coastalpediatrics

Dear Parents:

Welcome and thank you for choosing Coastal Pediatrics! We appreciate the opportunity to provide your child with the highest quality pediatric care. Additionally, we promise to offer superior and professional customer service. We are confident that you will find the staff courteous, friendly and willing to help in every way possible.

Our regular office hours at our Savannah location will be Monday through Friday, 9 a.m. to 5 p.m. Our Pooler location hours will be Monday through Thursday, 9 a.m. to 5 p.m., then on Friday from 9 a.m. to noon. All visits are by appointment only. We will be open on Saturdays from 9 a.m. to 11 a.m. for urgent care appointments at our Savannah location only. You must call the office to schedule these visits at 8:30 a.m. on Saturdays. Please keep in mind that **Saturday visits should be reserved for acute care problems only; ones that cannot wait until the following week**. Chronic problems or issues cannot be addressed during Saturday appointments. We provide emergency telephone coverage 24 hours a day, 7 days a week. If you call our regular office telephone number after hours, your call will be triaged by Nurse One.

While we welcome any after-hours calls about your child's health, please reserve these calls for truly urgent medical problems or questions that you feel cannot wait until normal business hours. Feel free to call during the day for any type of medical advice or questions.

Please take a moment to familiarize yourself with our office policies:

- Please call ahead to schedule your child's appointment. Unexpected walk-ins during the day cause the schedule to get behind and may delay the waiting time for other patients who have previously scheduled appointments. We will make every effort to schedule same day appointments if your child is sick. Please call before 2 p.m. to schedule a same day appointment.
- When calling to schedule your child's sick visit, please indicate to the receptionist if you have other children that also need to be evaluated so that they can be given an appointment slot.
- Please arrive fifteen minutes prior to the appointment so that paperwork can be processed and any changes made.
- If you arrive more than fifteen minutes after your scheduled appointment, you may be asked to reschedule for another day.
- If you need to cancel your appointment, kindly give our office 24 hours notice so that others may be scheduled in your child's place.

Coastal Pediatrics is using an electronic medical record (EMR) system to manage the administrative and clinical aspects of the practice. Initial documentation and registration may be slower, but ultimately the EMR will provide many benefits such as improved compliance, more thorough documentation, medical records that can be easily reviewed, and never having a "missing chart" again.

Please take a few minutes to fill out the following forms as completely and accurately as possible. Again, we appreciate the opportunity to care for your child and hope to develop a long nurturing relationship as he/she journeys through childhood. Comments and suggestions are always welcome.

Sincerely,

The Staff of Coastal Pediatrics

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Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the CDC and the AAP.
- We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism, other developmental disabilities or harm.
- We firmly believe that vaccinating children and young adults may be the single most important intervention we perform as healthcare providers, and that you can perform as parents/caregivers.

We at Coastal Pediatrics are dedicated to providing the best care that we can for our patients. To do so effectively, we feel that we must enter into a partnership based on mutual trust with the parents of our patients so that together we can achieve this goal.

We are obligated to deliver the best and safest healthcare possible for our patients and our community. We feel professionally uncomfortable caring for children who will not receive a minimal set of vaccinations. We want to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. **Should you have doubts, please discuss these with your healthcare provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Coastal Pediatrics.** Such additional visits may require additional co-pays on your part.

We strongly recommend the vaccine schedule published by the CDC. If your child is currently underimmunized, for whatever reason, we REQUIRE they receive at least two vaccines per month until they are caught up to the recommended schedule, with the only exceptions being Flu and HPV. Failure to comply will result in discharge from the practice.

We feel that by not vaccinating your child(ren), you do not trust our values, philosophies, or the science involved in providing safe and effective care. Although we respect your decision not to immunize your child(ren), we do not agree and feel you are placing your child(ren) and others at great risk. If you are unwilling to obtain the required vaccines for your child(ren) despite all of our efforts, we will, with great reluctance, send you a letter discharging your child(ren) from our care and ask you to find another healthcare provider who share your views. We do not keep a list of such providers, nor would we recommend any such physician. It is our hope that no patient is discharged from our practice due to vaccine refusal.

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,

The Staff of Coastal Pediatrics

Privacy Notice to Patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED BY COASTAL PEDIATRICS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

Effective Date: March 6, 2006

Under the HIPAA Privacy regulations, Coastal Pediatrics and all similar health care providers are required by federal law to maintain the privacy of your child's protected health information (PHI) and will abide by the terms in the Privacy Notice.

Please be advised that Coastal Pediatrics may use your child's PHI in rendering treatment to your child. For example, we are permitted to use your child's PHI in providing your child with medical care/treatment when your child visits our office or when we treat your child in a hospital or nursing facility. Under federal law, we may disclose your child's PHI to you or we can disclose your child's PHI to third parties for treatment. For example, if we refer your child to a specialist, we will forward your child's medical information to such specialists. We can disclose your child's PHI for payment purposes. For example, we will disclose your child's PHI to your insurance provider, your employer, Medicare, Medicaid, or other party responsible for providing your child with health insurance coverage in order for Coastal Pediatrics to be reimbursed for our services rendered to your child. We will also use or disclose your child's PHI when we engage in quality assurance and medical chart reviews, which are part of our health care operations. We may also disclose your child's PHI, when required by the Secretary of the U.S. Department of Health and Human Services.

Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your child's PHI without your authorization. Our practice may use or disclose your child's PHI in accordance with the specific requirements of the HIPAA rules without Coastal Pediatrics needing to obtain your authorization if the information is:

1. required by law,
2. required for public health purposes,
3. required disclosures about victims of abuse, neglect or domestic violence,
4. required by the health oversight agency for oversight activities authorized by law,
5. required in the course of any judicial or administrative proceeding,
6. required for a law enforcement purpose to a law enforcement official,
7. required by a coroner or medical examiner,
8. required by an organ procurement organization for research, and,
9. if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Coastal Pediatrics is permitted to disclose your child's PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission.

We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail or phone, our office personnel will note your request in your chart.

In the event our practice wishes to disclose your child's PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Coastal Pediatrics decided to release your child's PHI for reasons other than treatment, payment, or for our practice's operations. For example, if we desired to participate in outside research or a drug study, we would need your written authorization prior to being permitted to release your child's PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the ability to revoke such authorization at any time by sending Coastal Pediatrics a written revocation. However, if we have already released such information pursuant to your prior authorization, the revocation will be effective for all future disclosures.

Please be further advised that you have the ability to access, obtain a copy, inspect and request amendment to your child's medical information that we maintain. Additionally, if you desire, Coastal Pediatrics can provide you with an accounting of all disclosures for treatment, payment or healthcare operations and pursuant to authorization.

If you have a dispute with our practice regarding the use of your child's PHI or a disclosure by Coastal Pediatrics and believe that your child's primary rights have been violated, please contact Dr. Julie Howard, Coastal Pediatrics' Practice Manager. Please understand that Coastal Pediatrics will not retaliate against you in any way for filing a complaint.

Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your child's PHI to carry out treatment, payment or healthcare operations or disclosures by Coastal Pediatrics of your child's PHI to a family member, relative, or a close personal friend. However, we are not required by federal law to agree to your requested designation or restriction. If you request a copy of your child's PHI, you also have the ability to request that we send it to an alternative location (different address) and by alternative means. Additionally, if you have received this notice in an electronic form and you would like a paper copy, please contact Naomi Brist, Coastal Pediatrics' Privacy Contact. Coastal Pediatrics reserves the right to amend this Notice as revised. Notices will be posted in our office and provided to you upon your request.

Thank you and if you have any questions, please direct them to Dr. Julie Howard at (912) 353-7744.

PATIENT
REGISTRATION

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Patient Information *(legal first, middle and last name required)*

Last Name _____ First _____ Middle _____
Nickname _____ DOB _____ Sex: ☐ M ☐ F SS # _____ Preferred Phone # _____
Address _____ City/State/Zip _____

Parent/Legal Guardian Information *(legal first, middle and last name required)*

Mother _____
☐ Natural ☐ Adoptive ☐ Step-parent ☐ Legal Guardian
SS # _____ DOB _____
Address _____
City/State/Zip _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____

Father _____
☐ Natural ☐ Adoptive ☐ Step-parent ☐ Legal Guardian
SS # _____ DOB _____
Address _____
City/State/Zip _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____

Parents are: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sibling Information

Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____
Name _____ DOB _____ Name _____ DOB _____

Emergency Contact & Relationship _____ Phone # _____

Preauthorization to Treat Minors

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. This may include, but is not limited to, a grandparent, babysitter, or family friend. Please be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making. Please also note that the person bringing in the child is responsible for payment.

☐ I authorize Coastal Pediatrics and it's personnel to provide medical care to this child in my absence. _____ Initials

☐ I **do not** authorize Coastal Pediatrics to provide medical care in my absence. _____ Initials

Insurance Information *(you must also provide us with a copy of your current insurance card)*

Primary Insurance

Insurance Company _____
Name of Insured _____
Member ID # _____
Employer *(if applicable)* _____
Relationship to Patient _____
Group # _____ Effective Date _____

Secondary Insurance

Insurance Company _____
Name of Insured _____
Member ID # _____
Employer *(if applicable)* _____
Relationship to Patient _____
Group # _____ Effective Date _____

Authorization of Treatment and Assignment of Benefits

I have completed this form to the best of my ability and verify that the information is correct. I understand I am responsible for full payment of any and all services. I authorize the release of any medical or other information necessary to process any insurance claims. I request and authorize payment of any benefits from any insurance or medical plan, including those listed above or attached to Coastal Pediatrics.

Parent/Legal Guardian Signature _____ Date _____

Patient Eligibility Screening Record

Vaccines for Children Program

Coastal Pediatrics does not participate in the Vaccines for Children Program (VFC). If you meet the requirements of this program, you need to take your child to the local Health Department for immunizations. In order to determine eligibility, we must know if your child has insurance that pays for immunizations.

Child: _____ **Date of Birth:** _____

Last Name **First Name** **MI** **MM / DD / YYYY**

Parent/Guardian: _____

Last Name **First Name** **MI**

IMPORTANT:

It is the responsibility of the parent/guardian to find out if their insurance covers vaccinations and that the information provided is correct. The parent/guardian is ultimately responsible for the cost of vaccinations.

COMPLETE ONE BOX

INELIGIBLE FOR STATE-SUPPLIED VACCINE

☐ The child has insurance that pays for immunizations. *(Fully-insured / Private Pay)*

If the child's insurance does not pay for the immunizations, I will accept full responsibility for payment.

Parent/Guardian Signature: _____ Date: _____

ELIGIBLE FOR STATE-SUPPLIED VACCINE

This child qualifies for vaccination with state-supplied vaccine because *(check only one box)*:

☐ The child is enrolled in Medicaid/PeachCare for Kids.
☐ The child is American Indian or Alaskan Native.
☐ The child does not have health insurance or Medicaid/PeachCare for Kids (including Amerigroup/Wellcare). *(Not Insured)*
☐ The child has health insurance that does not pay for vaccines. *(Underinsured)*

I understand that it is my responsibility to take my child to our local Health Department for immunizations.

Parent/Guardian Signature: _____ Date: _____

SCREENING UPDATES

IMMUNIZATION DATE/ DATE SCREENED	PARENT/ GUARDIAN'S INITIAL	NOT ELIGIBLE	VFC ELIGIBILE* (Check only one category.)			
		INSURANCE COVERS VACCINATIONS**	MEDICAID ENROLLED/ PEACHCARE FOR KIDS	UNINSURED/ NO PRIVATE INSURANCE OR MEDICAID/ PEACHCARE	AMERICAN INDIAN OR ALASKAN NATIVE	UNDERINSURED (Insurance does not pay for vaccinations.)

*This form should be retained in the child's medical record for at least three (3) years and updated at each visit during which an immunization is provided. Further documentation of VFC eligibility is not required.

** Children with insurance that has coverage for immunizations are not eligible to receive VFC vaccines.

Your Child's Medical History

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Child's Name _____ **DOB** _____ **Date** _____

Child's Past Medical History

Has your child ever been treated or diagnosed with: *(explain)*

☐ ADD/ADHD _____
☐ Allergies (seasonal) _____
☐ Allergies (food) _____
☐ Anemia _____
☐ Asthma or reactive airway disease _____
☐ Broken bone _____
☐ Cancer _____
☐ Chicken pox _____
☐ Constipation _____
☐ Depression/anxiety _____
☐ Diabetes _____
☐ Ear infections (recurrent) _____
☐ Eczema _____
☐ Heart murmur _____
☐ Kidney disease _____
☐ Migraines _____
☐ Pneumonia _____
☐ Sickle cell disease _____
☐ Seizures _____
☐ Urinary tract infections _____
☐ Wheezing or bronchiolitis _____
☐ Other chronic medical conditions _____

_____

Has your child ever been hospitalized? ☐ No ☐ Yes

If yes, explain. _____

_____

_____

Past surgeries or procedures? ☐ No ☐ Yes

If yes, explain. _____

_____

_____

Please list any specialist your child has seen, dates and reason: _____

_____

_____

Allergies

List allergies to medicine:

_____

_____

_____

Medications

List current medications:

_____

_____

_____

Any concerns about your child's development/nutrition?

_____

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad

☐ step _____ ☐ siblings (#___) ☐ Grandparent(s)

☐ Other _____

Mom's age _____ Dad's age _____

Parents are: ☐ married ☐ unmarried ☐ divorced ☐ other

Do any household members smoke? ☐ No ☐ Yes

Family History

Do any family members have any of the following conditions?

	Family Member		
Condition	Mother	Father	Sibling(s)
ADD/ADHD	☐	☐	☐
Alcoholism	☐	☐	☐
Allergies	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Autism	☐	☐	☐
Blood disorder	☐	☐	☐
Cancer	☐	☐	☐
Depression/anxiety	☐	☐	☐
Diabetes	☐	☐	☐
Heart attack/disease	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Kidney disease	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Other issues	☐	☐	☐

Please explain all positives:

_____

_____

_____

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Financial Policy

We 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 payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. Co-payments will be collected at the time of check-in. Coastal Pediatrics accepts cash, personal check (in-state only), VISA, and MasterCard. There is a $30.00 charge for returned checks. Patients with an outstanding balance for more than 60 days must make arrangements for payment prior to scheduling an appointment. We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation you seek your child's immunizations and/ or medical care through a public health clinic or the Chatham County Health Department.

The parent/guardian that brings the child in for treatment is responsible for payment. This includes divorced parents, grandparents, babysitters, etc. There are no exceptions.

INSURANCE:
We bill participating insurance companies as a courtesy to you. Therefore, we will request a copy of your insurance card at **each** visit. Please understand that insurance is a contract between you and your carrier. Therefore, you are ultimately responsible for your bill. **You are responsible for knowing the coverage, limitations and exclusions specific to your insurance policy, *particularly concerning vaccinations and lab tests*.** If charges have been filed and we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You will be expected to contact your insurance carrier for explanation of why payment is delayed. If you need assistance paying your account, please speak to the receptionist.

MEDICAID/PEACHCARE:
Medicaid and PeachCare insurance plans (Wellcare, Amerigroup, CareSource and Peach State CMOs) are not accepted as primary nor secondary insurance.

MINOR PATIENTS:
A parent or guardian must accompany all minors before treatment can be provided.

REFUNDS:
Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE:
If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for your child. We ask that you kindly give 24 hour notice for cancellation of your appointment. Three missed appointments in a family will result in discharge from this practice. First appointments missed by new patients will not be rescheduled.

I have read and understand the Coastal Pediatrics Financial Policy. I agree to assign insurance benefits to Coastal Pediatrics 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 will be responsible for any legal and/or collection fees.

Signature of insured or authorized guardian:

_____ Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information & Receipt of Practice Privacy Policy

I hereby give my consent for Coastal Pediatrics to use and disclose protected health information (PHI) about me/my child to carry out treatment, payment and healthcare operations (TPO). Examples of such instances include, but are not restricted to: your medical insurance carrier, physicians to whom your child is referred, school health officials, etc. Coastal Pediatrics' Notice of Privacy Practices provides 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. Coastal Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A copy of the Notice of Privacy Practices may be obtained at any time by forwarding a written request to Coastal Pediatrics' privacy officer at 2 Wheeler Street, Savannah, GA 31405.

By signing this form, I acknowledge receipt of the office Notice of Privacy Practices. I also consent to allowing Coastal Pediatrics to call, email, fax or mail my home or any other alternative contact point I provide and leave a message on voice mail, in person or in writing, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, clinical care (including test results) and insurance issues. I understand that I have the right to request that Coastal Pediatrics restricts how it uses or discloses my PHI to carry out TPO. The practice does not have to agree to my requested restrictions, but if it does, it is bound by the agreement. All requests for restrictions must be submitted in writing.

By adding names to the bottom of this form, I agree that they are allowed to receive PHI in the same manner as described above (with the exception of information relating to STD, HIV/AIDS, pregnancy testing and records relating to drug, alcohol or mental health treatment, which all require an additional release).

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, Coastal Pediatrics may decline to provide treatment to me/my child.

For patients under 18 years of age:

_____ _____ _____
Patient Name Date of Birth Date

_____ _____
Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian

ADDITIONAL HIPAA APPROVED CONTACTS

_____ _____
Name/Relationship to Patient Name/Relationship to Patient

_____ _____
Name/Relationship to Patient Name/Relationship to Patient

******If the patient is over 18 years of age, they must sign for themselves.******

For patients 18 years of age and older:

_____ _____ _____
Patient Name Date of Birth Date

_____
Signature of Patient

Now that you have turned 18, you get to choose who may have access to your medical information. Remember to add your "ADDITIONAL HIPAA APPROVED CONTACTS" above. By providing your email address and phone number, we will update the primary contact information on your account.

_____ _____
Patient Email Patient Phone Number

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Authorization to Release or Request Medical Information

I, _____
Print Parents/Legal Guardian Name

_____
Relationship to Patient

Patient Name: (Only 1 per form) **Date of Birth:**

_____ _____

Authorize Coastal Pediatrics to **Release / Request** the following medical information:
(circle appropriate)

( ) All Medical Information

( ) Medical History and Physical Exam
( ) Immunization Record
( ) Lab Data
( ) X-Ray Data
( ) _____ please specify

The information requested in connection with:

( ) Further Medical Care
( ) Legal Proceedings
( ) Insurance Claims
( ) Compensation Claims
( ) _____ please specify

I understand that I may revoke this consent at any time except to the extent that action has been taken based on this authorization. I also understand this authorization shall expire, without my express revocation, 90 days from the date written below.

_____ _____
Signature of Parent/Legal Guardian Date

Release To: Coastal Pediatrics Request From: _____

_____ _____

_____ _____

Phone # (912) 353-7744 Phone # _____

Fax # _____ Fax # _____

Office Use Only

Request mailed ( ) or faxed ( ) by: _____ Date: _____