Main Street Pediatric Clinic
1508 Cogswell Avenue
Pell City, AL 35125
205-338-7866 Fax 205-778-4318

Patient Information

Patient Full Name _____

Preferred Name _____ DOB_____ Sex_____

Primary Phone _____ Secondary Phone _____

Email Address _____

Address _____

City / State / Zip _____

Ethnicity (circle): Hispanic or Non-Hispanic Race: _____

Parent Information

Mothers First and Last Name _____ Phone Number _____

Fathers First and Last Name _____ Phone Number _____

Insurance Information

Primary Insurance Company _____ Group # _____ Policy # _____

Policy Holder's Name _____ Policy Holder's DOB _____

Secondary Insurance Company _____Group # _____ Policy # _____

Policy Holder's Name _____ Policy Holder's DOB _____

Emergency Information

Person to notify in case of emergency

_____

Relationship to patient

_____

Phone#

_____

Parent/Guardian Signature

_____

Parent/Guardian Name (Printed)

_____

Patient Medical History Form

Patient Name Age DOB

_____

Physician your child was seeing previously

_____

Medical Problems (past or present)

_____

_____

_____

List all current prescription medicines (include dosages, reason for taking it and prescribing physician

_____

_____

_____

List all over the counter medicines, vitamins, and food supplements

_____

_____

_____

Allergies to medications or food (include reaction)

_____

_____

List surgeries (include year, surgeon, and hospital)

_____

_____

Describe hospitalizations/illnesses not included above (include year, hospital)

_____

_____

List any fractures or broken bones including the location and year

_____

_____

Has your child had any of the following conditions: (please circle all that apply)?

bleeding problems	feeding problems	jaundice	asthma	anemia	
constipation	blood clots	head injury	acid reflux	colic	
Strep throat	major infractions	seizures	pneumonia	eczema	
Lactose intolerance	heart murmur	lead poisoning	seasonal allergies	chicken pox	
Mono	depression	mental illness	hearing trouble	vision trouble	

Ear infections, how many? _____ Other _____

Immunizations (check one): up to date _____ delayed _____ I have elected not to immunize my child _____

Reason for delay or for declining immunizations _____

Birth History

Pregnancy or birth complications? _____ Full term or preterm? _____ Twins? _____

Patient Medical History Form (continued)

Name of household members?

_____

List primary caregiver for your child: List of other parties that temporarily watch your child:

_____

Primary languages spoken in the home: _____ Does your child live in a smoke free home (circle): yes/no

Does your child attend (check all that apply) daycare _____ preschool_____ school_____ home school_____

Name(s) of organization attending: _____

List any sports or organized activities your child participates in_____

Approximately how many hours a day does your child spend watching TV or play on the computer _____

Does your child use (circle one): seatbelt car seat none Are there guns/firearms in the home: Y/N

Does your child ride a bicycle: Y/N If yes, does he/she wear a helmet: Y/N

Does your child wear sunscreen: Y/N Do you have a swimming pool: Y/N

Do you have a pool fence/alarm: Y/N Do you have a home security system: Y/N

Do you have any concerns about your child's diet: Y/N If yes, please explain below:

_____

Do you have any concerns about your child's weight: Y/N If yes, please explain below:

_____

Do you have any concerns with your child's school performance or ability to learn: Y/N If yes, please explain below:

_____

Do you have any concerns with your child's behavior: Y/N If yes, please explain below:

_____

Do you have any concerns about the safety of your child: Y/N If yes, please explain below:

_____

Do you have any concerns about your child's breathing : Y/N If yes, please explain below:

_____

Do you have any concerns about your child's toilet training or habits: Y/N If yes, please explain: If yes, please explain below:

_____

Family History

Please only include the child's Mother, Father, Siblings, and Grandparents
Please indicate if grandparents are maternal or paternal

HISTORY	Y/N	FAMILY MEMBER	DETAILS
Alcohol Abuse			
Allergies			
Anxiety			
Arthritis			
Asthma			
Birth Defects			
Cancer			
COPD			
Depression			
Diabetes Type 1			
Diabetes Type 2			
Drug Abuse			
Emphysema			
Genetic disorder			
Glaucoma			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Other Mental Illness			
Seizures			
Sudden Death before the age of 50			
Thyroid Disease			
Tuberculosis			

MAIN STREET PEDIATRICS

Authorization to Use and Disclose Protected Health Information

Patient's Name:_____ Date of Birth: _____-_____-_____
Address: _____
Parent/Legal Guardian Name: _____
Daytime Phone #:_____

I authorize Main Street Medical Clinic LLC to request/release my child's protected health information (PHI) from/to the listed organization below:

Person / Organization information: (TO BE FILLED OUT BY PHYSICIAN OFFICE)

Name: _____
Address: _____
City, State, Zip: _____
Phone #:_____ Fax #: _____

Specific Information Requested:

Dates of treatment: from: _____to: _____

____ History & Physical
____ Immunization Records
____ Progress Notes
____ ADHD Evaluation
____ Entire Record
____ Labs
____ Radiology Reports
____ Pathology Report
____ Allergy Records
____ Sports Physical Evaluation
____ Other, specify_____

By initialing next to a category listed below, I specifically authorize Main Street Medical to use and/or disclose my highly confidential information. **Initial each category that Main Street Medical is authorized to release.**

_____Mental Health / Psychiatric / Psychological Records
_____Alcohol and/or Drug Abuse Records
_____Information about sexually transmitted diseases
_____HIV/AIDS related testing (whether the results were positive or negative)

_____The purpose for the use/disclosure of the information is:
_____Patient/Personal Representative request
_____Physician care
_____Educational Placement/Other Educational Concerns
_____Other, specify: _____
_____Legal
_____Insurance

Unless otherwise revoked, this Authorization will expire: One (1) year from signature date

I understand that once Main Street Medical discloses my PHI to the recipient, Main Street Medical cannot guarantee that the recipient will not redisclose my PHI to a third party. The third party may not be required to abide by this Authorization or applicable federal and state Privacy law governing the use and disclosure of my PHI.

I understand that according to state and federal law I may be charged a reasonable fee by the releasing facility for the photocopying of the requested records. I understand that Main Street Medical may directly or indirectly receive remuneration from a third party in connection with the use or disclosure of my PHI.

I understand that I may refuse to sign or may revoke (at any time) this Authorization and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Main Street Medical; except, however if my treatment at Main Street Medical is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Main Street Medical may refuse to treat me if I do not sign this Authorization.

I understand that if I revoke this Authorization, I must send a written notice of revocation to the Custodian of Records at the address listed below. The revocation will be effective immediately upon Main Street Medical's receipt of my written notice. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I may contact the HIM/Custodian of Records at the address and phone/fax listed below

---

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my PHI. By my signature, I hereby, knowingly, and voluntarily authorize Main Street Medical to use or disclose my PHI in the manner described above.

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

If signed by Legal Representative, Relationship to Patient **Signature of Witness** **Date**

· Please fill out the authorization completely. If sections are blank or incomplete, we may not be able to process your request.

. When submitting your request for medical records, please enclose a copy of your Photo ID.

Drivers License ___ Work Photo ID___ SS Card ___ Other Photo ID___ Notarized signature ____ Other___

· If the records are for a patient whom you have Power of Attorney, please enclose a copy of the POA.

. If the records are for a deceased patient, please provide a copy of the Executor of Estate or Death Certificate.

Completed Authorizations and any required paperwork can be mailed to:

Main Street Medical Clinic, LLC
1508 Cogswell Avenue
Pell City, Al 35125
Phone: 205.338.7866
Fax: 205.778.4318

Consent for Treatment

Consent for Treatment- I give consent to the Main Street Medical Clinic for examination and treatment, including drugs, medicine, performance of operations, or other studies that may be done by the attending physician, nurse practitioner, medical assistant, or staff, as needed (indicated for my care.) AUTHORIZATION OF BENEFITS- I authorize Main Street Medical Clinic to furnish any medical information requested by insurance companies including Medicare with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job injury. ASSIGNMENT OF BENEFITS- I hereby authorize payment directly to Main Street Medical Clinic for benefits otherwise payable to me including major medical insurance and Medicare also payment for surgical benefits, but not to exceed the Main Street Medical Clinic charges for these services. I understand that I am financially responsible to Main Street Medical Clinic for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. GUARANTEE OF ACCOUNT - For services furnished by Main Street Medical Clinic I hereby guarantee the payment of all accounts for services rendered for me and all the family members I am responsible for. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee and court costs. ACKNOWLEDGEMENT- I have received the currently effective Notice of Privacy Practices. This also serves as a PHI document release should I request treatment be sent to other medical facilities in the future. MSMC will only call the phone numbers provided by you unless you give instructions to remove contact information from your file. No emails or text messages will be sent from our office. This consent/authorization remains in effect until revoked in writing.

I give my permission for Main Street Medical Clinic to treat my child, _____(Please Print), according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating provider.

Parent/Guardian Name (Please Print) _____

Parent/Guardian Signature_____ Date_____

Authorization for Treatment in Absence of Parent or Guardian

I, _____ (Please Print), do hereby consent and authorize Main Street Medical Clinic and its providers and staff to examine and /or treat my child in my absence. I affirm that I have Legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who had the legal right and exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and /or treatments.

I give the providers and staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. Listed below are people who can bring my child in my absence for well child and/or sick visits, as well as getting vaccines. If we are unable to contact the guardian, the people listed below are authorized to be contacted by the provider's staff.

Name	Relationship to Patient	Phone Number

Parent/Guardian Signature_____ Date_____

Disclosure of Protected Health Information

Phone Communication:

According to our office policy, lab results may be provided to the patient and/or the guardian by telephone communication.

Do we have permission to leave messages on your voicemail? Y/N

Do we have permission to discuss lab results with the following listed phone numbers? Y/N

Please provide the telephone numbers in which lab results may be provided:

Phone: _____ Phone: _____ Phone: _____

Release of Paper Documents:

If you would like to provide permission to disclose protected health information via paper documentation to include; medical records, immunizations (blue forms) and Dr's excuses, to anyone other than the guardian on file please specify below their name and relationship to your child. By signing below you provide permission to the staff of Main Street Medical to disclose your child's PHI and fully understand that this disclosure is subject to any and all medical records pertaining to your child.

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Please note that in accordance with the HIPAA guidelines and in order to assure complete confidentiality of your child's PHI, disclosure of PHI will not be provided from the staff by email, mail or fax. Release of PHI via fax is permitted only in the event your child's medical records are requested by another treating physician, and only if the proper "authorization for release of information is received". All requests for PHI information to be released upon request to the parent, guardian, or anyone listed above must be picked up from Main Street Medical, and only if the proper "authorization for release of information is received".

Patient/Guardian Signature_____ Date_____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protective health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____.

Print Patient Name _____.

Signature _____.

Relationship to Patient _____.

No Show/Missed Appointment Policy

We at Main Street Medical understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the office number 205.338.7866.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE CAREFULLY REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24-hour notice. There is a waiting list to see the clinicians at Main Street Pediatrics and whenever possible we like to fill cancellations to shorten the waiting period for other patients.
2. If less than a 24-hour cancellation is given, or you do not attend the scheduled appointment, this will be documented as a “No Show/Missed appointment.”
3. After the first “No Show/Missed Appointment”, you will receive a phone call or letter warning that you have broken the “No Show/Missed Appointment” policy agreement. We will assist you to reschedule this appointment if needed
4. If you have multiple “No Show/Missed Appointments” within a one (1) year time period, your child may be discharged from Main Street Medical.
5. You will be notified by letter if it becomes necessary to discharge your child from the care of their physician due to continuous “No Show/Missed Appointments”.

I have read and understand Main Street Medical's “No Show/Missed Appointments” Policy and understand it is my responsibility to plan appointments accordingly and notify Main Street Medical Appropriately if I have difficulty keeping my scheduled appointments.

Parent/Guardian Name _____ Date _____

Parent/Guardian Signature _____

Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care Insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of every individual requirement for each plan.

It is the responsibility of each patient to know the details of his/her insurance plan, in addition to any lapses in insurance coverage. Any changes that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that may not be covered by your plan; we may bill you directly for those charges. If current Insurance coverage cannot be verified prior to each appointment, payment for those charges will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions regarding your laboratory bill, please contact the lab or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Main Street Medical offers a discount for uninsured patients and this payment is required at the time service is rendered.

If an account is not paid in full within 80 days, a 25% collection processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a $35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds.

I hereby authorize the physician to release all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and hereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- Patient Financial Responsibility including collections
- Confidentiality and Privacy of Medical Records

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____ Date _____