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of acadiana

Today's Date: _____

PATIENT INFORMATION:

First: _____ MI: ____ Last: _____ DOB: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: (_____)_____ Alternate Phone #: (_____)_____ SSN: _____

Gender: ____ Race: _____ **Ethnicity** (circle): Hispanic/Non-Hispanic/Declined **Preferred Language:** _____

Preferred Pharmacy & Location: _____

Please list all other children who have been seen in our practice along with their Date of Birth

_____

PARENT/GUARDIAN INFORMATION:

Contact 1 Circle One: Mother / Father / Other - Specify Relationship_____Lives with Patient? Yes / No

First: _____ MI: ____ Last: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: (_____)_____ Alternate Phone #: (_____)_____ SSN: _____

Email Address: _____ If NO email, please list cell phone carrier: _____

Contact 2

Circle One: Mother / Father / Other - Specify Relationship_____Lives with Patient? Yes / No

First: _____ MI: ____ Last: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: (_____)_____ Alternate Phone #: (_____)_____ SSN: _____

Email Address: _____ If NO email, please list cell phone carrier: _____

EMERGENCY CONTACT INFORMATION: (to be used in the event parent/guardian cannot be reached)

Name: _____ Phone: (____)_____

Address: _____ Relationship: _____

INSURANCE INFORMATION: (Insurance card must be presented at each visit.)

Primary Insurance Name: _____ Policy #: _____

Policy Holder Name: _____ DOB: _____

Policy Holder SSN: _____ Relationship to the Patient: _____

Secondary Insurance Name: _____ Policy #: _____

Policy Holder Name: _____ DOB: _____

Policy Holder SSN: _____ Relationship to the Patient: _____

Patient Name:_____

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How did you First hear about us? (Circle one)

- Family Member or Friend
- Sibling or Returning Patient
- Hospital Personnel
- Google Search
- Facebook
- Billboard
- Public Event
- Child's School
- Flyer
- Walk-In
- Insurance Referral
- Other:_____

CONSENT FOR MEDICAL TREATMENT

By signing below, I (for above named patient) do hereby give permission for Premier Pediatrics of Acadiana, LLC and its physicians, nurse practitioners, and/or their designee(s) to examine and treat my child as necessary in their judgement. I also consent to procedures including but not limited to medical testing, vaccinations, diagnostic evaluation and/or other forms of necessary treatment.

_____
INITIAL

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

Payments are due prior to the patient being seen by the physician/nurse practitioner. This includes copayments, coinsurance, deductibles, payments for noncovered services, as well as any outstanding account balances. Any other payment arrangements should be discussed and agreed upon prior to your appointment. Please note when making payment arrangements that some insurance/Medicaid settlements may not be final, and you may receive additional bills. Health insurance is an agreement between the cardholder and insurance company, and it is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. Although we make every effort to verify coverage and estimate what your insurance company may pay, this is not a guarantee of payment and it is the insurance company that makes the final determination of eligibility. You are fully responsible for any and all charges that your insurance company refuses to pay. Examples of noncovered services may include but are not limited to wart removal, ear irrigation, vaccines, strep test, flu test and urine dips or on occasion preventative medicine visits. It is strongly recommended that the cardholder verify coverage limitations prior to appointment date. Account balances older than 120 may be turned over to an outside collection agency and additional fees will apply.

There are circumstances that might result in a credit to your account. **Please check one below:**

[ ] I agree OR [ ] I do not agree (check one only) that any refund due back to me for services provided to my child/children, will be allocated to cover my co-pays/deductible in future visits for any patients in which I am responsible for

_____
INITIAL

Prescription refill request will only be addressed during normal office hours and will be sent directly to your pharmacy upon receipt of an electronic request. For nonemergent medical assistance, you may call (337) 237-1252 to reach the nurse on call. In the event of a serious or life-threatening emergency call 911 or proceed to the nearest emergency facility.

By signing below, I acknowledge that I have read, understand and agree to abide by all the above. I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, email, and/or Postal Service including the diagnosis, treatment or examination rendered to my child during the period of treatment for the processing of insurance claims, or to satisfy requirements of managed care organizations of which I am a member. I also authorize the payment of medical benefits directly to Premier Pediatrics of Acadiana, LLC, its physicians, and/or supplier for services rendered all payments for the medical services rendered to my child. I authorize Premier Pediatrics of Acadiana, LLC to leave or send appointment reminder messages on voicemail, text or email. I also authorize Premier Pediatrics of Acadiana, LLC to utilize any email address provided to them as a form of communication.

SIGNATURE: _____ DATE: _____

OFFICE STAFF WITNESS: _____ DATE: _____

Patient Name:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of health care services we provide to you. You may request to see and receive a copy of that record. You may also ask for correction of that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may request to review your record or get more information about it by contacting our privacy officer, Brittney Henry (337) 237-1252. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.
By my signature below, I acknowledge receipt of the Notice of Privacy Practices (Revision: 01/26/2024).

Parent or legally authorized individual signature	Date & Time
Printed Name of Legal Guardian that signed above	Relationship

PERMISSION TO TREAT FOR ALTERNATE CAREGIVERS

Please complete the section below if you give permission for someone other than the parent(s) or guardian(s) and emergency contact listed above to bring your child to any future appointments and authorize them to make any decisions necessary to have your child treated by Premier Pediatrics of Acadiana, LLC in office or by telephone.

I, _____, I hereby give my consent to the individuals listed below to discuss and authorize medical treatment in office or over the telephone for my child, _____. I understand the caregiver will be required to make payments due for each visit. I also understand it is my responsibility to notify Premier Pediatrics of Acadiana, LLC in writing for any caregiver changes.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below, I acknowledge that I have read, understand, and agree to abide by the above statement.

SIGNATURE: _____ DATE: _____

OFFICE STAFF WITNESS: _____ DATE: _____

PATIENT MEDIA RELEASE

I, the undersigned, hereby grant Premier Pediatrics of Acadiana, LLC, its representatives and employees, the right to take photographs of me and my child/family. I give permission to Premier Pediatrics of Acadiana, LLC and its affiliates to use my/my child's name, picture and/or likeness in any manner and in any media for any lawful purpose including but not limited to website entries, Facebook, or other electronic media without payment or any other consideration. I agree that I will not hold Premier Pediatrics of Acadiana, LLC responsible for any liability resulting from the use of my/my child's name, picture and/or likeness in the manner described above.

Patient Name:_____

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Parent or legally authorized individual signature	Date & Time
Printed Name if signed on behalf of the patient	Relationship

PATIENT PORTAL

Our patient portal lets established patients review test results and appointments but is not intended for 'Web Visits' or messaging the practice. The portal uses encryption to keep information secure and can only be accessed by someone who knows the right password to log into the portal site. Usage is voluntary and free of charge. If experiencing an emergency, dial 911 or go to the nearest Emergency facility.

I acknowledge that I have read and fully understand this consent form. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the patient portal.

Parent or legally authorized individual signature	Date & Time
Printed Name if signed on behalf of the patient	Relationship

Patient Name:_____

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Non-Guardian Permission Authorization Update Form

☆ PLEASE COMPLETE THE SECTION BELOW IF **YOU GIVE PERMISSION** FOR SOMEONE ELSE OTHER THAN THE LEGAL PARENT/ GUARDIAN TO BRING YOUR CHILD TO ANY FUTURE APPOINTMENTS AND /OR AUTHORIZE THEM TO MAKE ANY DECISIONS NECESSARY TO HAVE YOUR CHILD TREATED PROPERLY BY PREMIER PEDIATRICS OF ACADIANA, LLC IN OFFICE OR BY TELEPHONE.

I, _____, give my permission to have my child,

NAME: _____ DOB: _____, brought to the office or discuss medical information by telephone by the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Office Staff Witness: _____ Date: _____

☆ IF YOU **DO NOT GIVE PERMISSION** FOR ANYONE ELSE TO BRING YOUR CHILD TO HIS / HER APPOINTMENT OR MAKE MEDICAL DECISIONS, PLEASE COMPLETE THE SECTION BELOW:

I, _____, **DO NOT** give anyone permission to have my child,

_____, brought in to the office or disclose of medical information to anyone other than myself.

Signature: _____ Date: _____

Office Staff Witness: _____ Date: _____

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Consent for Telehealth Services

I _____, parent/legal guardian of _____ DOB_____ consent to telehealth services offered by Premier Pediatrics of Acadiana, LLC with the following understanding and stipulations:

a. Telehealth **MUST** be initiated by the patient/legal guardian.
b. The parent/legal guardian **MUST** attest to the patient being at home.
c. Telehealth services are only offered to established patients. New patients would not qualify for the telehealth visit as provider **MUST** have access to consent to treat, pertinent medical and social history.
d. The patient **and** the caregiver/legal guardian **MUST** be present throughout the entire visit.
e. The caregiver/legal guardian **MUST** confirm the patient's date of birth to authenticate the patient's identity.
f. The provider **MUST** disclose telehealth limitations.
g. The caregiver/legal guardian **MUST** verbally express understanding and consent to the Telehealth visit.
h. Appropriate and uninterrupted video and/or audio signal must be available throughout the visit.
i. HIPAA regulation MUST be followed.

Furthermore, I understand that telehealth services are a curtesy service provided by Premier Pediatrics of Acadiana, LLC with the intent to improve and facilitate access to Behavioral Health care. If I do not keep my telehealth appointment, I understand that I will be discharged from the program and all future visits will have to be in person at the clinic.

Parent/Legal Guardian Signature_____ Date: _____

PREMIER PEDIATRICS OF ACADIANA

Premier Pediatrics of Acadiana Vaccine Policy Statement

We, at Premier Pediatrics of Acadiana firmly believe:

-In the effectiveness of vaccines to prevent serious illness and to save lives

-In the safety of vaccines

-That all children and young adults should receive all recommended vaccines according to the schedule published by the Centers of Disease Control and Prevention and the American Academy of Pediatrics.

-That based on all available literature, evidence and current studies, vaccines do not cause Autism or Other developmental disabilities.

-That choosing not to vaccinate or to under-vaccinate puts not only your child at risk, but also puts at risk our young or chronically ill patients who are unable to receive vaccines due to medical contraindications. It also puts our staff and physicians at risk.

As of April 1, 2019, Premier Pediatrics of Acadiana will no longer accept new patients who do not plan to vaccinate. This includes new siblings of already established patients.

We recognize that the decision to vaccinate is a very personal choice for many parents, and we will do everything in our power to work with and educate our patients and caregivers about the importance of vaccination. In some cases, we may alter the schedule to accommodate concerns or reservations. ***Please be advised, however, that delaying or "breaking up vaccines" over two or more visits goes against expert recommendations and can put your child at risk for serious illness or even death and goes against our medical advice at Premier Pediatrics of Acadiana. In the event of lengthy delays, you will be required to sign a "Refusal to Vaccinate" acknowledgement.*** All patients in our practice should have a vaccination plan in place with your provider by your child's ***2-month wellness visit***. Failure to comply could result in dismissal from our practice. Should you have doubts, questions, or concerns, please discuss them with your physician, as the health and safety of our patients is our priority.

Patient Name _____ DOB_____ Date_____

Parent Printed Name_____ Signature_____

SICK VISITS VS. WELL VISITS OR BOTH

SICK VISIT-This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (Diabetes, Cholesterol, Blood Pressure, etc.)

WELL VISIT-This is an office visit for a routine physical exam or yearly health maintenance exam.

SICK/WELL VISIT-This is a combination visit of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a combination visit and must be billed differently than just a well visit or just a sick visit.

WHY IS IT BILLED DIFFERENTLY- It is billed differently to account for the additional work, expertise, and time required for a combination visit (additional lab work, x-ray referrals and/or prescription medications). It involves additional documentation as well. For example, think about taking your vehicle in for an oil change (routine maintenance), and mentioning to the mechanic that your brakes are squeaking, and your windshield wipers are not working well. In addition to the oil change, you might require additional brake work if a problem was found, and replacement windshield wipers. Since additional services were provided, you would be charged more than just for the oil change.

HOW THIS AFFECTS ME- Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay two co-pays or have additional costs applied to his/her annual deductible.

ANNUAL PHYSICAL EXAMS

Annual physical exams target preventative care and are billed as such. Medication refills and/or other ailments, injuries, or illnesses addressed during an annual physical exam are billed **IN ADDITION** to the annual physical exam. These charges may be passed on to the patient. Please check with your insurance company to confirm your coverage for all types of doctor visits.

We realize this can be confusing, and if you have any questions or concerns after reviewing this material, please ask.

_____ _____

Print Patient's Name Parent/Caregiver Signature

_____ _____

Date of Birth Today's Date

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Fairway Pediatrics, LLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for further care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of Protected Health Information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photo copy or fax of this consent is valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is use dor disclosed for the purposes of treatment, payment, or healthcare operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____

Patient's Name (Printed)

_____ _____

Parent/Guardian Signature Date

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Authorization for Release of Medical Record Information

PLEASE USE BLACK INK

If any section of this form is incomplete, form may be invalid.

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City/State/Zip:** _____

Phone number: _____

I hereby authorize:

The release of information TO:

☐ **Premier Pediatrics of Acadiana, LLC**
118 Hospital Drive, Lafayette, LA 70503
Phone: (337) 237-1252
Fax: (866) 451-2843

The release of information FROM:

☐ **Premier Pediatrics of Acadiana, LLC**
732 Young Street, Youngsville, LA 70592
Phone: (337) 704-7047
Fax: (866) 451-2843

☐ **FROM** (Previous practice or Doctor's name)
Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

☐ **RELEASE TO:**
Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Fax #: _____

The information is needed for the following reason:

- ☐ Transferring to another pediatric practice
- ☐ Transferring to an adult practice
- ☐ Personal use
- ☐ Attorney use
- ☐ Visit to a Specialist
- ☐ Other: _____

Type of information being released:

- ☐ Growth chart
- ☐ Immunization record
- ☐ Progress notes
- ☐ Labs/radiology
- ☐ Entire chart
- ☐ Other: _____

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a one (1) year period from the date it is signed.

By: _____ **Current date:** _____
Parent or legal guardian (if minor children)

Witness: _____ **Date:** _____