaches ☐ Seizures
☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional
☐ Anxiety/stress ☐Depression
☐ Sleep problem ☐ Anger concern
☐ Concerns with attention, impulsivity

Reviewed by _____ ***MD*** ***date*** _____



BAYOU PEDIATRICS

Practice Policies & Procedures

Thank you for choosing Bayou Pediatrics for your child's primary healthcare needs. Below you can find a detailed description of our policies and procedures to help navigate your visit.

Office Rules:
In order to keep our office clean, food and drinks are not allowed in our reception area or exam room. We need your full attention at your child's visit and request that you do not use cell phones in our exam room. If this becomes a problem, you will be asked to turn your cell phone off.

Appointments are available for newborns and new patients through the age of 17 years old. Our office Hours are Mondays- Thursdays from 8 AM to 5 PM, and Fridays from 8 AM to 12 PM. We are closed on Saturdays and Sundays. We are also closed on major holidays. In the event of an emergency, Bayou Pediatrics will make every attempt to notify patients via phone call. We will also post updated information on our Facebook page.

Phone Calls:
All calls should be made during office hours. This includes canceling and rescheduling of appointments, as well as medication refills and questions for the provider. If you get our answering machine, please leave your name, the patient's name, phone number, and the reason you are calling. We strive to return phone calls as quickly as possible, but please note that it may be up to 24 hours before messages are returned. If you are calling because your child's symptoms have not improved, you will be asked to schedule a follow up appointment so that we can reassess. If you are having a medical emergency, please call 911 or go straight to the nearest ER.

Appointment Cancellation/ No Show Policy:
As a parent, we ask that you be on time for your child's appointment. Please call if you realize that you will be running late. You will be allotted 15 minutes past your appointment time before you are rescheduled. In fairness to our provider and all our patients, we ask that you please call our office if you are unable to make your scheduled appointment. First time no shows will be given a courtesy call to reschedule. Any no show after that will be subject to dismissal from our practice.

Medication Refills:
If refills are remaining on your prescription, please contact your pharmacy. If no refills are left, you may submit a request for additional refills over the phone or through our portal system. Please allow up to 48 hours for your refill request to be processed.

While some drugs prescribed for ongoing or chronic care may be refiled if your child is current on well care and/or follow-up exams, most acute care medications will require an office visit to further assess your child's condition and the need for continuing medication.

ADHD medications will not be refilled unless a patient is current on ADHD follow-ups.

Referrals to Specialists:
As your child's primary healthcare provider, we attempt to provide the majority of healthcare needs in our office. In cases where a specialist referral is appropriate, please allow up to five business days for completion.

Medical Records and Forms:
We will complete a health, camp, or school form if the patient has had an up to date well care exam. You may drop off forms during our business hours for completion, and we will contact you when the form is ready to be picked up (please allow up to two business days).

Transfer or copying of medical records requires a signed release form from the parent/guardian of the patient. If records are being sent to another provider, please allow a minimum of five business days for processing.

Patient Portal:
We encourage you to use our portal through our secured EHR system. Through the portal, you will be able to access your child's medical records. You are also able to communicate with our staff by sending a message. You can also pay any outstanding balances posted to your account. BY providing your email, you will be sent a link to establish your portal access.

- By signing below, you verify that you have read, understood, and agree to comply with Bayou Pediatrics policies and procedures.

Patient Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

BAYOU PEDIATRICS

AUTHORIZATION to RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient Social Security #: _____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record of the above-named patient to:

Bayou Pediatrics
4624 Cypress Street Suite 6 West Monroe, LA 71291
Phone: 318-582-5208 Fax: 318-582-5216

The Protected Health Information will be used for the following purposes:

____Changing Physician

____Continuation of Care

____Other: _____

Specific information to be used or disclosed:

____Entire record ____ Specified dates of service: _____

____Immunization record ____ Most recent visit

Only records pertaining to: _____

This authorization remains in effect until written request to remove from file.

Parent/Guardian Name (Print): _____

Parent/Guardian signature: _____

Date: _____

Bayou Pediatrics
4624 Cypress Street Suite 6
West Monroe, LA 71291
Phone: 318-582-5208. Fax: 318-582-5216

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions.

However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

This consent was signed by: _____

Relationship to patient: _____

Date: _____

BAYOU PEDIATRICS

Payment Policy

It is important that you understand your insurance plan and our financial policies as well. Since it is our primary goal to provide the best healthcare for your children, please read this policy carefully, ask us any questions you may have, and sign below in the space provided.

Insurance: We participate with many insurance plans. If you are not insured by a plan in which we participate, payment in full will be expected at each visit. If you are insured by a plan with which we participate, it is your responsibility to provide a current insurance card at the time of your visit. Please contact your insurance company with any questions you have regarding your coverage to avoid any surprises.

Proof of insurance: All patients must complete our patient registration form before seeing the provider. We will need a copy of your driver's license and a current valid insurance card to provide proof of insurance.

Co-payments: All co-payments shall be paid at the time of service. This arrangement is part of your/our contract with your insurance company.

Claims submission: We will submit your claims 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 and any balance is your responsibility. If your insurance changes, please notify us before your next visit, or visit the patient portal to submit changes. If you fail to notify us of a change within 60 days, most insurances will consider this to be past timely filing and will not process your claims for the visit and the balance will become your responsibility. Your insurance benefit is a contract between you and your insurance company: we are not party to that contract.

Nonpayment: if your account is over 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please be aware that if a balance remains unpaid, you may be discharged from our practice. Should this occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our provider will only be able to treat you for emergency care. We hope this never happens!

Missed appointments: We reserve the right to charge for missed appointments. These charges will be your responsibility and billed directly to you. We understand that sometimes appointments cannot be kept, however a quick call to our office will avoid a "missed appointment" charge. Multiple missed appointments will result in discharge from our practice.

Patient Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Telemedicine Consent Form

At Bayou Pediatrics, we offer Telehealth appointments during times the office is closed; such as after hours, during holidays, or on the weekend.

CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS

I understand the purpose for this service is to seek medical advice and guidance for the care of my child who does not have an emergency condition. I also understand that at any time if I feel I cannot wait for a visit or feel my child's condition has become an emergency than I will call 911 and/or seek emergent care.

I understand that telemedicine is the use of video communication or telecommunication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell in assessing my child's condition.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment but there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment.
- Delay in care resulting from communication service or equipment failure.
- Inadequate visual resolution resulting in incomplete assessment.
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse result.

In addition to these risks, I understand that the remote provider evaluating my child does not have the opportunity to meet with my child in-person at the time and must rely on information provided by me and my child. I understand and acknowledge that the remote provider cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me, my child or others.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges for my child's telemedicine visit. I understand that my telemedicine visit may not be covered by my insurance plan.

My child and I have had the opportunity to review this information prior to any form of payment being collected. By signing this form, I indicate that I have chosen to proceed with any telemedicine visits for my child.

I consent to Bayou Pediatrics providing healthcare services to my child via telemedicine. As long as this consent has not been revoked by me, it remains in effect. Bayou Pediatrics may provide healthcare services to my child via telemedicine pursuant to this consent without the need for me to sign another consent form.

Authorization
By signing below, I represent and certify that I have legal authority to consent to medical treatment on behalf of the minor child.

Patient Name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____