Chart #

SUMMERVILLE PEDIATRICS, P.A.

312 Midland Parkway
Summerville, SC 29485

PATIENT INFORMATION SHEET

DATE _____

Patient's Name _____
First Middle Last (Jr, II, III, etc.)

Date of Birth _____ Sex _____ Race _____ Ethnicity _____

SS# _____ Home Phone _____

Mailing Address _____ Marital Status _____

City _____ State _____ Zip _____ School/Daycare _____

EMERGENCY CONTACT NAME & HOME PHONE _____
(Please do not use parents)

Father/Guardian _____ Date of Birth _____

SS# _____ Drivers License # _____ Marital Status _____

Address if different from above _____
Street City State Zip

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employer _____ Address _____

Mother/Guardian _____ (_____) Date of Birth _____
Mother's Maiden Name

SS# _____ Drivers License # _____ Marital Status _____

Address if different from above _____
Street City State Zip

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employer _____ Address _____

OTHER CHILDREN WHO ARE CURRENTLY PATIENTS WITH OUR PRACTICE _____

E-mail Address _____

Whom may we thank for referring you to our office? _____

By signing below I authorize the release of any medical information to any specialist that may request it on my child's behalf. I also authorize the release of any medical information to process insurance claims. I understand that I am financially responsible for any balance not covered by my insurance, and that my co-payment is due at the time service is rendered. I authorize payment of medical benefits to the provider for services rendered at each office visit.

Signed _____ Date _____

PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

PLEASE FILL OUT COMPLETELY.
(Please do not write "SAME AS BEFORE".
Previous Info Sheets will be destroyed.)
Insurance regulations require yearly updates.

Internal Use Only

Account #	Initial	Insurance

WE WILL BE UNABLE TO FILE YOUR INSURANCE IF FORM IS NOT FILLED OUT COMPLETELY.

_____
Chart #

Patient Name _____ **Date** _____

PATIENT INSURANCE COVERAGE

SELF PAY ☐

MEDICAID

Child's Medicaid # _____ Medicaid HMO Plan _____

PRIMARY INSURANCE

Patient's Insurance _____ Policy ID# _____ Group #_____

Policyholder's Name _____ Policyholder's Date of Birth _____

Policyholder's Social Security # _____ Relationship to Patient _____

Policyholder's Address _____

Policyholder's Phone #_____ Policyholder's Employer _____

SECONDARY INSURANCE

Patient's Insurance _____ Policy ID# _____ Group #_____

Policyholder's Name _____ Policyholder's Date of Birth _____

Policyholder's Social Security # _____ Relationship to Patient _____

Policyholder's Address _____

Policyholder's Phone #_____ Policyholder's Employer _____

THIRD INSURANCE

Patient's Insurance _____ Policy ID# _____ Group #_____

Policyholder's Name _____ Policyholder's Date of Birth _____

Policyholder's Social Security # _____ Relationship to Patient _____

Policyholder's Address _____

Policyholder's Phone #_____ Policyholder's Employer _____

Internal Use Only

Account #	Insurance	Date
_____	_____	_____

Acknowledgement of
Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices (NPP) for Summerville Pediatrics, P.A. I have had the opportunity to ask questions and discuss its content with the Contact Person as outlined in the NPP. I understand my rights as a patient and how Summerville Pediatrics, P.A. may us my personal information.

_____

Signature of Patient (if over 18 years old) or Personal Representative

_____

Printed Name of Patient

_____

Personal Representative's Relationship to Patient

Date: _____

Patient information may be given/released to the following:

- ☐ Mother
- ☐ Father
- ☐ Grandparent/family member
- ☐ Guardian (with proof of guardianship)
- ☐ School/Daycare (i.e.excuses, shot records)
- ☐ Information left on Answering Machine
- ☐ Mailed to home
- ☐ Other (please list):

_____

_____

Please list specific people who are allowed to bring patient in for treatment and/or sign for immunizations:

_____

_____

_____

Box for Office Use Only

_____

_____

_____

_____

_____

SUMMERVILLE PEDIATRICS, P.A.

Consent to the Use of Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, SUMMERVILLE PEDIATRICS, PA, originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among any health professionals who contribute to my care
- A source of information for applying my diagnosis and services information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a summary of Summerville Pediatrics' Notice of Privacy Practices. I know that I can request a copy of the full Notice, which provides a more complete description of how my information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I am aware that this practice reserves the right to change their notice and that the new notice will be available upon my next visit or will be mailed to me if there is a need to disclose my information prior to my return to the practice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that this practice is not required to agree to the restrictions requested. I also understand that Summerville Pediatrics may condition my treatment upon my consent. I understand that I may revoke this consent in writing, except to the extent that this practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

_____ _____

Patient's Name (Minor) Date

_____ _____

Signature of Patient or Legal Representative Relationship to Patient

Summerville Pediatrics, P.A.
Mark J. McCall M.D.

OFFICE AND FINANCIAL POLICY

Initial Visit/Subsequent Visits: We request payment at the time services are rendered. Payment can be made with cash, check, Visa, MasterCard, Discover Card, or American Express. If we are a designated provider for your insurance company, we will request the appropriate deductible and co-payment at the time services are rendered. We will gladly credit your account or reimburse you for any insurance submitted by you and paid to us. Please remember, the insurance coverage is an agreement between the carrier and the patient and you are responsible for the account and services rendered. Please be prepared to pay at each visit, or discuss this with our receptionist before coming in for your appointment. **Please provide correct insurance information within 60 days of the date of service, or you will be responsible of filing your own claim**. Incorrect information causes claim denials. You may be held responsible for unpaid claims due to untimely filing.

Service Charges and Collections: A $25.00 service charge will be added to your account for any checks returned by the bank due to insufficient or unavailable funds. Monthly statements are sent out on accounts with any unpaid balances. An appropriate amount of time is given to pay outstanding balances before further action is taken. **Once an account is sent to a collection agency for non-payment, you will be asked to seek medical care from another physician**. A fee of 30% of the balance submitted to our collection agency will be charged to your account once we have turned your account over to them.

Appointments/No Shows: Please give us 24-hours notice if you are unable to keep your appointment. This allows us sufficient time to accommodate the needs of other patients. As a courtesy to you, we will try to call to remind you of the appointment. Patients who do not show up will be called and notified of missed appointments. **If an excessive number of visits are missed without canceling, we reserve the right to ask you to seek care elsewhere. If you are 20 minutes late for your appointment, you may be asked to reschedule.**

Emergency Hours/Walk-In Fees: A fee of $87.00 will be charged if you fail to call in advance for an appointment. We will bill this fee to your insurance company. An extra fee of $51.00 is also applied to Saturday, Sunday, and Holiday visits.

Our staff is always available to answer any questions you may have concerning our policies. An open communication line should always be kept between the patient's family and our office in order to avoid any misunderstandings.

_____ _____

Responsible Party's Signature Date

Child's Name_____DOB_____Chart #_____

Patient Questionnaire

To be filled out by parent or guardian. Please circle any answers that apply or fill in the blank if needed.

Past Medical History

Birth History

Circle: Vaginal or Cesarean

Premature/ Full term: _____Weeks_____days

Weight: _____lbs._____oz. Length: _____in.

Hearing Screen: Pass or Fail

Hepatitis B given at hospital? (Please provide a copy for record) Date:_____

Jaundice: Yes or No

Any complications at birth? _____

_____

If child is a multiple (twin or triplet) circle order: A B C

Unknown: Adopted

Current Medications

List any medications (doses and strength, if known) the child takes daily:_____

_____

_____

Allergies

List any medication, food, insect, or vaccine allergies your child has had and the reaction: _____

_____

_____

Frequent Illnesses

Circle any that apply, such as: asthma ear infections wheezing strep eczema

List any others:_____

Development or behavioral problems

List any that apply:_____

Major Injuries/ Hospitalizations/ Surgeries

List the date and reason: _____

_____

_____

Social History

Circle: Home care Daycare School

Second hand smoke exposure: Yes or No

Does child use any of the following (15 years and up): Smoke Drugs Alcohol

Sexually active (15 years and up): Yes or No

Family History

Please list any that apply and tell us who has it in relation to the child: high blood pressure, high cholesterol, thyroid issues, heart problems, psych disorders, diabetes, allergies, cancer, etc.

_____

_____

_____

_____

SUMMERVILLE PEDIATRICS, P.A.

Consent to send immunization information to South Carolina Registry.

I understand that when Summerville Pediatrics, P.A. administers vaccines the vaccine information is entered into the electronic medical records and all vaccine information is transferred to the South Carolina State Registry.

Please check the appropriate boxes.

Protection:

☐ Yes, my child's name, DOB, phone number, and address may be transmitted to the South Carolina State Registry with their immunizations. (This will allow DHEC or other doctor's in South Carolina to see your child's immunization status if you move.)

☐ No, do not send any of my child's information to the South Carolina State Registry with their immunizations. (If you check this box, your child's immunization will be sent using their account number in our office only. The registry will contact us if we need to relay any important information to you.)

Publicity Code:

☐ Yes, the South Carolina State Registry may contact me if any vaccines my child has received have been recalled or if my child has not received any vaccines for an extended period of time.

☐ No, the South Carolina State Registry may not contact me for any reason.

_____ _____

Patient's Name (Minor) Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient