PA PEDIATRIC ASSOCIATES

☐ C. Guy Castles, III, M.D.
☐ Joe B. Castles, III, M.D.
☐ Shannon W. Easterlin, CPNP

PATIENT INFORMATION (MUST BE UPDATED ANNUALLY OR WHEN CHANGES OCCUR)

Name: Last	First	M.I.	Date of Birth	M/F	SSN#

Nickname	Pharmacy	Dentist

Other Children in Household	Date of Birth	M/F	SSN#

PATIENT'S HOME ADDRESS

Street Address	City	State	Zip	County	Country

CONTACT INFORMATION

Primary Phone #	Secondary Phone #
Email Address	Email Address

MOTHER'S / GUARANTOUR INFORMATION

Name: Last	First	M.I.	Date of Birth	SSN #

Street Address	City	State	Zip	County	Country

FATHER'S / GUARANTOUR INFORMATION

Name: Last	First	M.I.	Date of Birth	SSN #

Street Address	City	State	Zip	County	Country

PRIMARY INSURANCE

Insurance Company Name	Policy #
Group #.	Effective Date
Street Address	City
State Zip	County Country
Name of Policy Holder	DOB
SSN #	Relationship to Child

SECONDARY INSURANCE

Insurance Company Name	Policy #
Group #.	Effective Date
Street Address	City
State Zip	County Country
Name of Policy Holder	DOB
SSN #	Relationship to Child

EMERGENCY CONTACT INFORMATION (PERSON OTHER THAN PARENT'S OR GUARDIAN)

Name	Relationship	Primary Phone #

Patient: _____

DOB: _____

SOCIAL HISTORY

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced If divorced, for how long: _____

Who does the patient live with: □ Mother □ Father □ Brother(s) # ____ □ Sister(s) # ____ □ Other: _____

Relationship with siblings: □ Wonderful □ Good □ Strained □ Other: _____

Childcare: □ Yes □ No □ Hours per week: ____ □ Person: _____ □ Facility: _____

Car Restraint: □ Rear Facing Car Seat □ Front Facing Care Seat □ Booster Seat □ Seat Belt □ None

What type of home: □ House □ Apartment □ Townhome □ Condo □ Duplex □ Homeless □ Shelter _____

Does home have: □ Pool □ Spa □ Other: _____

Type of heat: □ Electric □ Gas □ Wood □ Coal □ Other: _____

Type of water: □ City □ Well □ Bottle

Preferred language at home: □ English □ Spanish □ Arabic □ Hindi □ Chinese □ Japanese □ Other: _____

Are there animals at home: □ Dog(s) # ____ □ Cat(s) # ____ □ Other _____

Do any household members smoke in home: □ Yes □ No

Is violence in the home a concern: □ Yes □ No

Are there guns in the home: □ Yes □ No

Yes: Amount ____ □ In a locked safe □ Ammunition stored separately □ Unloaded for storage □ Trigger Guard

Used for: □ Protection □ Hunting □ Recreation □ Occupation

Would you like to speak with the physician regarding the patient's:

□ Alcohol Use □ Tobacco Use □ Drug Use □ Sexual Activity □ Gender Fluidity □ Aggressive Behavior

How many hours per day does the patient spend doing these activities:

Homework ____Watching TV ____Playing Video Games____

Do you have any concerns about lead exposure due to an older home, plumbing, peeling paint: □ Yes □ No

Do you have smoke detectors in your home: □ Yes □ No

Who lives with the patient:

NAME	AGE	RELATIONSHIP	BIRTH DATE

Patient: _____

DOB: _____

	Living Status	Asthma	High Blood Pressure	Heart Disease	Stroke	Heart Attack	Cancer (Type)	Colon Polyps	Depression	Other
Mother										
Father										
Siblings										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Other Family Members Information: (Please write in)										

MEDICATIONS: *Please list all prescription and nonprescription medications, vitamins, home remedies, birth control, herbs, etc..*

MEDICINE	DOSE & FREQUENCY

ALLERGIES: *List all reactions to medicines, foods, and other agents.*

ALLERGY	REACTION & SEVERITY

** If you are on 3 or more medications – please bring them with you to each appointment. **

PERSONAL MEDICAL HISTORY: Please indicate whether the patient has had any of the following medical problems.

- □ ADHD
- □ Asthma
- □ Anemia
- □ Pneumonia
- □ Diarrhea
- □ Developmental Delay
- □ Hearing Problems
- □ Heart Disease
- □ Ear Infections
- □ Convulsions/Epilepsy
- □ Constipation
- □ Rhematic Fever
- □ Vision Problems
- □ Hay Fever
- □ Other:

_____

_____

_____

HOSPITAL VISITS: Please list all prior hospitalizations and dates.

REASON	DATE

Patient: _____

DOB: _____

PREGNANCY & BIRTH

Is the patient yours by: □ Birth □ Adoption □ Stepchild □ Other: _____

Where was patient born: □ Hospital _____ □ Center _____ □ Home

Patient's birth order: □ 1st □2nd □ 3rd □ 4th Other: ____

Were there any medical problems during pregnancy: □ Yes □ No

If yes, please explain: _____

Were there are problems during labor and delivery: □ Yes □ No

If yes, please explain: _____

Were there any problems (needing oxygen, trouble breathing, jaundice (yellowness), etc.) after the patient's birth: □ Yes □ No

If yes, please explain: _____

Method of Delivery: □ Vaginal □ Caesarean □ Emergency Caesarean

Birth Weight/Length: ____lbs. ____oz. ____inches

Was your child born prematurely: □ Yes □ No If yes how early: _____

For Male Patients Only: Is your child circumcised □ Yes □ No

NUTRITION & SLEEP

Type of feeding when the patient was a newborn:

□ Formula, brand: _____ □ Breastfeeding, how long: _____

Has the patient had any feeding/dietary problems or restrictions: □ Yes □ No

If yes, please explain: _____

Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ Other, please specify: _____

Number of ounces per day: _____

Has the patient seen a dentist: □ Yes □ No If yes, date of last visit _____

How many hours a night does the patient sleep: _____

How many naps does the patient take per day and length of naps: _____

Does the patient have any sleep problems: □ Yes □ No If yes, please explain: _____

DEVELOPMENT

At what age did the patient: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Train (Daytime) _____

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themselves: □ Yes □ No

If yes, please explain: _____

Are there any area of concerns about language or speech development: □ Yes □ No

If yes, please explain: _____

Does the patient wear a helmet while riding a bike: □ Yes □ No

Do you have concerns about the patient's behavior at home or in groups with other children: □ Yes □ No

If yes, please explain: _____

For Female Patients Only: Age at first menstrual period: _____

Patient: _____

DOB: _____

SCHOOL HISTORY

Did/Does the patient attend school/preschool: □ Yes □ No

Current School: _____Current grade in school: _____

Do you have concerns with how the patient is doing in school: □ Yes □ No

Any concerns about relationships with teachers or other students: □ Yes □ No

If more than 4 years old: does your child have a best friend: □ Yes □ No

Does your child play any sports: □ Yes □ No How many times a week: _____ How long (minutes): _____

What is the patient's dominant hand: □ Left □ Right □ Ambidextrous

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/ Parent/Guardian Printed Name Phone Number

_____

Relationship To Patient

FINANCIAL POLICY

The following is important information about office procedures and guidelines including our responsibilities and yours. We hope that having access to fees, payments, and insurance information at the beginning of our relationship will eliminate confusion and misunderstandings in the future. Please do not interpret this to mean that we are only concerned about payments. We want to focus on your treatment and care. From experience we have found that discussing financial and insurance policies upfront help patients make more informed decisions about how and when to set up their treatment.

1. Patients are responsible for knowing what services are covered or not covered by their health insurance policy. For example, some insurance companies only cover one well-visit per year; it is the patient's responsibility to know the date of the last well-visit to ensure it will be covered. Please note that payment for office services is due in full on the day of service.
2. If your insurance is pending/inactive and is not a state funded insurance, you will be charged a $20.16 administration fee per vaccine at the time services are rendered. This applies to any patient 2 months or older.
3. Our physicians participate and are contracted with numerous insurance plans as a convenience to our patients. Please verify with your insurance carrier that our physician is in your plan's network. As a courtesy to our patients, our office will submit claims for all covered charges to your insurance company. All non-allowed/ non-covered insurance charges are the responsibility of the insured. Co-payments and co-insurance are due at the time of service. By not paying your co-payment or co-insurance, you may be in violation of your contract with the insurance carrier.
4. There is an additional charge to the office visit if your child is seen after normal business hours, on Saturdays, Sundays, or on Holidays.
5. Several insurance plans require patients to have prior authorization for specialist visits and procedures performed outside our office. Insurance referrals that require prior authorization are the parent's responsibility. Please notify your doctor whenever you need this service.
6. Although we realize how difficult a separation/ divorce situation may be, our office must maintain the policy that payment is due at the time services are rendered from whoever brings the child in to be seen. Billing is done as a courtesy, with a monthly statement being sent to the party that is claiming financial responsibility. We are willing to work with families as situations arise regarding payment of services, however we cannot serve as a negotiator between two parties.

Providing our patients with quality medical care is our main goal. If we can assist you in any way or if you have any questions about our policies or practice, please ask one of our staff and we will do our best to help you.

I have read and understand the office procedures and guidelines that are stated above.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/ Parent/Guardian Printed Name Phone Number

_____

Relationship With Patient

•2601 Laurel Street, Suite 250, Columbia, SC 29204 •Phone: 803.799.9044 •Fax 803.256.8119

NOTICE OF PRIVACY PRACTICES

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.

The physicians at Pediatric Associates as well as all clinical personnel, non-clinical personnel and other office employees who provide services within our practice may use and /or share your health information for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive and for any and all other purposes described in this notice.

Understanding Your Medical Record/Health Information

As your health care provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice; however the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your request for any of these actions:

- Request Restrictions: You have the right to request restrictions on the use of your information. We are not required to agree to a requested restriction. If we do, we will comply with your request unless the information is needed to provide emergency treatment.
- Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice.
- Inspect and Copy: You have a right to inspect and receive a copy of your health information. Your request will be honored within 30 days. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
- Amend: You have the right to request that we amend or correct your health information. However, we are not required to agree to the requested amendment under certain circumstances.
- Obtain an Accounting of Disclosure: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for other than treatment, payment or healthcare purposes and is within a specified period of up to six years, not to include dates before April 14, 2003. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve —month period.
- Request Communications of your Health Information: You have the right to request that you receive communications regarding your health information in a certain manner or at a certain location. We will accommodate all reasonable requests.
- Revoke Your Authorization for Disclosure: You have the right to revoke a previous authorization for disclosure of information.

Our Responsibilities

Our practice is required to:

- Confidentiality: Maintain the privacy of your health information.
- Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
- Provide alternate means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations. We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

We may use and disclose your health information for purpose of Treatment, Payment, and Health Care Operations.

Treatment: We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments, and supplies used.

Healthcare Operations: the physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

Other Permitted or Required Uses and Disclosures of your Health Information

Business Associates: There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.

Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.

Communication with Family: We will use good judgment in disclosing to a family member or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher may access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Appointments: We may call or send information to remind you of an upcoming appointment or to reschedule an appointment. When appropriate, a message will be left on your answering machine. The content of that message will be kept as generic as possible so as to protect your privacy.

Treatment Alternatives, Health related Products and Services: We may contact you about possible treatment options or alternatives, or health-related benefits and services that may be of interest to you.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose information about you when required to do so by federal, state or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such a donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate military authority.

Workers Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

All other uses and disclosures of your health information will be made only with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time except to the extent that action has been taken.

For More Information

•If you have a question or would like additional information, you may contact our privacy officer 2601 Laurel Street, Suite 250 Columbia, South Carolina 29203 or by telephone (803)799•9044.

•If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the Secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers,
- Conduct normal health care operations such as quality assessments and physician certifications.

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Pediatric Associates, P.A. I understand that the practice may change its Notice of Privacy Practices from time to time and that I may contact the practice at any time to obtain current copy.

This acknowledgement has been issued and considered effective on the signed date. We will keep this signed form on file for a minimum of six (6) years.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Patient/Parent/Guardian Printed Name Phone Number

_____
Relationship to Patient

OFFICE USE ONLY

Attempted to obtain the patient's signature on this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

DATE	REASON	INITIALS

CONSENT FOR DISCLOSING PROTECTED HEALTH INFORMATION

EMAIL: I authorize Pediatric Associates to send the following PHI.

_____ *Doctor's Excuse* _____*Immunization Record* via email.

I understand that email is not a secure method of communication and is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Pediatric Associates from any liability for submitting PHI using email upon my verbal request and this signature located on this form below. Initial ____

FAX: I authorize Pediatric Associates to fax the following PHI.

_____*Doctor's Excuse* _____*Immunization Record* to my workplace (if applicable).

I understand that this is not recommended because it increases the risk that an unauthorized person may receive or interpret my child's or children's' protected health information. I release Pediatrics Associates from any liability for submitting PHI using my work's fax number upon my verbal request and this signature located on this form below. Initial ____

SCHOOL/DAYCARE: I authorize Pediatrics Associates to disclose the following PHI.

_____*Doctor's Excuse* _____*Immunization Record* _____*Permission for Medication*

Fax: _____ Email: _____

Mail: _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS AND RECORD RELEASE

•I consent to my child's treatment and allow Pediatric Associates to use and release their protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the Pediatric Associates Notice of Privacy Practices. A copy has been made available to me.

•I understand that my child's medical information including complete medical records, test results, and billing information may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

•I allow payment to be made directly to Pediatric Associates for all medical benefits otherwise payable to me under terms of my insurance.

•I understand that I am financially responsible for paying all co-payments, co-insurance, deductibles, and noncovered services.

•A photocopy of this form shall be considered as effective and as valid as the original.

•I know it is my responsibility to keep Pediatric Associates informed about changes to any of my contact information. Failure to do so may interfere with the ability to contact me concerning my child's health care.

_____ _____

Patient/Parent/Guardian Signature | Date

_____ _____

Patient/ Parent/Guardian Printed Name | Relationship With Patient

VACCINATION POLICY

We believe that all children and young adults should receive the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics. These are based on all available medical and scientific literature, evidence, and current medical studies, that vaccines do not cause developmental disabilities or autism. We believe that thimerosal, a preservative that has been in vaccines for decades does not cause developmental disabilities or autism. However, none of the vaccines that we offer in this office contain thimerosal.

Over the past several years, some people have chosen not to vaccinate their children or rather to vaccinate on alternative vaccine schedules. Unfortunately, some of these decisions were made based on one flawed study that was later formally retracted, in which it was suggested that the MMR vaccine caused autism. As a result, there have been outbreaks of all these preventable illnesses, leading to deaths and disabilities from complications of these diseases which should have never occurred.

Vaccinating children and young adults is one of the single most important preventative intervention we perform as health care professionals. The recommended vaccines and their schedule are the results of many years of scientific study and data-gathering on millions of children by thousands of our brightest scientists and physicians.

Not vaccinating your child puts your child and others in unnecessary risk for life threatening illnesses and disabilities. Not vaccinating places other children at risk that are too young or too sick to be vaccinated. Counting on others being vaccinated to protect those that are unvaccinated is not advised. Vaccines work best when each person in a community commits to preventing spread of communicable diseases.

We welcome and encourage discussing vaccines regarding your child. As medical professionals, we use evidence based in medicine, and believe very strongly that you vaccinate your child on the recommended vaccination schedule. Should you choose not to vaccinate as recommended or on an alternate schedule, you will still be provided with the vaccine information and will be required to sign a vaccine declination for at each visit in which vaccines are scheduled.

You are your child's advocate and you must do what you feel is best for your child and family. We want to respect your convictions just as we want ours respected, with that we will ask you to find an alternate practice if you completely decline to immunize your child.

Parental/Guardian Statement

I have read and fully understand the Pediatric Associates Vaccination Policy. I understand that failing to immunize my child according to this policy is a voluntary termination of the provider-patient relationship on my part and will result in my child having to transfer to another practice.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/ Parent/Guardian Printed Name Phone Number

_____

Relationship To Patient