Eastside Pediatrics, PA

Patient Restrictions Form

Patient Name:_____

- ☐ No restrictions needed: Ok to leave messages with information/ send mail.
- ☐ Restrictions: Speak with Patient/ Legal Guardian Only.
- ☐ Special Restrictions:

_____
_____
_____

Parent/ Guardian Signature:_____

Patient Information
Please Print

First Name:_____Middle:_____Last:_____

Date of Birth:_____ SS#:_____ Male or Female

Address:_____ Apt#_____

City:_____ State:_____ Zip:_____ Phone:_____

Mailing Address (if different):_____

Father's Name:_____ Date of Birth:_____

SS #:_____ Place of Employment:_____

Cell #:_____ Work #:_____

Mother's Name:_____ Date of Birth:_____

SS #:_____ Place of Employment:_____

Cell #:_____ Work #:_____

Insurance Information:

Insurance Company Name:_____

Insured's Name:_____ Effective Date:_____

Insured's SS #:_____ Date of Birth:_____

Insured's Employer:_____ Group #:_____

Release and statement to permit payment of private insurance benefits to provider. I, (WE), the undersigned patient and/or responsible party herby jointly authorize this office, its agency/employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.
I, (WE), authorize and request that payment of any third-party or insurance company benefits be made to this office any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis. I, (WE), the undersigned patient and/or responsible party hereby jointly authorize this office, its agency/employees the release and disclosure of any and all medical records to any other entity, including, but not limited to, referring physicians, hospitals or other healthcare providers, which may be of assistance in the opinion of this office, in providing the treatment of the patient. I, (WE), also give permission to release any information and medical records to the insurance company that request medical records.

_____ _____
Signature of Insured/ Guardian/ Parent Date

Email address:_____

Emergency Contact:_____ #:_____

Please Print : (Only One Child Per Sheet)

Date:_____ Acct #:_____

Child's Name: _____

Please list the following Names and Phone Numbers that have permission to bring child in and discuss patient care:

1._____ Relationship: _____ Phone: _____

2._____ Relationship: _____ Phone: _____

3._____ Relationship: _____ Phone: _____

4._____ Relationship: _____ Phone: _____

5._____ Relationship: _____ Phone: _____

Please Note: If child comes in with a person not listed on this sheet, we will NOT be able to see child.

Signature:_____

Relationship:_____

Pharmacy Name: _____

Pharmacy Number: _____

Eastside Pediatrics, PA Office/Financial Policies

Please read this page carefully! We try to ensure that our patients have a clear understanding of our expectations, so that we may better serve you. Please direct questions to our office staff. A signed copy of these policies is maintained in each chart. Please be sure you understand this prior to signing.

Payment for services: Our office staff will inform you on any co-pay or amount due at time of check-in/ check-out. Insurance companies require that we collect co-pays at time of service. You are responsible for knowing your co-pay amount and/or percentage and whether or not you have a deductible to meet. If you have not met your deductible, we expect payment in full. You may pay with cash, check or major credit card. It is your responsibility to notify us of changes in insurance. You will be expected to show your insurance card at each visit. If you are unable to pay your co-pay, your appointment may be rescheduled. Some services are not covered by insurance and you will be responsible for these. This may include Well-Child visits, as some insurance companies do not consider them as a covered service. If we are contracted with your insurance company, we will be glad to file your claim. Please understand that if your insurance company sends NO PAYMENT within 90 days of the date of service, it then becomes patient responsibility. Therefore, you should direct any insurance questions to them regarding payment (This is between you and your insurance company). Insurance is a contractual agreement between you and your insurance company!!!!!

Returned Checks: All checks returned to us will be charged a $35.00 returned check fee and payment has to be made in cash.

Collection Policy: Please be ensured that if you receive a bill, we have received insurance payment and the remaining portion due is your responsibility. Of course, of you have any questions, please feel free to contact our billing department. However, please remit payment promptly. Overdue accounts will be assessed a 20% surcharge and submitted to a collection agency. This will also be reported to the Credit Bureau.

Late Shows: If you arrive more than 10 minutes late for a WELL visit, you will be asked to reschedule your appointment. If you arrive more than 15 minutes late for a SICK visit, you will be worked in around other patients who have scheduled appointments.

Failed Appointments: If you fail to cancel your SICK or FOLLOW- UP appointment, you will be assessed a $25.00 fee. No show fee for a WELL-CHILD check will be assessed a $40.00 fee, and ADD/ ADHD/ CONSULTS will be assessed a $60.00 fee (NO EXCEPTIONS!!!!!). Insurance will not pay this fee and you will be responsible for it, prior to rescheduling additional appointments.

Walk-Ins: We will do everything possible to see your child if necessary. WE DO NOT ACCEPT WALK-IN APPOINTMENTS. Please call and you will be given a time when we are able to see your child.

Emergencies: Medical emergencies will take priority over scheduled appointments. Remember, you would want the same level of care for your child.

Address Change: It is your responsibility to notify our office of any changes in address, phone number, etc.

It is your responsibility for knowing your insurance benefits and requirements. You need to know if you plan covers well benefits and immunizations. Because each employer negotiates different contracts for their employees, it's also very important to know if you have to use a certain lab, provider, hospital, etc. (We, Eastside Pediatrics, PA, Physicians and staff are not responsible if you are sent to the wrong lab, etc). IT IS YOUR RESPONSIBILITY TO KNOW YOUR PLAN!!!

Signed: _____ Date: _____

Child's Name: _____ Chart# _____

EASTSIDE PEDIATRICS, PA

PATIENT CONSENT FOR USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Eastside Pediatrics, PA to use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Eastside Pediatrics, PA Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Eastside Pediatrics, PA reserves the right to revise its Notice or Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Eastside Pediatrics, PA Privacy Officer at 4501 Old Spartanburg Road, Suite 9, Taylors, SC 29687.

With this consent, Eastside Pediatrics, PA may call any phone number provided to the practice and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory and x-ray results among others.

With this consent, Eastside Pediatrics, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as missed appointment letters and patient statements. I have the right to request that Eastside Pediatrics, PA restrict how to use or disclose my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Eastside Pediatrics, PA use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior content. If I do not sign this consent, or later revoke it, Eastside Pediatrics, PA may decline to provide treatment to my child.

_____ _____

Signature of Legal Guardian Date

_____ _____

Patient's Name Received/ Declined Privacy Notice

_____

Print Name of Parent of Legal Guardian

Vaccine Policy Statement

Eastside Pediatrics, PA

If you plan to be a patient of Eastside Pediatrics, PA you will need to sign this form. If not, you have decided not to be a patient at this practice.

We firmly believe that the effectiveness of vaccines prevent serious illnesses and save lives. We believe that current studies and research indicate that vaccines do not cause autism or any other developmental disabilities.

We follow the CDC (Center for Disease Control) and AAP (American Academy of Pediatrics) vaccine guidelines. If you do not plan to vaccinate on the current schedule advised, we advise you to find another provider who shares your same views. We do not advocate alternative vaccine schedules. Please be advised that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness and even death.

We will be happy to discuss any questions or concerns you may have.

By signing this form, I agree to have my child fully vaccinated in a timely way as scheduled by the CDC and AAP.

_____

(Patient Name)

_____ _____

(Guardian Signature) (Date)

Date: _____

Vaccination Consent

Patient Eligibility Screening

I have read or have had explained to me the vaccine information contained in the vaccine information statements from the Center for Disease Control. I have been given the chance to ask questions that were answered to my satisfaction. I believe and I understand the benefits and risks of the vaccines noted below and ask that those vaccines be given to my child:
_____ for whom I am authorized to make this request.
(child's name)

Birth	**Hep B# 1**			
1 Month	**Hep B# 2**			
2 Months	**Pentacel #1**	**Prevnar #1**	**Rotateq #1**	
4 Months	**Pentacel #2**	**Prevnar #2**	**Rotateq #2**	
6 Months	**Pentacel #3**	**Prevnar #3**	**Rotateq #3**	**Hep B #3**
12 Months	**MMR #1**	**Prevnar #4**	**Hep A #1**	**HIB #4**
15 Months	**Dtap #4**	**Varicella #1**		
18 Months	**Hep A #2**			
4 Years	**Dtap #5**	**IPV #4**	**MMR #2**	**Varicella #2**
9-17 Years	**Tdap**	**Menactra**		

SIGNATURE OF PARENT/GUARDIAN: _____

RECORDS RELEASE AUTHORIZATION

_____ _____

(Please Print Patient's Name) (Date of Birth)

_____ _____

(Street Address/ PO Box) (SS Number)

_____ _____

(City, State, Zip Code) (Phone Number)

INFORMATION RELEASE FROM:

_____ _____

(Name of Prior Office) (Street Address/ PO Box)

_____ _____

(Phone Number) (City, State, Zip Code)

Please Release All Medical Records Necessary For Patient Care To:

Eastside Pediatrics, PA
4501 Old Spartanburg Road, Suite 9
Taylors, SC 29687
Phone: (864) 292-8868
Fax: (864) 268-9564
(PLEASE DO NOT FAX MEDICAL RECORDS)

CONDITIONS AND NOTIFICATIONS:

I hereby authorize the use of disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization is voluntary and that my healthcare and the payment for my healthcare will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and therefore, may be subject to re-discloser. This authorization for release of information expires 12 months from the date of patients (Guardian) signature unless otherwise specified. You may revoke this authorization in writing at any time by notifying Eastside Pediatrics, PA Attn: Office Manager, Eastside Pediatrics, PA, 4501 Old Spartanburg Road, Suite 9, Taylors, SC 29687. However, such notification will not affect any health information to be used or disclosed, consistent with the federal law.
NOTE: There may be a copying fee charged to the patient to cover labor and supplies used to reproduce medical records. Eastside Pediatrics, PA is authorized to disclose the health information listed above.

Signature: _____

Relationship to Patient: _____

Date: _____

Eastside Pediatrics, PA
Brian K. Few, MD
Roy A. Mages, MD Jeffrey M. Phillips, MD
Carolyn G. Schultz, MD Tabitha M. Randol, MD