

PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM

*****PLEASE PRINT & PROVIDE ALL INFORMATION BELOW*****

PRIMARY PHYSICIAN

Wood Brannon Blakeney Diebel Mukkamala McNally Speight Hooper Schull Troy Scott Rutland

PATIENT INFORMATION

First Middle Last Preferred Name Social Security #
M F
Date of Birth Sex Race Ethnicity Religion Preferred Language

ALLERGIES: Does your child have any known Drug/other Allergies? _____

Do we see any other children in your family? Yes No List Each: _____

FAMILY INFORMATION

Child lives with: Parents Mother Father Grandparent Foster Parent Other: _____

Primary Family Email Address: _____
(Best Email for Reminders, Notices and Information)

Primary Family Phone Number _____
(Best Phone Number for Reminders)

Parent/Legal Guardian Name

First Middle Last

Relationship to Child: _____

Street Address City, State, Zip

Home Phone Cell Phone
Authorization to Contact by Cell Phone and/or Text Yes No

DOB Social Security #

Employer Work #

Drivers License # State

Parent/Guardian Status Single Married Divorced Widowed If divorced, who has legal custody: _____

Legal Documents Provided: Yes No - If yes specify: _____ Other: _____

EMERGENCY CONTACT & AUTHORIZED PERSON(S)

List Person(s) to contact in case of an emergency other than parent/legal guardian and/or person(s) authorized to bring child to visits and have access to "ALL" patient medical and financial information.

Name/Phone Number: _____ Relationship to Patient: _____
Name/Phone Number: _____ Relationship to Patient: _____
Name/Phone Number: _____ Relationship to Patient: _____
Name/Phone Number: _____ Relationship to Patient: _____

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Company

Insurance Company

Primary Insurance Holder Name DOB

Primary Insurance Holder Name DOB

Member ID # Group ID #

Member ID # Group ID #

Employer

Employer

CONTINUED

PARTNERS IN PEDIATRICS, LLC
PATIENT REGISTRATION FORM CONTINUED

POLICIES & PROCEDURES

PLEASE READ CAREFULLY, INITIAL AND SIGN AUTHORIZATION BELOW

INSURANCE: Partners in Pediatrics, LLC accepts assignment of insurance benefits from most major insurance companies for payment of services on your behalf. It remains your responsibility to verify coverage with our physicians and your specific policy before treatment. Our business office is ready to assist you with your coverage questions.

Initial _____

CO-PAY: Your insurance policy and the agreement between your physician and the insurance company requires that we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay is not made at the time of service, then an additional \$10.00 service charge is added to your account.

Initial _____

SELF-PAY: If your child does not have medical coverage or is out of the network, then you must see the business office before treatment. You are responsible for all charges incurred at the time of service. The business office will assist you with the amount due. You may receive a copy of your itemized billing statement for insurance or tax purposes.

Initial _____

NO SHOW: As a courtesy, we will provide reminders for your appointment. If you are unable to make your scheduled time, then you must notify our office 24 hours prior to that time. Missing three (3) scheduled appointments will result in dismissal from the practice.

Initial _____

HOSPITALIZATION: In the event of hospitalization, we will file the hospital charges incurred for the physician treating your child. If newborn patient charges are incurred, then it is your responsibility to add the newborn to your policy or another acceptable policy within 30 days of date of birth. If no insurance is acquired, then you will be responsible for all newborn hospital charges and all subsequent office visit charges if any.

Initial _____

POLICY AGREEMENTS: I acknowledge that I have read the full **Financial Policy** and **Office Policy** available in the New Patient Registration Packet and at mykidsdr.com, and I agree to the terms set forth therein.

Initial _____

AGREEMENT TO PAY: In case of default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect monies you may owe, Partners in Pediatrics, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.

Initial _____

PRIVACY: I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Information Portability & Accountability Act of 1996 (HIPAA) and have been offered a copy of it.

Initial _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I, the undersigned, consent to the treatment necessary for the care of the below listed patient. I hereby authorize release of any or all medical records to the referring physician my insurance carries or those involved in payment of my account. Further, I acknowledge full financial responsibility for any services rendered by Partners in Pediatrics, LLC, and understand that payment of charges incurred in this office is due at the time of service. I consent for the charges to be filed electronically and/or via paper claims (I500 and UB04) by signing this consent form. I also understand that charges not covered by the insurance remain my responsibility and assign insurance benefits to PIP. In the event an account is not paid within 90 days, the undersigned agrees to pay all cost of collection including attorney's fees and hereby waives all right of exemption under the constitution of the State of Alabama.

I, as the parent, guardian, or legal personal representative, give my permission to Partners in Pediatrics, LLC and their employees to provide medical care to my child. I realize I am responsible for accompanying my child or children while on the premises. According to HIPAA law, I shall update this information at least annually or sooner if any change occurs.

Signature of Parent or Responsible Party

Date

Patient Printed Name

Patient Date of Birth

OFFICE USE ONLY

Rev. 07272020

Print or email this PDF to forms@mypartnersinpediatrics.net. Please attach a copy of your DL and Insurance card to the email.

Partners in Pediatrics, LLC

FINANCIAL POLICY

PRIVACY: A copy of our Notice of Privacy Practices is available and given to all patients in accordance with The Health Portability & Accountability act of 1996 (HIPAA). (Included with original Registration material)

INSURANCE CARD: We must have a copy of your current health insurance card on file and please be prepared to show your insurance card at each visit. Insurance eligibility must be verified prior to seeing the doctor or you will be required to pay at the time of service. If there is a change in your insurance coverage, please notify us promptly. Some insurance companies have time limits on when claims need to be submitted. If we do not have the correct information, we cannot file the claim in a timely manner.

INSURANCE: Our office accepts assignment of insurance benefits from most major insurance companies for payment of services rendered. The responsible party must verify specific coverage with our physicians and the specific policy before treatment. Refer to our Billing & Insurance Policy for a list of insurance plans we have contracted with and payment methods accepted. Our business office will assist you with coverage questions related to your insurance plan.

CO-PAYMENTS: Our physicians are contractually obligated per your insurance company to collect a co-payment at the time of service. Your insurance policy and the agreement between your physician and the insurance company requires we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay cannot be made at the time of service your appointment can be rescheduled and an additional \$10.00 service charge will be added to your account balance.

SELF-PAY: If there is no medical coverage at the time of service or our physician is out of network, then the responsible party is liable for all charges incurred at the time of service. The business office will assist with the amount due and provide a copy of any itemized billing statement for insurance or tax purposes.

PRIMARY CARE PHYSICIAN: We will ask you at our front desk to select a primary care physician, but it is your responsibility to notify your insurance company within 30 days that your child's primary care physician is at Partners in Pediatrics, LLC.

HOSPITALIZATION: In the event of hospitalization, our office will file for the hospital services provided by the physician treating the patient. If newborn patient charges are incurred, then it is the parent's responsibility to add the newborn to the policy or another acceptable policy within 30 days of the date of birth. If no insurance is acquired, then the parents or responsible party will be liable for all newborn hospital charges and any subsequent office visit charges incurred until insurance is in force.

BALANCES & DEDUCTIBLES: In the terms of our contracts with health insurance companies, we are responsible for billing you any portion of your treatment that your health insurance carrier does not pay. You are responsible for paying this portion of your bill. All balances are due at time of service or upon receipt of your financial statement. Failure to pay could result in collection activity or dismissal from the practice. Your child's appointment may be rescheduled if you are not prepared to pay any past due balances or deductibles at the time of service. In the event of a returned check for insufficient funds, your account will be charged \$35. Refunds will be issued on accounts with a credit of \$50 or more. Any account with credits less than \$50 will have funds held for future visits unless authorized by the business office.

PAYMENT PLANS: We understand at times families may experience financial hardship and do offer payment plans. Your first payment will be due upon signing a written agreement. Payments are based on the amount owed. No payment plan will be given to amounts less than \$100. If your payment plan is in default, the balance will be due in full. Failure to pay may result in collection activity and/or dismissal from the practice.

NO RESPONSE CLAIMS: If your insurance company does not respond to the claim within ninety (90) days from the date of the claim, you are responsible for the payment of the bill.

MEDICAID INSURANCE: We accept Alabama Medicaid insurance by state assignment only. Children on Medicaid are limited to 14 visits per calendar year and 1 well visit per calendar year. Once you reach 14 visits then you are responsible for payment in full. ER visits for routine health problems may count as a doctor visit. Using one doctor and one drug store is best for your child's health.

AGREEMENT TO PAY: The parents or responsible party agrees to pay any account balance. In case of a default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect any amount owed, Partners in Pediatrics, LLC and/or its agents may make contact by telephone at any telephone number associated with the account, including wireless telephone numbers, which could result in charges. We may also make contact by sending text messages or emails, using any email address provide for our use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.

Partners in Pediatrics, LLC

GENERAL OFFICE POLICIES

Registration/Demographic Information: At least annually we are required to obtain updated information from each patient which authorizing our clinicians to provide continuous medical services to that patient. Our policy is that all new patients must complete patient information forms prior to being seen and established patients must update the information sheet every twelve (12) months or whenever there is a change.

Privacy: A copy of our Notice of Privacy Practices is available to all patients in accordance with HIPAA (Health Portability & Accountability Act of 1996). This documentation can be found on our website and in our patient registration packet.

Minor Patients: A parent or legal guardian must accompany any minors to receive medical care services at our practice. Written authorization allowing other persons to accompany patients to office visits must be provided on the registration form. We may deny care unless this policy is followed.

Adolescent Consent: Adolescents age 16 years and older may be requested to sign a release of information form. Some exceptions are made for emergencies as listed under Ala. Code. Sec. 22-8-1, Ala. Code Sec. 22-8-3, Ala. Code Sec. 22-8-4 and Ala. Code Sec. 22-8-6.

Transition Age: It is our recommendation that once adolescent patients reach age 19 and/or has graduated from high school he/she should find an internal or family medicine provider that can give adult medical care. You may request us to recommend an adult physician by calling our office.

Patient Portal: Our front office staff will assist patients with Patient Portal access and instructions. Each patient is given a unique login per child. This system is to give our patients a convenient way to access information such as labs, office visit information, and a way to send messages to your care team.

Call-backs: If you leave a message and expect a call-back, be sure to speak clearly, leaving a detailed message with the patient name, reason for the call, person calling and best callback number. Your call will be returned promptly by the appropriate team member.

Prescription Refills: Our prescription refill line is available during normal business hours Monday-Friday. Please allow three (3) business days for processing. Medications for ADD/ADHD, asthma and some other medications may not be refilled if your child has not been in the office for a medication management visit within the last six (6) months.

Referrals: Most managed care insurance plans require referrals from your primary care physician before your child can be seen by a participating specialist. It is necessary to ask parents to provide us at least three (3) business days for a referral to be completed and forwarded to the specialist. Our Referral Specialists are available during normal business hours Monday-Friday.

Nurse Line: Our nurse line is available during normal business hours Monday-Friday. This service is for questions you may have about your child's health and for advice regarding minor medical issues. This line is not intended for routine questions that can be asked during your visits to our office or to schedule appointments.

Appointments: A parent or legal guardian must be present for the initial visit to receive medical care at our practice. Please be sure to be prepared for all appointments by having your insurance card and filling out any necessary forms prior to seeing the doctor. Same-day appointments are available with sick appointments given first priority. Appointments can be scheduled at any of our offices by calling the main office line during normal business hours Monday-Friday.

Late or Missed/No Show Appointments: If you are unable to make your scheduled appointment, you must notify our office by 24 hours prior to appointment. Missing three (3) scheduled appointments in a year will result in dismissal from the practice. If you are running late you should immediately call our office to determine if we must reschedule. Patients running 30 minutes late for an appointment regardless of reason will either be asked to reschedule and/or may be worked in when a physician is available.

After-Hours: Our physicians are on-call after normal business hours through our on-call system by calling the office line. The on-call system will route your message to the nurse or physician on-call. This service is for urgent problems that can't wait until the next business day (no medical refills or routine questions, please!).

Emergencies: We recommend all parents learn CPR and keep emergency numbers handy. Call 911 for life-threatening emergencies or go to your nearest emergency room. Ask the ER staff to contact our office upon arrival. For poisoning, call The Regional Poison Control Center Children's Hospital at 1-800-222-1222 for poison advice for all ages.

Medical & Immunization Records: Medical records must be requested in writing and signed by a parent or guardian. Please speak the billing office for questions regarding fees for records. If an immunization record is requested by fax, there MUST be written consent to release this information. All records can be picked up at the office.

Dismissal of Patient-Physician Relationship: Physicians may terminate a relationship with a patient at any time. If this happens, the patient will receive a written notice explaining the reason for dismissal. The physician will provide the patient access for 30 days of service for urgent medical matters only. Our practice reserves this action for any situation that constitutes a breakdown in the patient-provider relationship. This includes but is not limited to patients who demonstrate a lack of respect for their medical services and the practice by missing appointments repeatedly, disregarding the practice's stated policies, or behaving in a way that is deceptive, disrespectful, or dishonest.



Partners in Pediatrics, LLC

Partners with Parents for the health of their children

NEW PATIENT POLICY

Patient Name _____ MRN _____

- *Partners in Pediatrics, LLC* requires completed new patient paperwork before an appointment. This paperwork includes the Registration Form, New Patient Questionnaire, HIPAA Consent Form and HIPAA Notice of Privacy Practices. All forms are available on our website at www.mykidsdr.com under the “New Patients” tab.
- The responsible party is required to furnish a current and valid photo ID for our records at each appointment.
- A copy of the current health insurance card is required and will be copied for our records at each appointment.
- All newborn new patients coming to the office must be added to their appropriate health insurance policy by the parents within 30 days of the date of birth. If the infant is not added within 30 days, you will be responsible for payment in full.
- To be established as a patient in our practice, other than a newborn, we will schedule your initial appointment while we are waiting to receive your records. You may bring in or submit any medical records or immunizations that would be vital to your child’s care. Please keep in mind that a checkup may be required in order to obtain all the information needed to fill out future required forms or referrals in providing continuity of care. If you have had a checkup in the last year, please notify our staff as your insurance may not cover a second checkup.
- If your health insurance requires a co-payment or you have not met your deductible then a payment will be required at the date of the first visit, newborns included. We accept cash, checks, and all major credit cards. All credit card charges will incur a 3% convenience charge.
- Bring any medical records, x-rays, MRI scans, CT scans or any other studies you have recently completed at other facilities so we can add them to your chart for our reference. If at any time you obtain medical services at another facility you will provide those records so we can incorporate them into your chart.
- Provide any information for any medications the patient is currently taking.
- If you are a minor patient (younger than 18 years) then you must be accompanied by a parent or legal guardian to the appointment. The parent or legal guardian may designate an authorized representation to accompany the patient to future appointments.

By signing below, I agree to follow the new patient policy of *Partners in Pediatrics, LLC*.

Parent or Guardian

Date

Catherine L. Wood, M.D.
Susan A. Brannon, M.D.
Lamenda N. Blakeney, M.D.
Elizabeth W. Diebel, M.D.
Rama L. Mukkamala, M.D.
Melissa S. McNally, M.D.
Danielle F. Speight, M.D.



True B. Hooper, D.O.*
Katharine N. Schull, M.D.*
Adam W. Scott, M.D.*
Carroll Anna Troy, D.O.*
Sabrina McDaniel-Colburn, CRNP
K. Presley Rutland, CRNP

* Associate Physician

**PARTNERS WITH PARENTS FOR
THE HEALTH OF THEIR CHILDREN**

Consent for the Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Partners in Pediatrics, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use and Disclosure of Your Information

You may request a restriction on the use and disclosure of your protected health information.

Partners in Pediatrics, LLC may or may not agree to restrict the use and disclosure of your protected health information. If Partners in Pediatrics, LLC agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use and disclosure that has already occurred prior to the date on which your revocation of your consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Partners in Pediatrics, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Partners in Pediatrics, LLC for the use and disclosure of my health information in accordance with this consent.

Patient Name: _____

Signature (Parent or Guardian): _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**8160 Seaton Place ▪ Montgomery, Alabama 36116 ▪ (334) 272-1799 ▪ Fax: (334) 272-4876
8134 Seaton Place ▪ Montgomery, Alabama 36116**

Partners in Pediatrics, LLC

HIPAA Notice of Privacy Practices

(Effective Date - September 2013)

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Partners in Pediatrics, LLC

HIPAA Notice of Privacy Practices

(Effective Date - September 2013)

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Partners in Pediatrics, LLC, 8160 Seaton Place, Montgomery, AL 36116:

- **Right of Access to Inspect or Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Partners in Pediatrics, LLC, 8160 Seaton Place, Montgomery, AL 36116 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Catherine L. Wood, M.D.
Susan A. Brannon, M.D.
Lamenda N. Blakeney, M.D.
Elizabeth W. Diebel, M.D.
Rama L. Mukkamala, M.D.
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K. Presley Rutland, CRNP

* Associate Physician



PATIENT PORTAL RELEASE

Our Patient Portal offers you a convenient, anytime access to patient health information and puts YOU at the center of your healthcare. With the ability to view accurate health records, lab results, and communicate with your doctor, you are helping us to expand and improve your health care experience!

Always dial 911 for emergency situations. DO NOT leave a message on the Patient Portal as it could take 24-48 hours for a response.

I further acknowledge:

- I understand it is my responsibility to maintain the confidentiality of the information contained in the documents.
- I understand the patient portal should NOT be used for emergency situations.
- I understand messages **will not** be addressed if received from any individual who is not currently authorized on my Registration Form to obtain such information according to HIPAA patient health information (PHI) privacy rules.

Primary email address: _____

A link to register will be sent to this email address.

Patient Name: _____ D.O.B: _____

Patient/Guardian Signature: _____ Date: _____

8160 Seaton Place ▪ Montgomery, Alabama 36116 ▪ (334) 272-1799 ▪ Fax: (334) 272-4876
8134 Seaton Place ▪ Montgomery, Alabama 36116
688 Covered Bridge Pkwy ▪ Prattville, Alabama 36066



Immunization Policy Statement

Partners in Pediatrics, LLC is committed to practicing medicine in compliance with the evidence-based guidelines established by groups of experts such as the **American Academy of Pediatrics, Centers for Disease Control and Prevention, and the Advisory Committee on Immunization Practices.**

We have a firm policy on vaccination as we believe so strongly in the safety and efficacy of vaccines. Furthermore, we also have a duty to protect our community as well as our patients who are unable to receive certain vaccines (either due to young age or due to being immunocompromised, etc).

At Partners in Pediatrics, we firmly believe:

- in the safety and effectiveness of vaccines to prevent serious illness and to save lives;
- that all children and young adults should receive all of the recommended vaccines* according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics;
- based on all available literature, evidence and current studies, that vaccines do not cause autism, weakened immune systems or other developmental disabilities;
- that vaccinations may be the single most important intervention we perform as health care providers and the most important health intervention that you choose for your children.

The recommended vaccines and the published schedule are the results of years of scientific study and the accumulation of data on millions of children by the brightest scientist and physicians in our country. Vaccines prevent infections that can be extremely debilitating and/or life-threatening such as pertussis or whooping cough, measles, *Haemophilus influenzae type B* meningitis, and pneumococcal blood infections.

Unfortunately, the vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that parents are discussing whether or not they should be given. Because of vaccines, most parents have never seen a child with bacterial meningitis or even chickenpox; most people have never heard of a friend or family member who died from one of these diseases. Such successes can make us complacent about the need for vaccination. Unfortunately, this will likely lead to tragic results. In countries where there are low vaccination rates, these illnesses are still quite prevalent. In the US and in other well-developed countries, communities with under-immunized patients are showing a rise in these once-rare diseases. As we have witnessed with the recent measles outbreak, a resurgence of these diseases can occur unless we continue to immunize children.

We present these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to provide education and information regarding the recommended vaccines so that you can make an informed decision for your child. However, should you have doubts, please discuss these with your health care provider. **Delaying or "breaking up the vaccines" to give one or two at a time over two or more visits can put your child at risk for serious illness or death** and goes against our medical advice as providers.

It is for these reasons that Partners in Pediatrics requires all patients to be vaccinated according to the recommended schedule.*

While we are happy to answer questions and discuss the safety and efficacy of the vaccines, if parents chose to not begin routine vaccinations by the time their child is 6 months old, they will be expected to find a different primary care office. Additionally, we will not accept transfers of unvaccinated children over the age of 6 months into our practice. Children who transfer to Partners in Pediatrics will be given 30 days in which to provide confirmation of all childhood vaccines that are currently due per the AAP's vaccine schedule or will need to initiate vaccinations within those 30 days.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy and we will gladly address any additional items you would like to discuss on an individual basis.

By signing below, I acknowledge that I have read and understand the immunization policy of Partners in Pediatrics, LLC.

Parent/Guardian Name

Date

**PIP's minimum vaccination requirements are not inclusive of all vaccines, and there are other vaccines that are also very important in keeping children healthy (e.g. flu/influenza, COVID-19, Hepatitis A, HPV vaccines).*



Partners in Pediatrics, LLC

Partners with Parents for the Health of their Children

We encourage any parent who wants to learn more to visit the following websites with reliable, scientific information to explain all aspects about immunizations from manufacturing, to how they work to protect children, to data regarding safety and efficacy.

Find vaccine education here:

Clear Answers and Smart Advice About Your Baby's Shots," an excerpt from the popular book "Baby 411" by Dr. Ari Brown – www.immunize.org/catg.d/p2068.pdf



Vaccine- and Vaccine Safety-Related Q&A Sheets

Scan the QR Code to find
Q&A sheets developed by the Vaccine Education Center
Available in English and Spanish



Clear Answers and Smart Advice About Your Baby's Shots

Scan the QR Code to find
the article in a PDF version.

Vaccine Education Center at the Children's Hospital of Philadelphia
www.chop.edu/centers-programs/vaccine-education-center

-Q&A Vaccine sheets available in English and spanish

CDC Recommended Vaccine Schedule



Immunization Schedule - 0-6 years old



Immunization Schedule - 7-18 years old



Partners in Pediatrics Initial History Questionnaire

This form should be completed by a parent or legal guardian.

Patient Name

BIRTH DATE

M F

CHART NUMBER (OFFICE USE)

AGE

DATE COMPLETED

MOTHER'S NAME

AGE

OCCUPATION

FATHER'S NAME

AGE

OCCUPATION

Household

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

Name	Relationship to child	Birth date	Health problems

Do you live in a house, apartment, mobile home, or other? _____

Is your drinking water from the tap (public system) or well? _____

Are there any smokers in the household? Yes No

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

Lives with adoptive parents Joint custody Single custody

Lives with foster family Other _____

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Are there any problems with the condition of your home? (peeling paint, mold, insects, rats, or mice) Yes No

Are there any guns in the home? Yes No

Any swimming pools in the house? Yes No

Birth History

Don't know birth history

Mother's age at birth of child _____ Prenatal Care Doctor _____

How many weeks pregnant when child delivered? _____ weeks

Birth weight _____

Did mother have any illness or prenatal complications during pregnancy?

Yes No Explain _____

During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Used prenatal vitamins

What _____ When _____

Was the delivery Vaginal Cesarean If cesarean, why? _____

Did the baby have any trouble starting to breathe? Yes No

Did the baby have any trouble while in the hospital? (jaundice, infections, other?) Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

Was initial feeding Formula Breast milk How long breastfed? _____

If formula-fed, which one do/did you use? _____

General

DK = don't know

Do you consider your child to be in good health? Yes No DK

Where has your child gone for check-ups until now? _____

Date of last check-up: _____ Last dental check-up: _____

Immunizations up-to-date? Yes No DK

Has your child ever been hospitalized? Yes No

If yes, explain _____

Any serious injuries? Yes No DK

If yes, explain _____

Is your child allergic to any medications, foods, or insect bites? Yes No

If yes, explain _____

Has your child had any surgeries or procedures? Yes (List with dates) No

Are any medications taken regularly? Yes (Please list with doses) No

Review of Medical History

- ADD/ADHD
- Allergies
- Anemia
- Anxiety/Depression
- Asthma
- Autism
- Bedwetting
- Bleeding disorder
- Bronchiolitis
- Chicken pox
- Concussion
- Constipation
- Dental Decay
- Diabetes
- Diarrhea
- Eczema/Hives
- Frequent colds
- Frequent Strep or sore throat
- Fracture
- Handicaps/Disabilities
- Headaches
- Hearing problems
- Heart murmur
- Congenital heart disease
- <] \ VccX dfYgj fY
- ?]XbYmX]gYUj
- @]Yf X]gYUj/#- YdU]Hjg
- FYW/ffYbhYUf]bZ]M]cbg
- FYW/ffYbh]W]i [\
- D]Yi a cb]U
- Reflux/GERD
- G]ri fYg
- Thyroid Disorder
- Urinary Tract Infections
- Vision problems

Problems with Periods (Girls) Age of first period _____

C] \ Yf. _____

OTHER PROVIDERS: (Please list any other specialists your child sees.

Ex: physical therapy, ENT, etc)



Partners in Pediatrics, LLC
Partners with Parents for the Health of their Children



Initial History Questionnaire - Page 2

Patient Name _____

CHART NUMBER (OFFICE USE ONLY) _____

Development/Behavior

Where does the child reside during the day? _____

At what age did your child sit alone? _____

At what age did he/she walk alone? _____

Did he/she say any words by the time he/she was 1½ years old? Yes No

Does this child compare to others his or her age? Yes No

Does he/she have any trouble sleeping? Yes No

What grade is he/she in? ...SSSSSSSSSSSS

Has he/she had any trouble in school? ... M/g B/c

Does he/she get along with other children? ... M/g B/c

Does he/she have and IEP or 504 plan? ... M/g B/c

Daycare/School? _____

Check if your child has had any of the following:

nail biting bad temper speech problems

thumb sucking hyperactivity problems with discipline

bed wetting nightmares problems with toilet training

Other: _____

Adolescents:

Does your child smoke? Yes No Vape? Yes No

Use drugs? Yes No Sexually Active? Yes No

Drink alcohol? Yes No Have history of depression? Yes No

Drink caffeine? Yes No Suicide attempts? Yes No

Feeding & Nutrition

Is your child's appetite usually good? Yes No DK

Any severe colic or any feeding problems during the first year? Yes No DK

Do any foods disagree with him/her? Yes No DK

What type of milk does your child drink?

Whole 2% Soy Other _____

Breast Milk Formula (type) _____

How many ounces of milk is typically consumed in 24 hours? _____

How many ounces of juice/soda does your child drink per day? _____

Special Diet? _____

Does he/she take vitamins? Yes No DK

Has your child had any problems with growing? Yes No DK

Does your child eat non-food materials (dirt/paper, etc)? Yes No

If yes, what: _____

Do you feel your family has enough to eat? Yes No DK

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Sudden Death	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Other inherited/genetic disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____

Additional family history
