SEASIDE PEDIATRICS, PA

Dear Parent,

Welcome to Seaside Pediatrics! We are pleased to have your child as a patient. To provide the best care for your child, we have adopted the following policies for our office.

Our office hours are Monday through Friday 8:30 a.m. to 5:00 p.m.

If your child is due for a **well check**, please call *at least* six weeks in advance to schedule an appointment. If you are more than 15 minutes late for a scheduled well check, your appointment may have to be rescheduled. If you are unable to keep a regularly scheduled appointment, please call our office as soon as possible. There will be a ***$35.00*** charge if you do not show up for an appointment or cancel with less than 24-hour notice. If your child misses more than 3 scheduled appointments within a 12-month period, he/she may be dismissed from our office.

When your child is **sick**, please call as early in the day as possible. The office will answer the phones starting at 8:30 a.m. If your child needs to be seen by the doctor, we will schedule the first possible appointment. *We attempt to work all sick children into the schedule.* Patients within the age of 15-17 may be seen without a parent for an ill visit. However, the parent or guardian must complete a Permission to Treat a Minor Form. Additionally, the parent/guardian must also agree to be contacted by phone during the exam by the provider, if need be. If permission from a parent/guardian cannot be obtained, the child cannot be seen, unless it is life-threatening.

For urgent problems that arise when our office is closed, we continue to be available through an answering service. You can access the system through the regular office telephone number or ***843-284-2157***. There is always a provider on call. If you have waited over an hour for a call back, please call the service again.

If you have a life-threatening emergency, call **911.**
Poison control phone number is **1-800-222-1222.**

Co-pays, insurance deductibles and self-pays are to be paid at the time of your visit. There is a $35.00 returned check charge. We keep our office charge in line with other pediatric practices in the area. If you would like an *estimate* of charges before your visit, feel free to call our office. Prior to your child's well check, you must know whether or not your insurance covers immunization so that we will be able to determine your eligibility for the state vaccine program. You will otherwise be responsible for these charges. You are also responsible for alerting our staff if your insurance requires you to use a specific laboratory to send out tests. We use MUSC unless otherwise informed.

If you need **telephone advice** during office hours (including the lunch hour) the receptionist will take all the necessary information. Your child's chart will be pulled and given to the doctor's assistant. She(he) will call you back as soon as possible to discuss your child's signs and symptoms and to recommend appropriate care.*

Please call the office *at least* **48** hours in advance for refills on prescriptions.* It is **your** responsibility to call **before** your child runs out of medication. There is also a **48-hour** turn around time for sports physical forms, school/daycare immunization forms and school medication forms.* In order for a sports physical or camp form to be filled out, your child must have had a well check within **12 months.***

Once again, thank you for choosing Seaside Pediatrics.

X_____ Date_____
Signature of Parent/Guardian

**Please refer to our Non-Covered Services Agreement.*

Seaside Pediatrics

Janet White, MD Kimberly Zimlich, MD
Shannon Noble, MD Laura Bates, CPNP
Alice LoGuidice, CPNP

PATIENT INFORMATION

Patient Name: _____ _____
(First) (Middle) (Last) (Preferred Name)

Sex: Male / Female Date of Birth: _____/_____/_____

Race/Ethnicity: American Indian or Alaska Native / Asian / Black or African American / Hispanic or Latino / Native Hawaiian or OPI / White

Patient Address: _____

Daycare/School: _____ Preferred Pharmacy: _____
(Name) (Location)

PARENT'S INFORMATION

Names: _____ Mom DOB: _____ Dad DOB: _____

Email(s): _____ Marital Status: _____

Mom Ph#: _____ Dad#: _____ Phone #3: _____

Mom Employer Name: _____ Mom SSN: _____

Dad Employer Name: _____ Dad SSN: _____

Preferred method of contact for electronic reminders: __ Mom cell __ Mom email __ Dad cell __ Dad email

__ I prefer a phone call to be reminded of an appt

PRIMARY INSURANCE

Member / Policyholder – please circle one:

MOTHER / FATHER / PATIENT

Insurance Company _____

SECONDARY INSURANCE

Member / Policyholder – please circle one:

MOTHER / FATHER / PATIENT

Insurance Company _____

Has your child *ever* been seen in our office? ____ Y ____ N

Have any of your child's siblings been seen by our practice? ____ Y ____ N If yes, who: _____

If your child/children have not been seen before, whom may we thank for referring you to our office?

_____

Name of child's previous physician: _____

Name of mother's obstetrician/gynecologist: _____

Person **other than parent** to contact in case of an **EMERGENCY**: _____

Relationship: _____ Ph#1: _____ Ph#2: _____

SEASIDE PEDIATRICS, PA

NAME _____ **DATE OF BIRTH** _____

PLEASE SIGN BOTH AUTHORIZATIONS AND PROVIDE US WITH YOUR INSURANCE CARD(S) TO SCAN INTO YOUR FILE.

SEASIDE PEDIATRICS, PA

FINANCIAL POLICY

Payment of medical fees is the responsibility of the parent/legal guardian. Our office will file for insurance benefits for plans in which we participate. Deductibles and co-payments will be collected **at the time services are rendered**. Necessary information will be supplied to the patient to enable them to file their insurance for other plans.

We will allow thirty (30) days for your insurance company to process and pay assigned claims; after which time we will look to the patient for payment of their account. I understand that I am financially responsible for all charges whether or not the services are covered by my insurance. Your help in seeing that these claims are paid within this time is appreciated.

Insurance claims, which are denied, rejected, or not paid in full within thirty (3) days will become the patient's responsibility.

PARENT/GUARDIAN'S SIGNATURE _____ **DATE**_____

MEDICAL CONSENT/LIFETIME AUTHORIZATION

I, the undersigned patient or my authorized representative, hereby authorize my physician and whomever he/she may designate as his/her assistant to render medical treatment to me. I consent and authorize treatment of reasonable and proper medical care by today's standards for my child.

I, the undersigned patient or my authorized representative, hereby authorize my physician and whomever he/she may designate as his/her assistant to release any medical information accumulated in the course of my examination and treatment to any other doctor, hospital, or party assisting with my medical care.

I, the undersigned patient or my authorized representative, hereby authorize the release of medical information and request payment of benefits to Janet O. White, MD, Kimberly Zimlich, MD, Shannon M. Noble, MD, Laura C. Bates, CPNP, and/or Alice G. LoGuidice, CPNP when they accept assignment. I understand that I am responsible for any amount not covered by my insurance. I authorize use of photostatic copy of this assignment in lieu of the original when necessary.

PARENT/GUARDIAN'S SIGNATURE _____ **DATE**_____

Seaside Pediatrics

Immunization Policy Statement

Effective October 13, 2014

We firmly believe that routine childhood immunization prevents illness and save lives.

We firmly believe that routine childhood immunizations are safe.

We firmly believe that immunization is the single most important preventive healthcare measure available to children in the United States.

We firmly believe that all eligible children should be immunized according to the U.S. Child and Adolescent Immunization Schedule published yearly by the CDC.

Immunizations are the biggest medical success story of the 20th century. As a result of routine immunization:

- American children no longer contract polio
- Smallpox no longer exists
- German measles (rubella) and its threat of birth defects have decreased dramatically
- The incidence of whooping cough, bacterial meningitis, measles and chicken pox was declining in many locations (until delayed or alternative immunization schedules were started)

We cannot over-emphasize the importance of having your child immunized. We understand that many good parents have questions and even some concerns about childhood vaccines. We also understand that a very few patients have medical contraindications to certain immunizations. We will do everything we can to convince you that completing the immunization schedule on time is in your child's best interest. However, should you still have reservations, please discuss these with your provider. In certain cases, we may agree to alter the recommended schedule to accommodate specific parental concerns or reservations. Please be advised that if you elect to follow an unconventional immunization schedule, you will be required to present that schedule to your provider for review before we will consider following it. In most cases, these unique requests will result in additional vaccine visits with a provider and additional co-pays as required by your insurance company. In addition, for each encounter that results in a child that is incompletely immunized as per the U.S. Child and Adolescent Immunization Schedule, you will also be required to sign a "Refusal to Vaccinate" acknowledgement which will be kept on file.

Any patient who remains unimmunized by his first birthday will have his medical record reviewed by the partners Seaside Pediatrics, PA. Unless there is an existing medical contraindication to immunization, you may be asked to comply with a catch-up immunization schedule or be asked to find another health care provider. We hold this position because we firmly believe the decision to delay immunization puts your child and others at unnecessary risk of life-threatening illnesses, disability and death.

Please feel free to discuss any questions or concerns you may have about vaccines with any of us. We strive to keep each one of "our kiddos" happy, healthy and free of preventable diseases.

Sincerely,
The Providers at Seaside Pediatrics

Seaside Pediatrics

309 Wingo Way, Suite 101
Mt Pleasant, SC 29464

NON-COVERED SERVICES AGREEMENT

Dear Seaside Families,

Over the past several years, we have experienced a steady increase in staff hours dedicated to providing the many services we provide that are not covered by insurance. These services include but are not limited to: telephone advice during office hours and after hours; filling out forms for school & daycare: immunizations/medication administration, forms for sports participation/summer camp; authorizations for home health/physical or occupational therapy/equipment; specialty referrals; medication refills and/or authorizations; school excuses; call-in medications when appropriate; and letters to authorized recipients. Most of these services include a careful review of the patient's history and require time-consuming telephone calls and forms to be filled out (Not included: legal affidavits).

Because insurance does not cover these services, many offices are requiring an office visit for each item in order to be reimbursed for the time spent. We know this solution can be inconvenient for parents; instead, as a value-added service and an attempt to accommodate our patients, we are asking families to pay a modest monthly fee for these services. Previously, we have seen other practices institute this policy or charge for telephone care; we have been resistant to this change. However, in order to continue to provide great service, we must finally cover this increased expense.

The following administrative charge for non-covered services @ Seaside Pediatrics will be applicable for 1 year from the date of sign up:

- ☐ **$84.00 for one child ($7.00 per month)**
- ☐ **$144.00 for two children ($12.00 per month)**
- ☐ **$204.00 ($17.00 per month) for three or more children**

If you believe that you are a low-use or no-use family of these inter-visit services, you may opt out of this monthly fee and you will be scheduled for an office visit as needed for these services or charged individually for services rendered (Fee schedule available upon request). We will continue to provide phone advice for emergencies for all patients, regardless of whether you opt in or out of this agreement.

We consider it a privilege to participate in the health and well-being of your family and value our level of care and service. Thank you for understanding that this is a necessary step to continue to provide these services.

Parent/Guardian signature _____ Date_____

Circle one: **Opt in** **Opt out**

Please list your children's names and birthdates that will be covered under this service:

_____

_____

Patient(s) Name and DOB: _____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I received a copy of the Seaside
(PRINT NAME)
Pediatrics, P.A. Notice of Privacy Practices.

_____ _____
Date Signature of Patient or Patient's Representative

_____
Description of Representative's Authority

AUTHORIZATION FOR ALTERNATE CAREGIVERS

Seaside Pediatrics, P.A.

Please list any caregivers that you authorize to obtain medical care for child/children in your absence. This includes office visits and telephone advice/information. Examples of people who should be listed: a nanny, a babysitter, a family member who may care for your child while you are on vacation or at work, etc.

It is your responsibility for any current caregivers to be listed and any past caregivers to be removed from the list. Because of the HIPPA laws, we will not be able to provide an office visit or even telephone advice without a parent, unless the alternate caregiver is on this list.

CAREGIVER	RELATIONSHIP TO CHILD
_____	_____
_____	_____
_____	_____
_____	_____

Parent's Signature: _____ Date: _____

(Patient Signature if 18 or Older)

IN OFFICE USE ONLY Processed by: _____ Date: _____