**SHOALS PEDIATRIC GROUP**
**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

Patients Full Name: _____

Date of Birth: ____/____/_____

**The disclosure will be made to the following person or entity:**

SHOALS PEDIATRIC GROUP
208 ANA DRIVE
FLORENCE, AL 35630

PHONE: 256.766.3983
FAX: 256.764.1554
EMAIL: SHOALSPEDIATRICGROUP@COMCAST.NET

**The following person or entity is authorized to disclose my medical records:**

Doctor/Clinic/Hospital: _____

Address: _____

Phone and Fax Number: _____

**For the purpose of:**

At the request of the patient/parent/legal guardian
Consultation with non-healthcare providers/school nurse about child, person, or entity
Other _____

**Information to be released:**

Entire Record
History and Physical Exam
Lab Reports
Immunization Records
Consult Reports
X-Ray Reports
Other _____

**I hereby authorize the use or disclosure of information about the above named individual and I understand that:**

1. This information about me is protected under federal law.
2. I may refuse to sign the authorization.
3. I have the right to revoke this authorization in writing.
4. Any revocation will be effective only to the extent that action has not been taken in reliance of my prior authorization.
5. Unless I revoke this authorization, it will expire on the following date __/__/__, event or condition _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
6. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this disclosure and may no longer be protected under federal law.
7. Treatment or payment will not be based on my signing this authorization.
8. I will receive a copy of this authorization.

_____ _____
**Signature of Patient/Parent/Legal Guardian** **Date**

_____ _____
**Relationship to the Patient** **Signature of Witness**

# SHOALS PEDIATRIC GROUP
# 208 ANA DR FLORENCE, AL 35630
# 256.766.3983

## Patient Information

Patients Full Name: _____

Date of Birth: ____/____/_____ Sex: _____

Street Address: _____

Billing Address (if different than above): _____

## Responsible Party Information

Fathers Name: _____ Date of Birth: ____/____/____

Contact Number: _____ Employer: _____

Fathers SSN: _____

Mothers Name: _____ Date of Birth: ____/____/____

Contact Number: _____ Employer: _____

Mothers SSN: _____

Emergency Contact: _____ Contact Number: _____

## Appointment Reminders

Email: _____ Cell: _____

**FEES ARE DUE IN THE OFFICE AT THE TIME THE SERVICE IS RENDERED.**

I authorize the release of any medical information necessary to process any claim and request payment of benefits to the party who accepts assignment.

**Signed:** _____ **Date:** _____

(We) the undersigned, hereby agree to pay all amounts and charges hereafter incurred by members of my family for services by the office. (We) the undersigned agree to pay for services not covered by my insurance in full. Failure to make payment when requested is basis for legal action and undersigned agrees to pay all costs of collection including a reasonable fee and hereby waive their rights of exemptions under the law of the state of Alabama and any other state.

**Signed:** _____ **Date:** _____

I have received a copy of the "Notice of Privacy Practices" for Shoals Pediatric Group.

**Signed:** _____ **Date:** _____

# SHOALS PEDIATRIC GROUP
## PERMISSION FOR CHILDREN TO BE SEEN WITH NON-PARENT/GUARDIAN

Patients Full Name: _____

Date of Birth: ____/____/_____

Shoals Pediatric Group can no longer treat your child by telephone or in person without a biological parent or guardian present in a non-emergency situation. The only exception to this is if Shoals Pediatric Group has this form on file.

The following people have permission to bring my child to Shoals Pediatric Group to be seen and to call the triage staff of Shoals Pediatric Group to get medical information via the telephone for my child. Examples would be grandparents, babysitters, or other family members or friends that might bring the child to the doctor for you or need to call our office regarding your child or make payments for you. They have full authority to act on my behalf should authorization be necessary for testing or treatment (i.e., labs, x-rays, etc.). They may also receive financial information such as the balance on my account. I understand that if any person who is not on this list calls Shoals Pediatric Group or brings my child to Shoals Pediatric Group except in the case of an emergency, Shoals Pediatric Group will not speak with that person nor see my child in office. I understand that it is my responsibility to ask for and fill out a new form if any of the following people should be removed. I understand that I can ask that the following people not be given any financial information regarding my account and I will note this restriction beside their name below if I do not want them to receive this information.

| NAME OF NON-PARENT/GUARDIAN | RELATIONSHIP TO PATIENT |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____

Name of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Witness

**PEDIATRIC PATIENT INFORMATION SHEET**
**New Baby**

**Patient:** _____
**Last** **First** **MI**

**Date of Birth:** _____

**Race:** Native American
Asian
Black or African American
White
Hispanic
Decline to Answer
Other/ mixed-race: _____

**Language:** English
French
Chinese
Vietnamese
Spanish
Decline to Answer
Other: _____

**BIRTH HISTORY**

Birth Weight: _____ Discharge weight: _____

Gestational age: _____ Hospital: _____

Vaginal or C-section: _____ If C-section, reason (repeat, breech, emergency, etc.):
_____

Hepatitis B given in hospital? Yes No Unsure

Vitamin K shot given in hospital? Yes No Unsure

Passed hearing? Yes No Unsure

Passed heart screen? Yes No Unsure

Formula or breast-fed?

Was your child breech at any point during the third trimester? Yes No Unsure

Were you GBS positive? Yes No Unsure
If yes or unsure, were you treated with antibiotics prior to delivery? Yes No Unsure

Any complications with pregnancy and/ or delivery? _____
_____

Any medicines during pregnancy besides prenatal vitamin?
_____

# Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

# PEDIATRIC PATIENT INFORMATION SHEET

Patient_____
Last First MI

Date of Birth_____

Race: Native American
Asian
Black or African American
Native Hawaiian
White
Hispanic
Decline to Answer

Language: English
French
Chinese
Italian
Vietnamese
Spanish
Decline to Answer

## BIRTH HISTORY

Birth Weight:_____ Term Birth:_____ If No, lit weeks gestation:_____
Complications:_____

## MEDICAL HISTORY

Please CIRCLE AND EXPLAIN if your child has ever been diagnosed with any of the following conditions:

Infectious illnesses (Chickenpox/ AIDS/ HIV/ Hepatitis)_____
Frequent infections (ear infections, sinus infections, tonsillitis, strep, URI)_____
_____
Allergies (food/ seasonal/ animals/ antibiotics)_____
Respiratory condition (asthma, CF)_____
Heart condition (high blood pressure, congenital heart disease, Kawasaki)_____
Gastrointestinal condition (GERD/ constipation/ Chrons/ UC/ IBS/ liver failure)_____
_____
Urinary tract infections/ reflux_____
Kidney condition (glomerulonephritis, lupus)_____
Vision/ eye condition_____
Hearing/ ear condition_____
Skin conditions (eczema/ psoriasis)_____
Anemia or bleeding condition (sickle cell disease)_____
Neurologic condition (seizures/ migraines)_____
Mental health issue (ADHD/ depression/ bipolar/ PTSD/ anxiety)_____
Orthopedic problems_____
Endocrine problems (obesity, diabetes/ hypo/hyperthyroidism)_____
Developmental delay (autism)_____
Genetic condition (Trisomy 21, Turners)_____
Sleep problems/ snoring_____
History of personal or family violence/ abuse_____
Girls only: Has patient had her first period?_____ Age of first period if applicable:_____

Other:_____

_____

_____

**FAMILY HISTORY**

| | Father | Mother | Grandparent | Brother | Sister |
|---|---|---|---|---|---|
| Bleeding Disorder | | | | | |
| Cancer | | | | | |
| Diabetes | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| Kidney Disease | | | | | |
| Mental Illness (describe) | | | | | |
| Migraines | | | | | |
| Seizure Disorder | | | | | |
| Stroke | | | | | |
| Thyroid Disease | | | | | |
| Asthma | | | | | |

**SOCIAL HISTORY**

**Family Dynamic:** Adopted (IS CHILD AWARE? _____) Foster Care Parents Still Married

Parents Divorced: Dad with Custody Parent Deceased: Father

Joint Custody Mother

Mom with Custody

Lives with Grandparents

**Does anyone in the home smoke?** _____

**PAST SURGICAL HISTORY**

**List ALL surgeries the patient has had, with approximate dates:**

_____

_____

**PREVIOUS HOSPITALIZATIONS**

**List ALL previous hospitalizations, with approximate date and reason for hospitalization:**

_____

_____

**Medicines**

**List ALL medicines with dose and prescribing physician. Please also include daily OTC meds:**

_____

_____

# NOTICE OF PRIVACY PRACTICES

## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

# NOTICE OF PRIVACY PRACTICES

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 4.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

# NOTICE OF PRIVACY PRACTICES

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## Other Instructions for Notice

- Effective Date of this Notice:
  **September 14, 2023**
- For further information concerning our privacy practices contact:
  **Glenda Marks**
  **Shoals Pediatric Group**
  **208 Ana Drive**
  **Florence, Alabama 35630**
  **256.766.3983**