TUSCALOOSA PEDIATRICS

4880 HARKEY LANE,
TUSCALOOSA, AL 35406
PHONE: 205-333-8222
FAX: 205-333-8233

Dear Expecting Parents,

Congratulations on your pregnancy! We are honored that you have chosen Tuscaloosa Pediatrics to provide medical care for your child. We look forward to getting to know your family over the first 18 years of your child's life.

In order to provide the best care possible for your new baby, we request that you fill out this new patient packet and **return to our office at least two months before your baby is due.** That way we will have all the needed information to schedule your baby's first appointment with his or her pediatrician as soon as they are born. Please **indicate your first and second choice pediatricians** on the demographic form. We will make every attempt to make sure your child is scheduled with one of these physicians for all of their checkups. We ideally try to keep you with the same physician each time but in the event that particular physician is unavailable, we will try to schedule you with your second choice. If you desire to change at any point and begin using a physician you did not originally schedule as a first or second choice, please let our front office know. If you prefer to see a particular pediatrician for sick visits, we recommend you call and make an appointment rather than come to walk-in clinic as the physician seeing patients during walk-in hours varies from day to day.

If you are delivering at DCH Regional Medical Center, your baby will be seen by one of our pediatricians within 24 hours of birth. Please be sure and let them know your baby is a patient of Tuscaloosa Pediatrics when you arrive to the hospital. If you deliver on the weekend, it is possible you may be seen by one of the other pediatricians in town who share call with us. If you are delivering at Northport DCH or at a hospital in Birmingham, your baby will be seen by a hospitalist pediatrician. Please let them know you will be a patient of Tuscaloosa Pediatrics so they can send us all the necessary records. Please call us on the day you are getting discharged to schedule your baby's first checkup. Also, don't forget to call and have your baby added to your insurance policy after they are born.

All babies will need a weight and jaundice check within 1-3 days after discharge from the nursery. Your baby will be scheduled for a visit at our office with our lactation consultant and/or one of our physicians to make sure they are doing well and answer any questions you may have. Our lactation consultant, Vickie Lyle, RN, IBCLC, is available for prenatal consults as well as for any issues that may arise with nursing after your baby arrives. You are always welcome to call and schedule a visit with Vickie for any concerns.

Again, we are so happy you have chosen Tuscaloosa Pediatrics as your baby's medical home. Please feel free to contact us with any questions.

Sincerely,

The Physicians and Staff of Tuscaloosa Pediatrics

*****PLEASE RETURN THIS PACKET AT LEAST 2 MONTHS BEFORE YOUR BABY'S DUE DATE*****

****It is not necessary to have the baby's full name, social security number, or date of birth at the time you turn in the packet as we are aware you may not have all this information yet.**

Tuscaloosa Pediatrics, P.C.

___ Denise Brown, M.D.
___ Allison Cunningham, M.D.
___ Megan McGiffert, M.D.

Select 1st & 2nd Choice Physician

___ Michelle Parchman, M.D.
___ Kaila Sullivan, CRNP
___ Julie Vaughn, M.D.

Account #: _____ Date: _____

Name you prefer we call your child: _____ Social Security #: _____

Last: _____ First: _____ Middle Name: _____

Date of Birth: _____ Sex: Male_____ Female_____

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling: _____ DOB_____ Sibling: _____ DOB_____

Sibling: _____ DOB_____ Sibling: _____ DOB_____

Ethnic Group: Hispanic Non Hispanic **Race:** Asian Black White Other_____

Language: Arabic English German Korean Spanish Other_____

Select one for Appointment Reminders: Text#: _____ **Phone#:** _____

Email: _____

Mother Stepmother Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
Home Number: (_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Social Security #: _____
Driver License/St.: _____
Marital Status: _____

Father Stepfather Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
Home Number:(_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Social Security #: _____
Driver License/St: _____
Marital Status: _____

Emergency Contact (other than parent): _____ Phone#: _____

Patient's cell phone number if age 14 years or older. (State of AL Age of Consent is 14)_____

Primary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Does your insurance require a Primary Care Doctor or any type of Physician Referral?_____
Does your insurance require you to use a specific lab or x-ray facility? ___ If so, which one?_____

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, Alabama 35406
Phone 205-333-8222
Fax 205-333-8233

Consent to Receive Cell Phone Calls or Text Messages

As a service to our clients we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone you consent to receive such calls or text messages on your cell phone. If you do not want to be contacted in the above manner, please do not provide your cell phone number when you complete the Demographics information.

Parent/Patient Signature: _____

Date: _____

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

HIPAA Authorization Statement

(Please complete the following so we may contact you properly & securely)

Please list the family members or to the persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment, and healthcare operations).

Name _____

Phone # _____

Name _____

Phone # _____

Please list the family member or significant others, if any, whom we may inform about you r child's medical condition ONLY IN CASE OF EMERGENCY.

Name _____

Phone # _____

Name _____

Phone # _____

If you would like your billing statement and/or correspondence from our office to be sent to an address other than you home, please list below.

Name _____

Address _____

Please list the telephone number(s) you would like to be contacted at for appointment, lab, and x-ray results or other health care information if other than your home telephone number. (Please be aware that a cell phone is not a secure and private line).

Telephone #_____ Telephone #_____

Can confidential messages be left on your telephone answering machine? YES / NO

_____

Paticnts Name (Please Print)

_____

Signature (Parent/Guardian if under 18 years of age)

Tuscaloosa Pediatrics Vaccine Policy

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of the vaccines we provide.

We firmly believe that all children and adolescents should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all the available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in only a very few vaccines now, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and adolescents may be the most important health-promoting intervention we provide to your child as their pediatrician. The recommended vaccines and the schedule by which they are given are the results of years and years of scientific study and data gathered on millions of children around the world by thousands of our brightest scientists and physicians.

This being said, we recognize that there has always been and will likely continue to be controversy surrounding vaccination. The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that many people do not understand the severity of the illnesses we are trying to prevent. Because of vaccines, many people have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. Less than a century ago these illnesses were commonplace and they caused the majority of early infant and childhood deaths. The success of vaccines has led our generation to complacency about vaccinating which can have tragic results.

Over the past two decades, many people in Europe chose not to vaccinate their children with the MMR vaccine due to a fraudulent study suggesting a link between the MMR vaccine and Autism Spectrum Disorder. This resulted in multiple outbreaks of measles in Europe. The results of this study have since been proven false multiple times by numerous follow-up studies. But these outbreaks still occur and they are not without complications including permanent neurologic deficits and several deaths. There is a fatal, progressive disorder called Subacute Sclerosing Panencephalitis that only occurs 7-10 years after a natural measles infection so consequences may be still to come from these outbreaks.

While Europe and these disease outbreaks may seem a long distance from us in the United States, they are really only a plane ride away. We have had our own outbreaks of measles, mumps, Hemophilus Influenza B meningitis, meningococcal meningitis, and whooping cough in the U.S. in the past few years. These cases have mainly occurred in unvaccinated babies, children, and even adults.

We are making sure you are aware of these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the decision to vaccinate your child may be a very emotional one for some parents. Should you have doubts, please discuss them with us. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time goes against expert recommendations, and it can put your child at risk for serious illness or death. This goes against our medical advice as physicians at Tuscaloosa Pediatrics.

Should you absolutely refuse to vaccinate your child, you will be asked to find another health care provider who shares your views.

We appreciate the trust you have put in us to care for your children. Thank you for reading this policy. Should you have any questions we will be happy to discuss them during your office visit. We have several handouts available regarding vaccines and the diseases they prevent. We also have links to reliable vaccine information sites on our website www.tuscaloosapeds.com and we encourage you to look closely at those.

Thank you,
The Physicians of Tuscaloosa Pediatrics

I, _____, have read the above Tuscaloosa Pediatrics Vaccine Policy and I plan to vaccinate my child according to the recommended vaccination schedule from the American Academy of Pediatrics and the Centers for Disease Control.

_____	_____	_____
Signature	Relationship to Patient	Date

Tuscaloosa Pediatrics Financial and Office Policies

Please be aware if you are a new patient and fail to show up for your 1st appointment without giving a 24 hour notice, you may be asked to find another medical office or physician for medical care.

Please be aware our office does not accept all insurances. You may be asked to transfer out of the practice if you change to an insurance we do not accept, change to a plan we are no longer participating with, or our enrollment for your insurance is full at that time.

All professional services rendered by Tuscaloosa Pediatrics, P.C. are charged to the patient. We will gladly file your insurance for you. However, the parent or guardian is responsible for all fees that are not covered by the insurance.

We are required to report visits outside of normal business hours to your insurance provider. Any appointment scheduled before 8am, after 5pm, and on Saturday or Sunday will incur an additional fee. This fee will be billed to your insurance provider, but may be applied to your copay, coinsurance, or annual deductible.

Payment is due at time services are rendered (such as co-pays, deductibles and non covered services) regardless of who brings the patient in for his/her visit. There will be a $10.00 administrative fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover.

No well visits or immunizations will be given if you have an outstanding account balance.

It is the patient's responsibility to know your insurance benefits and whether the physicians in this practice are preferred providers. Some insurance companies require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours if you are seeing or have seen another physician. Don't assume that referrals are done if you don't speak to someone in our insurance office, even if our physicians or nursing staff refer you.

We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance, for a life-threatening emergency or we instruct you to go because we are unable to schedule an appointment here in a timely manner.

Most insurance companies allow 30-45 days for you to add your newborn to your insurance policy. We require you to pay for the visit in full for the 2 month check-up if we cannot verify your baby's enrollment before the visit.

We must have a release signed by a parent or guardian on file to release medical records. We request your account be paid in full in order to release your medical records if you are transferring your child/children to another physician. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

There is a fee and a 72 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

There is a $10.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

There will be a $40.00 No Show/Cancellation fee for failure to cancel your Well Check-up appointment 24 hours prior to the scheduled appointment time and 4 hours prior to sick or recheck appointment time. You could be asked to find another physician for repeat offences.

There is a $25.00 fee on all returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscaloosa Pediatrics, P.C. has provided my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand the collection agency charges Tuscaloosa Pediatrics a 33 1/3% fee in an effort to collect outstanding balances. This fee will be added to my bill and become my responsibility. I also understand there will be a $10.00 fee added to my bill for any notification sent to me by certified mail.

I hereby authorize Drs. Brown, Cunningham, McGiffert, Parchman, Vaughn and Kaila Sullivan, CRNP to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for the medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Communications Regarding My Account
Until my account is finally settled, I give my direct consent to receive communications regarding my account from any servicers and any collectors of my account, through various means such as 1) any cell or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Patient Name	Patient Date of Birth	
Signature	Relationship	Date

UPDATED: 5/4/2020

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

Receipt of Privacy Practices Written Acknowledgement Form

I, _____ as parent or legal guardian of

_____ have received a copy of the Notice of Privacy
(Name of Child)

Practices Form from Tuscaloosa Pediatrics, P.C.

Signature of Parent or Guardian: _____ Date: _____

FAMILY HISTORY

Date form completed: _____

Is your child adopted? YES NO

Please list medical history for biological relatives:

	Name	**Age**	**Medical Problems**
Mother			
Father			
Siblings			

Have any family members had the following? If YES then list what relative and any known details.

Deafness YES NO _____

Allergies YES NO _____

Asthma YES NO _____

Tuberculosis YES NO _____

Heart Disease (under 50 years old) YES NO _____

High Blood Pressure (under 50 years old) YES NO _____

High Cholesterol YES NO _____

Anemia YES NO _____

Bleeding Disorder YES NO _____

Liver Disease YES NO _____

Diabetes (specify type 1 or 2, age of onset) YES NO _____

Seizures or Epilepsy YES NO _____

Febrile (Fever) Seizures YES NO _____

Alcohol or Drug Abuse YES NO _____

Mental Illness (depression, anxiety, OCD, schizophrenia, bipolar disorder, etc.) YES NO

_____

ADHD or Learning Disorders YES NO _____

Autism Spectrum Disorder YES NO _____

Mental Retardation YES NO _____

Immune System Disorders (AIDS, etc.) YES NO _____

Thyroid Problems YES NO _____

Gastrointestinal Problems (Reflux, Irritable Bowel Syndrome, Crohn's Disease, Ulcerative Colitis, etc.) YES NO

_____

Migraine Headaches YES NO _____

Cancer (type, age at diagnosis if known) YES NO _____

Blood Clots YES NO _____

Arthritis (age of onset if known) YES NO _____

Lupus YES NO _____

Fever Blisters/Cold Sores YES NO _____

Kidney Disease (including kidney reflux) YES NO _____

Skin Problems (Eczema, Psoriasis, etc.) YES NO _____

Blindness/Vision Problems YES NO _____

Any other medical problems in the family that you feel we need to know about?

_____

_____

_____

_____

_____

_____

_____