ALL CHILDREN'S PEDIATRICS
PATIENT INFORMATION SHEET

PATIENT INFORMATION TODAY'S DATE _____/_____/_____

PATIENT _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC.# _____ SEX _____ RACE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ FAMILY CODE NAME _____

MOTHER/LEGAL GUARDIAN'S INFORMATION

MOTHER'S NAME _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC.# _____ SEX _____ RACE _____

DRIVER'S LICENSE # _____ STATE _____ HOME PHONE _____

ALTERNATE PHONE _____ WORK PHONE (___) _____

EMPLOYER _____

EMPLOYMENT ADDRESS _____
CITY STATE ZIP

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

FATHER'S INFORMATION

FATHER'S NAME _____
LAST FIRST MI PREFER TO BE CALLED

DATE OF BIRTH _____ SOCIAL SEC.# _____ SEX _____ RACE _____

DRIVER'S LICENSE # _____ STATE _____ HOME PHONE _____

MAILING ADDRESS IF DIFFERENT THAN ABOVE _____

CITY _____ STATE _____ ZIP _____

ALTERNATE PHONE _____ WORK PHONE (___) _____

EMPLOYER _____

EMPLOYMENT ADDRESS _____
CITY STATE ZIP

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ POLICY # _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF BIRTH

SECONDARY INSURANCE COMPANY _____ POLICY # _____

EFFECTIVE DATE _____

NAME OF POLICY HOLDER _____ POLICY HOLDER'S DATE OF **BIRTH** _____

****MEDICAID PATIENT'S WITH PRIMARY INSURANCE IF APPLICABLE ARE REQUIRED TO PAY THEIR CONTRACTUAL COPAYMENTS AT THE TIME OF SERVICE****

EMERGENCY CONTACT _____ PHONE# _____
NAME OF PERSON THAT DOES NOT RESIDE AT YOUR RESIDENCE RELATIONSHIP

****** CONTINUED ON NEXT PAGE ******

********** PATIENT INFORMATION SHEET CONTINUED **********

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits directly to All Children's Pediatrics for any services furnished to me. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company any information concerning healthcare, treatment, or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

SIGNATURE_____ **DATE** _____

MEDICAL SERVICES AUTHORIZATION

I, authorize All Children's Pediatrics to give me reasonable and proper medical care by today's standards

SIGNATURE _____ **DATE** _____

PAYMENT AGREEMENT

It is the policy of All Children's Pediatrics that charges for services rendered by our physician(s) and staff including contractual co-pays and deductibles are paid at the time of service unless other formal arrangements have been made in advance with our business office.

For your convenience, All Children's Pediatrics will file electronic insurance claims; however, it will be your responsibility to provide our office with the necessary information and signed authorization for filing insurance. This information and authorization must be provided to our office at your first visit, accompanied with a copy of your health insurance card(s).

Arrangements for monthly payments may be made with our business staff for any patient account balance in excess of $200. A minimum is required each month to keep your accounts active. You are responsible for making the monthly payment by the 5th working day of each month regardless if a statement has been sent to you or not. A patient's account that becomes delinquent (monthly payment not made within 30 days of the last payment) will be processed in our collections department, and the complete balance will become due immediately. In addition to the complete account balance, you will also be responsible for all attorney fees, court costs, and any collection fee that is incurred.

I agree to the above financial agreement for any services provided to me by All Children's Pediatrics

SIGNATURE _____ **DATE** _____

Initial History Questionnaire

NAME: _____

ID Number: _____

DOB: ____/_____/_____ AGE: _____ M / F

_____ _____

Form Completed by Date Completed

Household

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date	Health Problems	Notes
				Are there any siblings not listed? If so, please list their names, ages, and where they live.
				If mother and father are not living together or if child does not live with parents, what is the child's custody status?
				If one or both parents are not living in the home, how often does he/she see the parent(parents not in the home?

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illnesses or problems with her pregnancy?

❑ Yes ❑ No Explain _____

During pregnancy, did mother:

Smoke ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No

Use drugs or medications ❑ Yes ❑ No

What _____ When _____

Was the delivery ❑ Vaginal ❑Caesarean

If Caesarean, why? _____

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain

_____

Was initial feeding ❑ Breast ❑ Bottle

Did your baby go home with mother from the hospital?

❑ Yes ❑ No Explain

_____

General

Do you consider yourself to be in good health?	❑ Yes ❑ No	Explain:	
Does your child have any serious illness or medical condition?	❑ Yes ❑ No	Explain:	
Has your child had serious injuries or accidents?	❑ Yes ❑ No	Explain:	
Has your child had any surgery?	❑ Yes ❑ No	Explain:	
Has your child ever been hospitalized?	❑ Yes ❑ No	Explain:	
Is your child allergic to any medicines or drugs?	❑ Yes ❑ No	Explain:	

Development

Are you concerned about your child's physical development?	❑ Yes ❑ No	Explain:	
Are you concerned about your child's mental or emotional development?	❑ Yes ❑ No	Explain:	
Are you concerned about your child's attention span?	❑ Yes ❑ No	Explain:	

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in a special or resource classes? _____

Family History

Have any family members had the following:

Deafness	❑ Yes	❑ No	Who_____	Comments _____
Nasal allergies	❑ Yes	❑ No	Who_____	Comments _____
Asthma	❑ Yes	❑ No	Who_____	Comments _____
Tuberculosis	❑ Yes	❑ No	Who_____	Comments _____
Heart disease (before 50 years old)	❑ Yes	❑ No	Who_____	Comments _____
High blood pressure (before 50 years old)	❑ Yes	❑ No	Who_____	Comments _____
High cholesterol	❑ Yes	❑ No	Who_____	Comments _____
Anemia	❑ Yes	❑ No	Who_____	Comments _____
Bleeding disorder	❑ Yes	❑ No	Who_____	Comments _____
Liver disease	❑ Yes	❑ No	Who_____	Comments _____
Kidney disease	❑ Yes	❑ No	Who_____	Comments _____
Diabetes (before 50 years old)	❑ Yes	❑ No	Who_____	Comments _____
Bed-wetting (after 10 years old)	❑ Yes	❑ No	Who_____	Comments _____
Epilepsy or convulsions	❑ Yes	❑ No	Who_____	Comments _____
Alcohol abuse	❑ Yes	❑ No	Who_____	Comments _____
Drug abuse	❑ Yes	❑ No	Who_____	Comments _____
Mental illness	❑ Yes	❑ No	Who_____	Comments _____
Mental retardation	❑ Yes	❑ No	Who_____	Comments _____
Immune problems, HIV, or AIDS	❑ Yes	❑ No	Who_____	Comments _____

Additional family history: _____

_____

_____

Child's History

Does your child have, or has he/she ever had:

Chickenpox	❑ Yes	❑ No	When _____
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 doctors visits	❑ Yes	❑ No	Explain _____
Bladder of kidney infection	❑ Yes	❑ No	Explain _____
Bed-wetting (after 5years old)	❑ Yes	❑ No	Explain _____
(For girls) Has she started her menstrual periods?	❑ Yes	❑ No	Explain _____
(For girls) Are there problems with her period?	❑ Yes	❑ No	Explain _____
Any chronic or recurrent skin problem	❑ Yes	❑ No	Explain _____
(acne, eczema, etc.)	❑ Yes	❑ No	Explain _____
Frequent headaches	❑ Yes	❑ No	Explain _____
Convulsions or other neurological problem	❑ Yes	❑ No	Explain _____
Diabetes	❑ Yes	❑ No	Explain _____
Thyroid or other endocrine problem	❑ Yes	❑ No	Explain _____
Any other significant problem	❑ Yes	❑ No	Explain _____
Use of alcohol or drugs	❑ Yes	❑ No	Explain _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _____and will remain in effect until we replace it.

We reserve the right .to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information, listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services *we* provide to you,

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section, of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or heath. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health Information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that *we* provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.00 for each page, $ 10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee-for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which *we* or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003, If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in anyway If you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Lana Simmons

Telephone: (843) 522-3870 Fax: (843) 522-0691 E-mail: acpedl@aol.com

Address: 1875 North Paris Ave. Port Royal, SC 29935

Signature (Patient / Guardian): _____