Eastern Shore Children's Clinic – Patient Information

Child 1 Information:

Last Name: _____ First Name:_____

Middle Name:_____ Preferred Name:_____

Date of Birth:_____ Gender (circle): Male I Female SSN:_____

Primary Language (circle): English I Spanish I French I Other:_____

Ethnicity (circle): Hispanic I Non-Hispanic I Unknown

Race (circle): American Indian/Alaskan I Asian I Black I White I Other:_____

Child 2: Name:_____ Date of Birth:_____

Child 3: Name:_____ Date of Birth:_____

Child 4: Name:_____ Date of Birth:_____

Child 5: Name:_____ Date of Birth:_____

Address:

_____

Mailing address City State Zip

_____

Physical address (if different than mailing) City State Zip

Parent/Guardian 1:

Name: _____ Date of Birth:_____

Relationship to patient: _____ Lives with patient (circle) : Yes I No

Address (if different from child):_____

Employer:_____Occupation:_____

Primary phone: (____)_____ Work phone: (____)_____

Reminder calls (circle): Primary I Work I Text Primary I Other: _____

Email:_____ Will you accept email notifications (circle): Yes I No

Parent/Guardian 2:

Name: _____ Date of Birth:_____

Relationship to patient: _____ Lives with patient (circle) : Yes I No

Address (if different from child):_____

Employer:_____Occupation:_____

Primary phone: (____)_____ Work phone: (____)_____

Reminder calls (circle): Primary I Work I Text Primary I Other: _____

Email:_____ Will you accept email notifications (circle): Yes I No

Emergency Contact: other than Parent/Guardian 1 and 2

Name:_____ Relationship:_____ Phone:_____

Pharmacy Information:

Preferred Pharmacy:_____ Location:_____

Child 1 Insurance Information:

Subscriber's Last Name:_____ First Name:_____ Middle Initial: ___

Gender (circle): M I F Date of Birth:_____ Relationship to Subscriber:_____

Insurance Company:_____ Policy # : _____ Group # :_____

Co-pay Amount: _____ Secondary Insurance (circle): Yes I No

Child 1 Birth Information:

Hospital:_____ City:_____ Obstetrician:_____

Birth Weight:_____ Birth Length: _____ Type of Feeding: _____

Birth Gestational Age: _____ Jaundice requiring treatment (circle): Yes I No

Complications of Pregnancy, Labor, or Delivery (describe): _____

_____

Child 1 Past History:

Previous Medical Problems: Please list significant past medical problems.

_____

_____

Chronic Medications: Please list the child's dose and frequency of medication.

_____

_____

Allergies: Please list any drug and/or food allergies and reaction.

_____

_____

Surgeries: Please list any past surgeries and dates.

_____

_____

Hospitalizations: Please list any past hospitalizations and dates.

_____

_____

Child 1 Social History:

Who lives in the household? _____

Does anyone in the household smoke? (circle) Yes I No If yes, (circle) Inside or Outside?

If the child is 13 or older, does the child smoke? (circle) Yes I No

Are the child's biological parents married? (circle) Yes I No If no, what is the custody arrangement?_____

Does the child attend daycare? (circle) Yes I No If yes, where?_____

Family History: Please indicate with an X the specified relatives with any of the following conditions.

Diagnosis	None	Mom	Dad	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
ADD									
Alcohol/Drug Abuse									
Anemia									
Anxiety									
Asthma									
Birth Defect (type?)									
Bleeding/Clotting Disorder									
Cancer (type?)									
Cholesterol Problem									
Depression									
Developmental Delay									
Diabetes									
Foster Care									
Heart Disease									
Stroke									
Tuberculosis									
Other									

Details from above:
Other relevant personal or family history:

Health Literacy:

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? (circle a response below)

1-Never I 2-Rarely I 3-Sometimes I 4-Often I 5-Always

Your signature: _____ Date: _____ Relationship:_____

What was the reason you chose our practice? _____

Eastern Shore Children's Clinic - PHI Patient #(s): _____

With my consent, Eastern Shore Children's Clinic may use and disclose protected health information (PHI) about me to carryout treatment, payment and health operations (TPO). Please refer to Eastern Shore Children's Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eastern Shore Children's Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to Eastern Shore Children's Clinic Privacy Officer at 150 South Ingleside St., #7 Medical Park, Fairhope, AL 36532.

With my consent, Eastern Shore Children's Clinic and/or their forwarding collection agency, may call my home or other designated location(s) and leave a message or voice mail, or in person in reference to any items that assists the practice in carrying out TPO, such as appointment reminders, insurance items, delinquent balances and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Eastern Shore Children's Clinic may mail to my home or other designated location any items that assists the practice in carrying out TPO, such as appointment cards and patient statements. I have the right to request that Eastern Shore Children's Clinic restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by agreement. By signing this form, I am consenting to Eastern Shore Children's Clinic's use and disclosure of my PHI to carry out TPO.

With my consent financial and medical information, as well as being allowed to accompany my child to the office for a physician visit will only be given to the persons below identifying themselves as one of the following:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

*******Availability of Records to Both Parents (AL ST § 30-3-154)

AL ST § 30-3-154
Unless otherwise prohibited by court order or statute, all records and information pertaining to the child, including, but not limited to medical, physiological, dental, scholastic, athletic, extracurricular, and law enforcement, shall be equally available to both parents in all types of custody arrangements.

Please be aware that ALL information will be available to BOTH parents regardless of custody arrangement unless legal documentation is presented to Eastern Shore Children's Clinic revoking all parental rights.

In signing this agreement I realize that Alabama state law considers my child an adult at age fourteen (14) regarding medical decisions. When my child reaches age fourteen (14) we must have your child sign a document giving permission for access of records.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Eastern Shore Children's Clinic may decline to provide treatment to me.

I have been made aware of the Notice of Privacy Practices for Eastern Shore Children's Clinic. I understand that I may receive a complete copy of the Notice of Privacy Practices upon request.

I have been made aware that Eastern Shore Children's Clinic provides care for patients under the age of 19. I understand that once a patient reaches the age of 19 it is the responsibility of the patient to find another healthcare provider.

_____	_____	_____
Signature of Patient/Legal Guardian	Date	Printed name of Patient/Legal Guardian
_____	_____	
Patient's Name	Date of Birth	
_____	_____	
Patient's Name	Date of Birth	
_____	_____	
Patient's Name	Date of Birth	

(Revised 02/02/19)

EASTERN SHORE CHILDREN'S CLINIC
FINANCIAL POLICY

We here at Eastern Shore Children's Clinic (ESCC) are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is expected at the time services are rendered unless other arrangements have been made in advance. I understand that I am responsible for any unpaid balance, copayments, coinsurance, deductibles and non-covered charges and unconditionally guarantee payment in full to ESCC for all treatment and services rendered to the patient. Failure to pay copayments on the service date may result in an additional fee. ESCC accepts cash, checks, debit cards, VISA, MasterCard, American Express, and Discover. There is a service charge for returned checks and we reserve the right to make your account a "cash only" account for future visits.

Patients with an outstanding balance are asked to pay their balance in full at time of receipt of their statement. We do realize that patients may have financial difficulty. Therefore, we advise you to call our Patient Account Representative, at 928-0624, extension 233, Tuesday through Friday between 9:00 a.m. and 4:00 p.m. to discuss your account.

INSURANCE

We bill participating insurance companies as a **courtesy** to you (*this includes Commercial Insurance, Group Insurance, and Medicaid*). You are expected to be familiar with what your copayment amounts are, what your yearly deductible is, what your insurance does or does not cover, etc. There are too many plans within plans for us to be able to know them all. Your employer provides numbers for you to call to ask these questions. When we check for eligibility at the time of your appointment and your insurance shows ineligible, you are responsible for the entire bill at the time of service.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Cancellations should be made no later than 1 hour prior to your scheduled appointment time. Appointments not cancelled at least 1 hour prior will be considered "no-shows". Arriving more than 15 minutes late for an appointment will also be considered a no-show. No-show appointments represent a cost to us, to you, and to other patients that could have been seen at the time set aside for you. We reserve the right to bill you $25 for each no-show. After three (3) no-shows we reserve the right to dismiss your family from our practice.

I have read and understand the ESCC Financial Policy. I agree to assign insurance benefits to ESCC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the 33% fee charged by the collection agency on the total balance owed.

Signature of Insured or Authorized Representative: _____

Printed Name of Insured or Authorized Representative: _____

Date:_____