TLC Pediatrics

22335 U.S. Hwy 72 East, Ste C, Athens, AL 35613

256-870-4111

Patient Information

Patient's Name________________________________ Name child goes by:__________________________

Address:____

City:______________________________ State:_____ Zip:______________

Date of Birth: ____________________ Sex: M F Preferred Language:___________________________

Cell Phone:___________________________ Home Phone:___________________________

Race: American Indian or Alaskan White Black Asian Hispanic Native Hawaiian Unknown

Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by patient

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Parent's Name:_______________________________ Second Parent's Name:_________________________

DOB:____________________ DOB:____________________

Work #:_________________ Cell#:______________ Work #:________________Cell#:______________

Email:______________________________________ Email:____________________________________

Emergency Contact:________________________________ Relationship to patient:____________________

Home #___________________________Cell #_____________________ Work #_____________________

Siblings that we see:____

Insurance Information

Primary Insurance

Policy Holder Name:__________________________

Insurance Company:__________________________

Policy #____________________________________

Group # _____________________ DOB:_________

Secondary Insurance

Policy Holder Name:______________

Insurance Company:___________________________

Policy #____________________________________

Group # _______________________DOB:_________

Signature: ____Date:_________________________

Insurance Release: I hereby authorize TLC Pediatrics to furnish the above named insurance company all the information they may Request concerning the patient's present illness or injury. I hereby assign to TLC Pediatrics all benefit for service rendered.

Pediatric or Minor Patient

I,____, parent/legal guardian/legal custodian/caretaker of

(your name)

_____________________________________, date of birth ____/____/______ give permission for my minor

(Child's name)

_____________________________________, date of birth ____/____/______ give permission for my minor

(Child's name)

_____________________________________, date of birth ____/____/______ give permission for my minor

(Child's name)

child to receive health-related services such as a physical examinations, immunizations, prescriptions, referrals, and other services as indicated. I understand that the child's medical records are strictly confidential. I hereby authorize use of these records by all persons within TLC Pediatrics office (such as physicians, nurses, and other providers) participating in the provision of my health-related services.

I release TLC Pediatrics and their health officers, employees and agents from my liability resulting from their use of this form. I hereby authorize payment of insurance benefits to the above-named clinic to release any information acquired during the examination or treatment so that the insurance benefits may be promptly and correctly filed.

Furthermore, I authorized the following individuals who are listed below (1) to sign any necessary papers on subsequent visits, (2) t read and sign the information statements required before immunizations can be administered, and (3) to advise the nurse of any conditions following previous treatments or immunizations which would prevent my child's receiving further treatments or immunizations on a subsequent visit which my be made in my absence. Information given to the persons listed below and signature made by them will have the same effect as if I had personally received the information and signed by name on any documents on behalf of my child.

Person's authorized to bring my child to TLC Pediatrics for services and sign papers on my behalf:

Name:_________________________________ Relationship to Patient:__________________________________

Name:_________________________________ Relationship to Patient:__________________________________

Name:_________________________________ Relationship to Patient:__________________________________

Name:_________________________________ Relationship to Patient:__________________________________

____ _____________________

Signature of Parent/Guardian Date

TLC Pediatrics
HIPAA FORM

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests, and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations: Your health information may be used as necessary to support the day-to-day activities and management of TLC Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION
Information about treatments: your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

INDIVIDUAL RIGHTS
You have certain rights under federal privacy standards. These include:
**The right to request restrictions on the use and disclosure of your protected health information
**The right to receive confidential communications concerning your medical condition and treatment
**The right to inspect and copy your protected health information
**The right to amend or submit corrections to your protected health information
**The right to receive an accounting of how and whom you protected health information has been disclosed
**The right to receive a printed copy of this notice

NOTE: There is a charge for copying a medical record or any part of a medical record. All fees will be pain in advance. This fee is set by the State of Alabama.

TLC PEDIATRICS DUTIES
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice

RIGHT TO REVISE PRIVACY PRACTICES
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on you next office visit. The revised policies and Practices will be applied to all protected health information that we maintain

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the privacy officer.

COMPLAINTS
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to: Privacy Officer, TLC Pediatrics, 22335 US Hwy 72 E. Ste C, Athens, AL 35613. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

CONTACT PERSON
The name and address of the person you can contact for further information concerning our privacy practice is: Privacy Officer, TLC Pediatrics, 22335 US Hwy 72 E. Ste C, Athens, AL 35613, (256) 870-4111

EFFECTIVE DATE
This Notice is effective on or after May 1st, 2020

TLC Pediatrics

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ____, have received a copy of TLC Pediatrics notice of privacy practices.

I, ____, authorize TLC Pediatrics to release any information acquired in the course of my child's examination or treatment. I also authorize any insurance payment directly to TLC Pediatrics for medical benefits. I understand any monies received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges and will be responsible for any collection fees, attorney fees, or court costs should my account become delinquent. I understand that all payments for services rendered are expected at the time of service.

____ _____________________

Signature of Parent/Guardian Date

TLC Pediatrics

New Patient Registration Form 4 of 5

Patient Eligibility Screening Record

Alabama Vaccines for Children Program

Child's Name:____ DOB:____________________

Parent/Guardian/Individual of Record Name: ____

This child qualifies for vaccinations through the VFC program (please circle on if applicable) because he/she

A. Is enrolled in Medicaid
B. Does not have Health Insurance
C. Is American Indian or Native Alaskan
D. Do Not have Medicaid (skip to EPSDT Child Health Medical Record)

Medicaid Program Release of Information

I, ________________________________, _______________________, of __________________________

Name Relationship Child's Name

A qualified participant in the Alabama Medicaid Program, hereby agree to the release of my child's records to the Alabama Medicaid Agency and to any participating contractors or subcontractors with his/her medical care and follow-up. I also agree to the release of any program records pertaining to my child.

____ _______________________

Parent/Guardian or Custodian Signature Date

____ _______________________

Witness Date

EPSDT Child Health Medical Record

I give permission for the child whose name is on this record to receive services at TLC Pediatrics. I understand that he/she will receive test, immunizations, and exams including physicals/screenings. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

________________________________ _______________________ _______________________

Signature Relationship Date

TLC Pediatrics
New Patient Registration Form 5 of 5
After Hour Calls

I,______________________________________, parent/legal guardian/legal custodian/caretaker of
(your name)
___________________________________, date of birth ____/____/______
(Child's name)
___________________________________, date of birth ____/____/______
(Child's name)
___________________________________, date of birth ____/____/______ understand that After Hour
(Child's name)

Calls are for Emergency. All After Hour Calls are subject to a $10 charge.

If you need the after hours please call, we are here for you, but do note that after hours calls are not for:

- Refill on medication
- Request an appointment
- Request Blue card

Medication will only be called in after hours on a case to case bases.

_____________________________________ ____________________
Signature of Parent/Guardian Date
……
May we leave text reminders and leave a voice mail on your phone? Sign if yes for both
_____________________________________ ____________________
Signature of Parent/Guardian Date

Preferred Pharmacy

Please list below your Main pharmacy and then if you have 2 others or mail in please list those as well.

Preferred Pharmacy:_____________________________ Road Names:___________________

2nd Pharmacy:__________________________________ Road Names:___________________

3rd Pharmacy:__________________________________ Road Names:___________________

Mail in Pharmacy:____

TLC Pediatrics

Patients Name:____________________________________Date of Birth:_________________________

Patients Name:____________________________________Date of Birth:_________________________

Patients Name:____________________________________Date of Birth:_________________________

We understand things come up. However, please respect our time as well. A simple call, text, or email could let us know you are unable to make your appointment time. If you do not contact our office prior to your appointment to reschedule you may be subject to a No Call/ No Show fee. This fee will be $30.00 each time and third time to No Show/ No Call you may be subject to being discharged as a patient.

Parent Signature:___________________________________Date:______________________________