Smart Start Pediatrics	Patient's Name:
460 Alabama Hwy N	Mom's Name:
Albertville, AL 35951-3838	Dad's Name:

ALLERGIES – Please list the **patient's** drug, food, or other allergies:

☐ No known drug allergies Or, list drug allergies:
☐ No food or other allergies Or, list food/other allergies:

MEDICATIONS – Please list all of the patient's medications and supplements:

Medication Name	**Dose**	**Medication Name**	**Dose**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

PAST MEDICAL HISTORY – List the **patient's** medical conditions:

1.	5.
2.	6.
3.	7.
4.	8.

PAST SURGICAL HISTORY – List the **patient's** previous surgeries and approximate dates:

Operation	**Date**	**Operation**	**Date**
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FAMILY MEDICAL HISTORY - Please check and list relationship to patient, include **immediate family** members only:

- ☐ Lung Disease _____
- ☐ Heart Trouble _____
- ☐ Kidney or Bladder Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Cancer - Type of Cancer and Affected Family Member(s) _____
- ☐ Other Family Disease _____

BIRTH RECORDS

Birth Facility: _____

Facility City: _____ Facility State: _____

The following information MUST match birth records:

Patient Date of Birth: _____

Patient's Name (First Last): _____

Birth Mother's Name (First Last): _____

Birth Mother's Social Security Number: _____

IMMUNIZATION HISTORY

Please attach a complete shot record.

If you do not have a complete shot record, please list all facilities where the patient has received immunizations:

_____

_____

_____

_____

_____

PATIENT REGISTRATION

smart start pediatrics

Patient's Legal Name: _____
Last First Middle

Date of Birth: _____ Social Security #: _____

Address: _____
Street & Apartment # City State Zip Code

Home Phone: (_____) _____ Cell phone: (_____) _____

Email: _____

We are required to collect the following information for each patient. Please complete this section before returning the form.	
Preferred Provider:	Sex (Circle): M F
Your Preferred Language: ☐English ☐Spanish ☐Haitian/Haitian Creole ☐Other: _____	
Your Child's Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Hawaiian Native or Pacific Islander ☐Hispanic or Latino ☐White ☐Multiracial ☐Unknown ☐Decline to Answer ☐Other_____	
Your Child's Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic o Latino ☐Unknown ☐Decline to Answer ☐Other _____	

Parent/Legal Guardian: _____

Date of Birth: _____ Social Security #: _____

Address (if different): _____

Home Phone: (_____) _____ Cell phone: (_____) _____

Parent/Legal Guardian: _____

Date of Birth: _____ Social Security #: _____

Address (if different): _____

Home Phone: (_____) _____ Cell phone: (_____) _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐ Yes ☐ No Amount: _____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Social Security #: _____

Patient's Relationship to Policy Holder: _____ Copay: ☐ Yes ☐ No Amount: _____

I agree that the above information is true and correct to the best of my knowledge. I authorize Smart Start Pediatrics LLC and its personnel to treat my child and consent to all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent in writing.

_____ _____ _____
Print Name (Patient or Guardian if minor) Signature (Patient or Guardian if minor) Date

_____
Relationship to Above Patient

PATIENT REGISTRATION smart start pediatrics

Delegation of Consent for Minor Children

Please list all of your children who attend Smart Start Pediatrics below:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I, _____, authorize the following people to bring my child(ren) in for treatment and to
Print name of biological parent or legal guardian
consent to any and all medical care and attention which is deemed necessary and appropriate by a healthcare provider licensed in the state of Alabama. This consent includes, but is not limited to, medical treatment, surgical intervention, elective procedures, and emergency care. This delegation shall be valid until I withdraw my delegation of consent in writing.

Name: _____ Phone: _____ Relationship to child(ren): _____

Name: _____ Phone: _____ Relationship to child(ren): _____

Name: _____ Phone: _____ Relationship to child(ren): _____

Name: _____ Phone: _____ Relationship to child(ren): _____

Name: _____ Phone: _____ Relationship to child(ren): _____

Name: _____ Phone: _____ Relationship to child(ren): _____

Please Note: The individuals listed above are the **ONLY** people (other than biological parents or legal guardians) authorized to bring your child(ren) to the doctor.

_____ _____
Print name of biological parent or legal guardian Relationship to patient

_____ _____
Signature of biological parent or legal guardian Date

_____ _____
Witness translator/reader (if applicable)

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OFFICE INFORMATION & POLICIES

We have regular hours of operation.

We are open Monday through Friday 8 am to 5 pm. We are closed on the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, Christmas Day, and half-day on Christmas Eve. Any other closures will be posted on our Facebook page.

We are available after hours when you need us.

We understand that kids get sick at night, on weekends, and on holidays! Our pediatric triage nurse is always available when the office is closed. If the triage nurse cannot offer advice, one of our providers is always on back-up call.

We are a vaccinating practice.

Vaccines are one of the most important services we offer as a pediatric practice. We follow the schedule endorsed by the American Academy of Pediatrics and Centers for Disease Control. We understand there may be times when you have questions or are hesitant about certain vaccines and we are here to help! We will gladly answer all your questions about vaccinations. If you ultimately decide that vaccines are not right for your family, we will ask you to find a different pediatric medical home.

Well child visits are a priority and required of our patients.

We do not only want to see you when your child is sick! Well child visits are vital to maintaining the health of children. At well visits we are looking at weight, height, conducting vision, hearing and developmental screenings, which are necessary to ensure proper growth. Well child visits are required at the following ages: newborn, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years and every year annually until age 18. The **well waiting** room is for well-baby and well child check-ups only, and you should not enter that room if you or anyone with you are showing signs of illness. Failure to maintain regular well child exams may result in dismissal from the practice.

We offer same day sick appointments.

We understand that when your child is sick, you'd like for them to be seen in a timely manner. We are not a walk-in clinic, but we offer same day sick appointments during our regular office hours. Please call us to schedule a same day appointment.

Scent-Free Zone

The chemicals used in scented products can make some people sick, especially those with asthma, allergies, and other fragrance sensitivities. Please **do not** wear perfume, scented lotions, or other fragrances on days you will be visiting our office.

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We strive to be on time.

We know that life is busy and that all of us have many obligations every day. We understand the need to stay on time, and we strive to do so. On occasion there are unexpected issues that arise which cause us to run behind. Usually these are related to patient care. We will do our best to communicate with you if we are significantly behind so that you are never left wondering.

We value mutual respect.

We ask that you communicate with us if you are going to be late or need to cancel an appointment. Arriving more than 15 minutes late may result in the need to reschedule your visit. Multiple missed appointments will result in dismissal from the practice. With few exceptions, we will not reschedule patients who no-show their first appointment with our practice.

We do not tolerate verbal or physical aggression towards our staff.

All our staff is committed to providing the best possible care to your children. Any patient, parent, caregiver, etc. who yells, becomes verbally or physically aggressive, makes threats to our staff, or uses profanity will be dismissed from the practice without exception. We want our office to be a safe place for both patients and employees.

Child Custody

We will allow either parent to accompany their child to an office visit and to have equal access to their child's health information unless we are given a legal document that states otherwise.

Financial Information

- It is your responsibility to bring your current insurance card to all appointments and notify our office of any changes in insurance, address, telephone, or family status at the time of check-in.
- If you fail to provide complete and accurate insurance information on the date of service, you will be held financially responsible for services rendered that day.
- When active insurance coverage cannot be verified, you will be considered self-pay and payment will be due at the time of the appointment.
- All co-pays and deductibles are due at the time of service.
- If you are uninsured or seeking care on a (self-pay) basis for services that were scheduled 3 days in advance, you have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services.

I have received a copy of Smart Start Pediatrics office policies. I have read and understood the policies and I understand that I am financially responsible for all services and fees not covered by my insurance. I authorize the release of necessary information needed for Smart Start Pediatrics to receive payment for services.

Signature_____ Date_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

DOB: _____ / _____ / _____

I, _____, have received or been offered a copy of **Smart Start Pediatrics'** *Notice of Privacy Practices.*

Parent/Guardian Signature: _____

Relationship to Patient: _____

Date: _____ / _____ / _____

Notice of Privacy Practices

smart start pediatrics

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Smart Start Pediatrics (hereafter "SSP") may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at SSP or the hospital. For example, we may disclose medical information about you to people outside SSP who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run SSP and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other SSP personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes SSP's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other SSP personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at SSP. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by SSP, whether made by SSP personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. A request form may be obtained at the front desk. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, SSP. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. A request form may be obtained at the front desk. We may deny your request for an amendment.

Right to Request Removal from Fundraising Communications: You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan: You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which you have paid out of pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. A request form may be obtained at the front desk.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. A request form may be obtained at the front desk.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. A current copy will be available at the front desk.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with SSP or with the Secretary of the Department of Health and Human Services. To file a complaint with SSP, contact LaShea Dalton, (256) 891-0300, 460 AL Hwy 75 N, Albertville, AL 35951-3838. All complaints must be submitted in writing. A complaint form is available upon request. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.