Premier Pediatrics of Louisiana
325 W. 8th Street • DeRidder, LA 70634
Phone (337) 221-3075 • Fax (337) 221-3076
www.premierpediatricsla.net

PARENT'S ACCEPTANCE OF POLICIES

Patient Privacy Practices

By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patient Privacy Policy. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ **INITIALS**

Patients' Bill of Rights

By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patients' Bill of Rights. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ **INITIALS**

Patient Responsibilities

By signing here, I am acknowledging that I have received a copy of Premier Pediatrics of Louisiana' Patient Responsibilities. I understand that it is my responsibility to thoroughly read and understand the policy that has been given to me. By signing, I also am agreeing to read and abide by the policy as presented to me.

_____ **INITIALS**

Financial Responsibilities

I understand that I am responsible for payment of this account, and hereby assume and guarantee prompt payment of all expenses occurred. I am also aware that certain services provided may not be covered by my insurance carrier. I understand that Premier Pediatrics of Louisiana will make every effort to notify me if services are known to be non-covered, but in the event that services performed are not covered, I will be responsible for payment of these services. I further understand that payment is due at the time of service, including co-payments. I give Premier Pediatrics of Louisiana permission to bill my or my child's insurance company on my behalf, and understand that any outstanding balance after my insurance company has paid in full will be my responsibility. If my account becomes past due and has to be turned over to collections, I will be responsible for additional fees to cover agency's fees.

_____ **INITIALS**

Consent to Treat and/or Random Drug Screen

By signing here, I am consenting to treatment and/or random Drug Screens (when applicable) of myself or my dependent by the provider(s) of Premier Pediatrics of Louisiana. Also, I am consenting to use of photograph or audio record for the best possible treatment of myself or my dependent by the provider(s) of Premier Pediatrics of Louisiana. I understand that my medical information may be viewed or shared amongst the staff of Premier Pediatrics of Louisiana and that every effort will be made by Premier Pediatrics of Louisiana to protect my health information as is required by HIPAA regulations.

_____ **INITIALS**

Consent to obtain Pharmacy Records

By signing here, I am consenting to release Pharmacy Records for myself or my dependent by the provider of Premier Pediatrics of Louisiana. I understand that my medical information may be viewed or shared amongst the staff of Premier Pediatrics of Louisiana and that every effort will be made by Premier Pediatrics of Louisiana to protect my health information as is required by HIPAA regulations.

_____ **INITIALS**

Permission to Release Medical Information

By signing here, I authorize Premier Pediatrics of Louisiana to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, third-payers or their reviewing agencies. This information will be limited to that which is necessary to expedite claim processing. ***This authorization is valid for every visit to Premier Pediatrics of Louisiana until written notice revoking this authorization is provided by the patient or patient's legal representative.***

_____ **INITIALS**

_____ _____

Patient or Parent/Guardian Signature **Date**

If you are signing for the patient, please indicate your relationship to the patient here: _____

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NEW PATIENT INFORMATION

PATIENT INFORMATION

Today's Date _____/_____/_____

Last Name: _____ First Name: _____ M. I. : ____

Date of Birth: (MM/DD/YYYY) ____/____/____ Social Security #: _____-_____-_____

Sex: Male ☐ Female ☐ Age: Place of Birth:

Current Doctor: Office Phone #: ( )

School (If applicable) :

Permission to send School Excuse directly to school? YES ☐ NO ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian (First, M.I., Last): DOB: / /

Relationship to Patient: Social Security #: - -

Parent/Guardian E-Mail:

Address:

City: State: Zip:

Home Phone: ( ) Cell Phone: ( )

Permission to leave message? Home YES ☐ NO ☐ Cell YES ☐ NO ☐ E-Mail YES ☐ NO ☐

PHARMACY INFORMATION

Pharmacy Name:

Address: Phone #: ( )

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:
Policy Holder Sex: Male ☐ Female ☐	Policy Holder DOB: / /
Policy Holder SSN#: - -	Relation to Patient:
ID #:	Group #:

Secondary Insurance:	Policy Holder Name:
Policy Holder Sex: Male ☐ Female ☐	Policy Holder DOB: / /
Policy Holder SSN#: - -	Relation to Patient:
ID #:	Group #:

Patient or Parent/Guardian Signature | Relationship to Patient | Date

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INITIAL HISTORY QUESTIONNAIRE

Patient Name (First, M.I., Last) : _____ **DOB:** _____/_____/_____

Form Completed By: _____ **Date Completed:** _____/_____/_____

HOUSEHOLD

# of BROTHERS:_____ ***# of SISTERS:_____***

What is the child's living situation if not with both biological parent?

☐ Joint custody ☐ Single custody ☐ Lives with adoptive parents ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

BIRTH HISTORY ☐ Don't know birth history

Birth Weight _____

Was the baby born at term? _____ or _____ weeks

Was the delivery ☐ Vaginal ☐ C-Section
If C-Section why? _____

Were there any prenatal or neonatal complications? ☐ Yes ☐ No Explain_____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain _____

During pregnacy, did mother:

Use tobacco ☐ Yes ☐ No
Drink Alcohol ☐ Yes ☐ No
Use Drugs or Medication ☐ Yes ☐ No
What _____
Used Prenatal Vitamins ☐ Yes ☐ No
When_____

GENERAL DK= Don't Know

Does your child have ANY serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK
Explain

_____

Has your child had ANY surgery? ☐ Yes ☐ No ☐ DK Explain

_____

Has your child EVER been hospitalized? ☐ Yes ☐ No ☐ DK Explain

_____

Is your child allergic to ANY medicine or drug? ☐ Yes ☐ No ☐ DK Explain

_____

Is there any important family medical history that we should be aware of?

_____

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AUTHORIZATION TO PROVIDE MEDICAL CARE

I,_____, being the parent/guardian of _____, authorize the following list of individuals to consent for treatment of my above mentioned child. I understand that by providing the following information about the individuals, I am allowing Premier Pediatrics of Louisiana to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of my child, I may do so by requesting a new form, filling it out, and signing again. I also understand that if there is any necessary treatment that requires a major decision be made, Premier Pediatrics of Louisiana will make every effort to contact me first. However, if no contact can be made with a parent, and I have authorized the individual to consent for treatment, the individuals listed below have my permission to make decisions for my child's medical care. This authorization will be indefinite and will only expire if I fill out a new form. All individuals listed below will be required to provide at least one form of identification that must include a photograph as well as the information provided below for verification purposes. I understand that this is being done to protect my child's well-being.

The following individuals are authorized by me to consent for treatment:

Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth
Name of Individual	Relationship to Patient	Date of Birth

Signature of Parent/Guardian	Name of Parent/Guardian	Date

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____ **Phone #:** _____

Address: _____ **City, State, Zip:** _____

PLEAS **OBTAIN** INFORMATION **FROM:**	PLEASE **SEND** INFORMATION **TO:**
_____	**Premier Pediatrics of Louisiana**
Name of Provider/Clinic/Organization	*Name of Provider/Clinic/Organization*
_____	**325 W. 8th Street**
Street Address	*Street Address*
_____	**DeRidder, LA 70634**
City, *State, Zip*	*City, State, Zip*
_____ _____	**337-221-3075** **337-221-3076**
Phone *Fax*	*Phone* *Fax*

I AUTHORIZE the ***FULL MEDICAL RECORD*** to be disclosed.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. *Unless otherwise revoked, this authorization will expire in one year.*

ADDITIONAL PATIENT INFORMATION: If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Patient or Parent/Guardian Signature **Relationship to Patient**

_____ _____

Name of Patient or Parent/Guardian **Date**