

Southside Pediatrics of Aiken, LLC

Responsibility Form

I, _____, understand that I have a responsibility to pay for medical services provided to my child by Dr. Jonathan C. Collins, Dr. John B. Tiffany, Dr. Paula A. Luther, and/or any other physician associated with Southside Pediatrics of Aiken, LLC.

I understand that I must complete all necessary paperwork before my child is seen by the physician. I also understand that it is my responsibility to inform the personnel at Southside Pediatrics of Aiken, LLC of any changes in my child's information. This information includes address, telephone number, insurance coverage and dates of eligibility, etc..

I understand that this information must be given at the time service is rendered so that the correct insurance information can be updated and the correct insurance company be billed for services rendered.

I understand that Southside Pediatrics of Aiken, LLC requires payment at the time services are rendered. This includes all co-payments, deductibles and co-insurance.

I understand that if I do not call the office to cancel my child's appointment I am aware that Southside Pediatrics of Aiken, LLC will consider excessive no show appointments a reason for termination of services provided and may result in discharge of the patient and other family members from this practice. *You will be notified by mail of this event.*

I understand that the use of profanity by myself or a member of my family will not be tolerated in this office and will result in an immediate dismissal from this practice.

I understand that if I am late for my scheduled appointment I **may** be asked to reschedule my appointment.

I accept the above conditions and request that services are provided to:

Patients Name _____ DOB _____

Signature of Parent or Responsible Party: Date: _____

Relationship to child

Witness: _____ Date: _____

Parental PRE-AUTHORIZATION for Medical Care to Children

For families who are ongoing patients of **Southside Pediatrics of Aiken, LLC** it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize: Jonathan C. Collins, M.D., John B. Tiffany, M.D., Paula A. Luther, M.D. and/or any physician associated with **Southside Pediatrics of Aiken, LLC** and its personnel to deliver medical care to my (our) child(ren) listed below: PLEASE PRINT:

Name: _____ Name: _____
DOB: _____ DOB : _____
Name: _____ Name: _____
DOB : _____ DOB : _____
Name: _____ Name: _____
DOB : _____ DOB. : _____

I (we) authorize the following people to bring my child in for treatment:

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Name: _____ Name: _____
Relationship: _____ Relationship: _____
Name: _____ Name: _____
Relationship: _____ Relationship: _____

Please try to contact me (us) regarding the health care of my (our) child(ren) at the following phone number(s):

Parent's or Legal Guardians:
Name: _____ Relationship _____
Phone (office/cellular/home): _____ / _____ / _____
Name: _____ Relationship _____
Phone (office/cellular/home): _____ / _____ / _____

Signature of person completing this form _____ Date _____

Print Name _____ Relationship of person completing this form: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with one non-parent, ect.), please explain in the space below. also include your signature, printed name, and phone number at which you may be contacted.

Southside Pediatrics of Aiken, LLC
Financial/Office Policy

The physicians at Southside Pediatrics of Aiken, LLC are dedicated to providing the best possible care for your child (ren) and we want you to completely understand our financial policies

Please read carefully:

- All Patient information forms must be completed before the physician can treat your child. It is the responsibility of the parent or Legal Guardian to provide any changes in the child's information. This also includes address, telephone number, insurance information, etc...
- You may be asked to reschedule an appointment that you are late for.
- If you do not call and cancel your child's appointment and have had several "no shows" that these excessive missed appointments may result in a discharge from this practice. If this occurs it will include all family members. *You will be notified by mail of this event.*
- Payment is due at the time services are rendered unless other arrangements have been made in advance.
- Keep in mind that **your insurance policy is basically a contract between you and your insurance company.** Southside Pediatrics of Aiken, LLC has contracted with many insurance companies to provide a service. If your insurance company does not pay the practice in a reasonable time we will have to look to you for payment. If we later receive a check from your insurer, we will refund any amount of overpayment to you.
- We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, **but you are required to pay your co-payment, deductible or percentage of the negotiated fee at the time of your visit.**
- If you are insured by a plan with which we do not have a prior arrangement with, the full charges for your child's care are due at the time of service. **It is your responsibility to contact your insurance company to find out if we are listed as a provider and to also know the terms and benefits of your policy.**
- Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non covered," you will be responsible for the charges in full. **Payment is due within 20 days upon receipt of a statement from our office. Statements are mailed out on a monthly basis.**
- We will submit a claim for our services to your insurance company for all services that the physicians at Southside Pediatrics of Aiken, LLC provide in the hospital. You are responsible for any balance due.
- Southside Pediatrics of Aiken, LLC reserves the right to forward any amount delinquent over 90 days to a collection agency for non-payment of services. If needed, please contact our office to set up a regular payment plan. We will make every effort to bill you for any balance owed and to notify you that your account will be placed for collection. **In the event this occurs, each account forwarded will be charged an additional fee of 50% of the balance due. If we are forced to assign your account to collection, we will discontinue all treatment. You will be notified by certified mail of this event.**
- All returned checks would be charged a return check fee of \$30.00 per check written.

It is our intention that this Financial Policy will eliminate any future misunderstandings between our office and you.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Parent, Legal Guardian or Responsible Party

Date

Please print the Name of the Patient

Patients Date of Birth



Southside Pediatrics of Aiken, LLC

Jonathan C. Collins, M.D., FAAP • John B. Tiffany, M.D., FAAP
Paula Luther, M.D.

Centre South Executive Park • 206 Centre South Boulevard
Aiken, South Carolina 29803 • (803) 642-9204

DRUG ALLERGIES:

Date _____

Patient's Last Name _____ First Name _____ Middle Name _____

P.O. Box _____ Street Address _____

City/State _____ Zip _____

Home Phone No. _____ Cellular No. _____

Date of Birth _____ Age _____ Male Female

Father's Name _____ Date of Birth _____
Last Name First Middle

Employer _____ Phone No. _____
(name & address)

Mother's Name _____ Date of Birth _____
Last Name First Middle

Employer _____ Phone No. _____
(name & address)

Father's SSN _____ Mother's SSN _____

Siblings' Names (brothers & sisters) and Birthdate

- (1) _____
- (2) _____
- (3) _____

Referred by _____

Child's Previous Physician: _____
(name) (address) (phone)

Nearest Relative not living with you _____ Address _____ Phone # _____

Person Responsible for Payment _____

It is the policy of this office that payment is due and payable at the time services are rendered.

CONSENT FOR TREATMENT

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicines, performance of operations and conduct of laboratory, x-ray or other diagnostic studies that may be used by the attending physician, or his nurse, or qualified designate.

Date _____ Signature _____

INSURANCE INFORMATION

PRIMARY:

Ins. Company Name _____ ID No. _____

Subscriber _____ Group No. _____

Date of Birth _____ Relationship to Patient _____ SS# if different than above _____

SECONDARY:

Ins. Company Name _____ ID No. _____

Subscriber _____ Group No. _____

Date of Birth _____ Relationship to Patient _____ SS# if different than above _____

I HEREBY AUTHORIZE THIS OFFICE TO FURNISH INFORMATION TO MY INSURANCE CARRIER CONCERNING THE PATIENT AND/OR TREATMENT. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY BILL AT THE TIME SERVICES ARE RENDERED.

DATE _____ SIGNATURE _____

Southside Pediatrics of Aiken, LLC
Initial History Questionnaire

The following information is very important to your child's health. Please take time to fully and completely fill out this important information.

Name of Child	Date of Birth	Chart#
Last well Exam:	Today's Date	

Birth History

State, Country where child was born	Pregnancy/ Delivery problems
Delivery type <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean	Any complications Explain
Was baby discharged with mother? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial feeding <input type="checkbox"/> Breast <input type="checkbox"/> Bottle
Birth weight lbs. oz.	Apgar
Length of baby's hospital stay	
During pregnancy, did mother Smoke <input type="checkbox"/> yes <input type="checkbox"/> no Drink alcohol <input type="checkbox"/> yes <input type="checkbox"/> no Use any medications/drugs <input type="checkbox"/> yes <input type="checkbox"/> no	
What?	When

Household/ who lives in the house with this child listed above

Name	Age	Relationship to child	Any health problem

Present Medications

Prescription	OTC (over the counter)

Medical History

Explain:

Allergies to Food, Environment, Animals or Medications	
Hospitalizations	
Surgeries	
Injuries/ Accidents	

Child's name _____

Family History

<input type="checkbox"/> yes <input type="checkbox"/> no Alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no Drug abuse	<input type="checkbox"/> yes <input type="checkbox"/> no Sickle Cell Disease/Trait
<input type="checkbox"/> yes <input type="checkbox"/> no Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no High blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no Thyroid problems
<input type="checkbox"/> yes <input type="checkbox"/> no Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no Epilepsy
<input type="checkbox"/> yes <input type="checkbox"/> no Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no Bed-wetting	
<input type="checkbox"/> yes <input type="checkbox"/> no Deafness	<input type="checkbox"/> yes <input type="checkbox"/> no Learning disability	
<input type="checkbox"/> yes <input type="checkbox"/> no Depression	<input type="checkbox"/> yes <input type="checkbox"/> no Obese	
<input type="checkbox"/> yes <input type="checkbox"/> no Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no Seizures	

If you answered Yes to any of the above please explain below

Social/ Cultural History

School name:	Grade:
Language spoken at home:	# family members in household:
Primary caretaker of child:	Did child repeat any grades? <input type="checkbox"/> yes <input type="checkbox"/> no

Past Medical History

Does your child have or ever had

Chickenpox <input type="checkbox"/> yes <input type="checkbox"/> no	Constipation <input type="checkbox"/> yes <input type="checkbox"/> no
Frequent ear infections <input type="checkbox"/> yes <input type="checkbox"/> no	Kidney or Bladder infections <input type="checkbox"/> yes <input type="checkbox"/> no
Problems with ears or hearing <input type="checkbox"/> yes <input type="checkbox"/> no	Frequent headaches <input type="checkbox"/> yes <input type="checkbox"/> no
Nasal allergies <input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no
Problems with eyes/vision <input type="checkbox"/> yes <input type="checkbox"/> no	Problems with hearing <input type="checkbox"/> yes <input type="checkbox"/> no
For girls (has she started menstrual periods? <input type="checkbox"/> yes <input type="checkbox"/> no	Other

Immunization History

Immunization record obtained? <input type="checkbox"/> yes <input type="checkbox"/> no	Immunization's current? <input type="checkbox"/> yes <input type="checkbox"/> no
--	--

Parent or Legal Guardian Signature

The above is true and correct to the best of my belief.

Signature of Provider who obtains /reviewed history

Date

Southside Pediatrics of Aiken, LLC
Authorization for Release of Protected Health Information

Patient's Name _____ DOB _____

I, _____, hereby authorize:
Name of Parent or Guardian

(Name of Physician, Hospital, Clinic, Etc)

(Street Address)

(City/ State/ Zip)

to release the medical records maintained on my above listed child to:

Southside Pediatrics of Aiken, LLC
206 Centre South Blvd
Aiken, SC 29803
803-642-9204
Fax 803-648-3633

Please specify the information to be released:

_____ Entire Record	_____ E.R. Treatment	_____ Prenatal/Delivery
_____ Immunization Records	_____ In-Patient Care	_____ Radiology/Ultrasound
_____ Office Visits	_____ Surgical Reports	_____ Pathology Reports
_____ Labs		

I understand that I may request to inspect or obtain a copy of my child's protected health information prior to its disclosure.

This authorization for disclosure of protected health care information is being used to carry out treatment, payment and/or health care operation of **Southside Pediatrics of Aiken, LLC**.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that **Southside Pediatrics of Aiken, LLC** will not deny treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) if I refuse to provide authorization for the requested use or disclosure.

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent anytime except to the extent that action has been taken in reference thereon.

Signature of Parent or Guardian

Relationship

Date

Witness

Permission to fax health information: In cases where health information is needed immediately, I consent to having this signed authorization and my health information faxed to **Southside Pediatrics of Aiken, LLC at (803) 648-3633**. I understand that my confidentiality can not be guaranteed by sending this information by facsimile. Please initial paragraph to consent to release of information by facsimile.
_____(Initial of parent or guardian)

Southside Pediatrics of Aiken, LLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of **Southside Pediatrics of Aiken, LLC's Notice of Privacy Practices.**

Signature of Parent or Responsible Party

Date