Eastman Pediatric Clinic

Date: ____________________

Patient Name: ______________________________ DOB: _____/_____/_____

Age: _____ M _____ F _____ Race: W B H O SS# _____-_____-_____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

Address: ______________________________ City: ______________________

______________________________ State: __________ Zip: __________

Mother: ______________________________ Maiden Name: ______________

Birthday: _____/_____/_____ Age: _____ SS#_____-_____-_____

Address if different from Patient: ______________________________

Place of Employment: ______________________ Phone: (_____) _____-_____

Father: ______________________________

Birthday: _____/_____/_____ Age: _____ SS#_____-_____-_____

Address if different from Patient: ______________________________

Place of Employment: ______________________ Phone: (_____) _____-_____

E-Mail: ______________________________

Nearest relative not in household: ______________________ Relation: ______________

Phone :(_____) _____-_____ Cell: (_____) _____-_____

In case of emergency: ______________________ Relation:______________

Phone: (_____) _____-_____ Cell: (_____) _____-_____

Primary Ins. Co: ______________________ Policy#: ______________

Policy Holder: ______________________ DOB: _____/_____/_____

Policy Holder Address: ______________________________

Secondary Ins.Co: ______________________ Policy#: ______________

Policy Holder: ______________________ DOB: _____/_____/_____

Medicaid#: ______________________________

Where may we get your child's shot record? ______________________________

What drug store do you use? ______________________ Phone: (_____) _____-_____

I agree to pay all co-pays and deductibles at the time of service unless prior arrangements are made. X________ (PLEASE INITIAL)

Patient Name: ____ Birthday: ______/______/________

Mother's Age: ___________________________ Father's Age: ______________________________

Is there a family history of early death before age 60? _______

If so, please explain: ____

Is there a family history of any birth defects? _______________

If so, please explain: ____

Is there a family history, up to the first cousin, of any of the following medical problems?

If so, please list the relationship to the child being seen today.

	Yes	No	Relationship
Asthma			
Eczema			
Chronic Bronchitis			
Tuberculosis			
Hay Fever			
Diabetes			
Thyroid Disease			
Liver Disease			
Kidney Disease			
Stomach Problems			
Gallstones			
Cancer			
Early Heart Disease			
Heart Murmur			
Stroke			
Rheumatic Fever			
High Blood Pressure			
Muscular Dystrophy			
Seizures			
Mental Retardation			
Mental Illness			
Anemia			
Hemophilia			
Down's Syndrome			
Alcohol/Drug Abuse			
HIV/AIDS			
Herpes			
Gonorrhea			
Syphillis			

Please list any other medical problem(s) or disease(s) that might be helpful in the treatment of myself: ____

____

THE INFORMATION LISTED ON THIS FORM IS CONFIDENTAL.

1223 Plaza Ave
PO Box 698
Eastman, GA 31023
Phone (478) 374-3814
Fax (478) 374-1478

33 S 2nd Ave
PO Box 428
McRae, GA 31055
Phone (229) 868-2020
Fax (478) 374-1478

Johnny R. Peeples, M.D.
Cynthia J. Stephenson, D.O.
Steven M. Moore, PA-C
DeanAnne D. Fordham, PA-C
Joy R. Scarborough, DNP

Assignment of Benefits and Responsibility

I hereby authorize payment directly to Eastman Pediatric Clinic of insurance benefits otherwise payable to us, but not to exceed the balance due on medical services rendered. ***I understand Eastman Pediatric Clinic files my insurance as a service to me and that I am responsible to Eastman Pediatric Clinic for any co-pays, deductibles, and services that my insurance company states is not covered under my plan.*** In the event that my child is scheduled for a well child checkup with possible lab testing, hearing and vision testing, and vaccines if due, ***I understand that it is my responsibility to know if my insurance company covers these services or part of them*** because there are so many plans to choose from and coverage benefits change often. ***I understand if I am unsure of my benefits, I need to call and check with my insurance company.***

Patient Signature: ______________________________ Date: _____/_____/_____

Treatment Authorization

I, the named patient give Eastman Pediatric Authorization to treat myself.

Print Name: ____

Patient Signature: ______________________________ Date: _____/_____/_____

Sharing of Medical Information

I voluntary give permission to share my medical information with the following parties:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I reserve the right to revoke these authorizations at any time by writing to the above named provider of service.

Patient Signature: ______________________________ Date: _____/_____/_____

Eastman Pediatric Clinic

Patient Name: ______________________________ Birthday: ______/______/______

Dear Patient,

We have on our staff, Melissa Hardison a Nurse Practitioner, Steven Moore a Physician's Assistant, and Deananne Fordham a Physician's Assistant. They have been trained and certified to treat patients in the same scope as a Physician and will be in close contact with Dr. Johnny Peeples, M.D. concerning your child's care.

You will be offered to choose to see Dr. Peeples, Melissa Hardison, Steven Moore, or Deananne Fordham as they are available. This form, if signed by you, the parent or guardian, will be your consent for you to be seen by our Nurse Practitioner or Physician's Assistants.

Also, by signing this form, you are telling us that you understand the role of a Nurse Practitioner and a Physician's Assistant. If you have any questions concerning this, please do not hesitate to ask us for more explanation.

Patient Signature: ______________________ Date:______/______/______

Please check on the line _____ if you DO **NOT** wish to see a Nurse Practitioner or a Physician's Assistant and notify the receptionist of this when making appointments in the future.

Thank you.

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print your name: ______________________ **Signature:** ______________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notices of Privacy from this patient but it could not be obtained because:

O The patient refused to sign

O Due to an emergency situation, it was not possible to obtain an acknowledgement

O We were not able to communicate with the patient.

O Other (please provide specific details)______________________

Employee Signature:______________________ Date: ______/______/______

This form does not constitute legal advice and covers only federal, not state, law.

Consent for Use / Disclosure of Health Information and Fax Waiver

Patient's Name: ______________________________ DOB_______/________/_________

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment, and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities, and health care operations. If there is not a copy of the Notice accompanying this consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this Consent Form after you signed it.

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities, and health care operations.

Signature of Patient : _________________________________ Date: _______/_______/________

Printed Name of Patient: _________________________________

Our Privacy Officer can be contacted as follows:

Johnny R. Peeples, M.D.
1223 Plaza Avenue/P.O. Box 698
Eastman, GA 31023
Phone: 478-374-3814   Fax: 478-374-1478

Fax Privacy Waiver

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve Eastman Pediatric Clinic and its Physician's of all liability. I give my consent to fax my child's records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

Patient Name: ______________________________

Patient Signature: _________________________________

Date: _______/_______/__________

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PATIENT'S RIGHTS

- The patient has the right to considerate and respectful care.
- The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis, in terms he can understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
- The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure. Except in emergencies, such information should include the specific procedure and/or treatment, the risks involved, and the probable duration of incapacitation. When alternatives exist, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures.
- The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his action.
- The patient has the right to privacy concerning his own medical-care program. Those not directly involved in his care must have the permission of the patient to be present.
- The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
- The patient has the right to expect that within its capacity this facility must make reasonable response to the request of a patient for services. A patient may be transferred to another facility only after he has received complete information concerning the needs for such a transfer, and the alternatives. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
- The patient has the right to obtain information as to any relationship of his visits to other healthcare and educational intuitions insofar as his care is concerned.
- The patient has the right to be advised if this facility proposes to perform human experimentation affecting his care (and) refuse to participate.
- The patient has the right to expect reasonable continuity of care.
- The patient has the right to examine and received an explanation of his bill regardless of the source of payment.
- The patient has the right to know what rules apply to his conduct as a patient.

PATIENT'S RESPONSIBILITIES

- To provide to the best of his ability accurate and complete healthcare information to enable the physician and staff to treat and care for him properly.
- To indicate whether he/she understands the contemplated plan of medical and nursing management and the kind of compliance expected of him/her.
- To follow the treatment plan recommended by the physician or staff.
- The patient must take responsibility for actions if he/she refuses treatment or does not comply with the plan of care and/or treatment.
- The patient or his representative individually obligates himself to pay his/her account in accordance with the regular rates and terms of his/her doctor.
- Just as the the patient has the right to considerate and respectful care from every employee of this facility, he is also expected to be considerate and cooperate with the staff. Any abusive language and threats will not be tolerated and may be subject to dismissal from this practice.

Patient Signature: ______________________ Date: ______________