FIRST PEDIATRIC
CARE CENTER, P.A.

Margaret Lubega, M.D.
Medical Director

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH

INFORMATION

Patient Last *(Apellido)*	**First** *(Nombre)*	**MI**	**Date of Birth** *(Fecha de Nacimiento)*
_____			_____

I hereby authorize: *(Yo autorizo)*
(Name and address of releasing facility)
(Nombre y dirección de la clínica anterior)

_____

_____

_____

To release Information to: *(De mandar informacion a)*
(Individual name, facility, organization and address)
(Nombre y dirección del individuo, facilidad u organización)

First Pediatric Care Center, P.A.
2644 Court Drive,
Gastonia, NC 28054
Tel: (704) 823-1698
Fax: (866) 777-2205

[ ] Date & Time of Appointment _____

PURPOSE OF DISCLOSURE

[ ] Continuing Care
[ ] Payment of Claim
[ ] School
[ ] Physician Request
[ ] Legal
[ ] For Personal Use

[ ] Other (*specify*) _____
_____

INFORMATION TO BE RELEASED

[ ] H & P Exam/Initial Evaluation
[ ] Progress Notes
[ ] Correspondence
[ ] Vaccination Record
[ ] Lab/X-Ray Reports
[ ] Consultation
[ ] Hospital
[ ] other (*specify)* _____
_____

ACKNOWLEGMENT OF UNDERSTANDING

- I understand the expiration date of this authorization in one year from today's date.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations.
- I understand this consent for release of school and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make to disclosure, has already acted in reliance on it.
- I understand that First Pediatric Care Center, P.A. may not condition my treatment, payment, enrollment or eligibility for benefits on me signing this authorization.
- I understand I will receive a copy of this form after I have signed it.
- I understand that in compliance with NC statute (N.C G.S.A 90-411); I may be requiring paying a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand a photocopy or fax of this form is the same as original.

_____

Signature of Patient or Guardian **Relationship to the Patient** **Date**

_____

Witness Signature **Date**

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OFFICE POLICIES

Thank you for choosing First Pediatric Care Center, P.A. for your child/children's Pediatrician. We will strive to do our best to meet your expectations. We have high volume of patients that depend on us every day and we do our best to accommodate this need. To help us in meeting our goals, we have established certain office policies and procedures that we hope will be beneficial to everyone.

1. We accept patients from newborn to 21 years of age.
2. We verify all insurance cards prior to your visit as a courtesy to you. Ultimately, you as a card holder are responsible to know what your insurance will or will not cover concerning your child/children's sick and well visits. We commend that you call your insurance company to verify wellness benefits before your appointment by calling customer service number on your card.
3. You must present your current insurance card at each visit or you will be responsible for payment of that day of visit. That money will not be reimbursed to you, should you present the insurance card later.
4. You should be prepared to pay your child/children's at each appointment including deductibles and co-payments prior to receipt of medical services.
5. Because of the limited space in our waiting rooms, we ask that you limit the number of family members that accompany the patient.
6. If your child/children are under the age of 18, you are responsible for those child/children and you must accompany the patient to the appointment. Please control the conduct of your child/children in our waiting rooms and be courteous to other patients.
7. Employees of this office are implementing the policy and procedures directed by the Doctor and the Office Manager. Should you have any concerns with the policy or conduct of an employee, please contact the Office Manager or Doctor. We do not tolerate the parents or guardians that use abusive language argue and/or fail to cooperate with First Pediatric Care Center's office policies and procedures. This type of behavior is ground for being discharged from First Pediatric Care Center, P.A.
8. If you are more than 30 minutes late for your appointment, without prior notification you will be rescheduled.
9. NO FOOD OR DRINK is allowed in our waiting and examination rooms.
10. Please do not move/reposition the chairs in the waiting and examination rooms.
11. Physical forms that are dropped off after the physical has been completed will required a $10.00 charge, and 5 business days to be completed by the Doctor.

Thank you for your cooperation.

I understand and agree to follow the policies stated above.

Parent/Guardian Signature ***Date***

Print Name ***Patient's Name***

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HIPPA (Health Insurance Portability) Compliance Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide stand for certain health care providers to obtain the patient's consent to uses and disclosures of health information about the patient to carry our treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about your treatment; payments for health care operations and only to those we feel are in need that information in order to provide care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships in the course of your care (such as with reference laboratories that only interact with physicians and not patients), and may have to disclose Personal Health Information for purposes of treatment, payment or other health care operations. These entities are most often not required to obtain patient consent.

You might refuse to consent to the use of the disclosure of your Personal Health Information, but this must be in writing. Under the law, we have the right to refuse to treat you, refuse to disclosure your Personal Health Information (PHI). If you do choose to give consent in this document, and some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this, please ask to speak with our HIPAA Compliance Office.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ ***Date:*** _____

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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for the purposes that are permitted or required by lay. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses of disclosures of Protected Health Information: Your Protected Health Information may be used and disclosed by your physician, our office staff and other outside of our office that involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We would use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose you Protected Health Information as necessary, to a home health agency that provides care to you. For example' your Protected Health Information may be proved to a physician to whim to have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant Protected Health Information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your physician's practice. These activities include, but are not limited to qualify assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your Protected Health Information to medical school student that see patients at our office. In addiction we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your Protected Health Information as necessary, to contact you to remind you of your appointment.

We may use or disclose you Protected Health Information in the following situations without your authorization. The situations include: as required by law; Public Health issues as required by Law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration Requirements; Legal Proceeding; Law Enforcement Coroners; Funeral Directors; and Organ Donation; Research, Criminal Activity; Military Activity, and National Security; Workers' Compensation; Inmate; Requires Uses and Disclosures; Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use and disclosure indicated in the authorization.

Your rights: Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information: Under federal law, however, you may not inspect or copy of the following records; psychotherapy notes, information compiled in reasonable anticipation of; or use in a civil, criminal, or administrative action or proceeding, and Protected Health Information that is just subject to law that prohibits access to Protected Health Information.

You have the right to request a restriction of your Protected Health Information: This means you may ask not to use or disclosure any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your Protected Health Information may not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed this notice alternatively i.e. electronically.

You have the right to receive an accounting of certain disclosure we have made, if any, of our protected health information.

We reserve the right to change the term of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided is this notice.

Complains: You may complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint to us by notifying our privacy contact or your complaint. ***We will not retaliate against you for filling a complaint.***

This notice was published and becomes effective on/or before ***April 14th, 2003.***

We required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with the respect to Protected Health Information. If you have any objections to tis form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature bellow is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____ ***Date:*** _____

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First Pediatric Care Center, P.A.
2644 Court Drive
Gastonia, NC 28054

Patient's Name: _____

- First Pediatric Care Center, P.A. is committed to providing the best possible care to our patients. The following information is needed to ensure that patient confidentiality is protected at all time under the HIPAA regulations.
- Please circle yes or no to the categories listed with regards to what action First Pediatric Care Center, P.A. should take in order to inform you of result and/or information from your medical records including, but not limited to, your medical diagnosis, information regarding your upcoming appointment, and other pertinent information related to your medical care.

I hereby give permission to First Pediatric Care Center, P.A. and the office staff to discuss the information or issue samples and prescriptions to the following people:

PLEASE CIRCLE

YES NO ***Name:*** _____ ***Phone:*** _____

YES NO ***Name:*** _____ ***Phone:*** _____

YES NO ***Name:*** _____ ***Phone:*** _____

YES NO ***Name:*** _____ ***Phone:*** _____

YES NO First Pediatric Care Center, P.A. may leave detailed information on my answering machine at home. ***Phone:*** _____

YES NO First Pediatric Care Center, P.A. may leave detailed information on my voicemail at work. ***Phone:*** _____

YES NO I would like my child's medical information to be discussed only with me.

I hereby give permission for the following people to bring my child to First Pediatric Care Center, P.A. for sick or well care visits in my absence, until I give notice of any change.

Name: _____ ***Relationship to child:*** _____

Name: _____ ***Relationship to child:*** _____

Name: _____ ***Relationship to child:*** _____

Signature: _____ ***Date:*** _____

Witness: _____ ***Date:*** _____

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Initial History Questionnaire	
	Patient Name and Lastname
Form Completed By ***Date***	***Date of Birth*** ***Age*** ***Male or Female***

Household (Please list all those living in the child's home.

.

Name	*Relationship To child*	*Birth date*	*Health Problems*

*Are there any siblings not listed? If so, please list their names, ages and where they*_____
_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____
_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____
_____

Birth History

Birth weight _____
Was the baby born at term? ____ *Early* ____ *Late*____
If early, how many weeks gestation? _____

Was the delivery _____ *Vaginal* _____ *Cesarean*
If cesarean, why? _____

Did mother have any illness or problem with her pregnancy? ____
Yes ____ *No Explain* _____

Did your baby have any problems right after birth?
____*Yes* ____*No Explain* _____
_____

During pregnancy, did mother
Smoke ___ *Yes* ___ *No* *Drink Alcohol* ___ *Yes* ___ *No*
Use drugs or medications ___ *Yes* ___ *No*
*What*_____ *When* _____

Was initial feeding _____*Breast* _____ *Bottle*
Did baby go home with mother from the hospital?
_____*Yes* _____ *No Explain* _____
_____

General

Do you consider your child to be in a good health? ___ *Yes* ___ *No Explain* _____
Does your child have any serious illness or medical condition? ___ *Yes* ___ *No Explain* _____
Has your child had any serious injuries or accidents? ___ *Yes* ___ *No Explain* _____
Has your child ever been hospitalized? ___ *Yes* ___ *No Explain* _____
Is your child allergic to any medicine or drugs? ___ ***Yes*** ___ ***No Explain*** _____

Development

Are you concerned about your child's physical development? ___ *Yes* ___ *No Explain* ___ _____
Are you concerned about your child's mental/emotional development? ___ *Yes* ___ *No Explain* _____
Are you concerned about your child's attention span? ___ *Yes* ___ *No Explain* _ _____

If your child is in school

How is his/her behavior in school? _____
Has he/she failed or repeated a grade in school? _____
How is he/she doing in academic subjects? _____
Is he/she in special or recourse classes? _____

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Family Medical History

Have any family member had the following:

Deafness	___ Yes	___ No	Explain _____
Nasal Allergies	___ Yes	___ No	Explain _____
Asthma	___ Yes	___ No	Explain _____
Tuberculosis	___ Yes	___ No	Explain _____
Heart Disease (before 50 years old)	___ Yes	___ No	Explain _____
High Blood Pressure (before 50 years old)	___ Yes	___ No	Explain _____
High Cholesterol	___ Yes	___ No	Explain _____
Anemia	___ Yes	___ No	Explain _____
Bleeding disorder	___ Yes	___ No	Explain _____
Liver Disease	___ Yes	___ No	Explain _____
Diabetes (before 50 years old)	___ Yes	___ No	Explain _____
Bed-wetting (after 10 years old)	___ Yes	___ No	Explain _____
Epilepsy or convulsions	___ Yes	___ No	Explain _____
Alcohol Abuse	___ Yes	___ No	Explain _____
Drug Abuse	___ Yes	___ No	Explain _____
Mental Illness	___ Yes	___ No	Explain _____
Mental Retardation	___ Yes	___ No	Explain _____
Immune problems, HIV, or AIDS	___ Yes	___ No	Explain _____

*Additional family history*_____

Past Medical History

Does your child have, or has he/she ever had:

Chickenpox	___ Yes	___ No	Explain _____
Frequent ear infections	___ Yes	___ No	Explain _____
Problems with ears or hearing	___ Yes	___ No	Explain _____
Nasal Allergies	___ Yes	___ No	Explain _____
Problems with eyes or vision	___ Yes	___ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	___ Yes	___ No	Explain _____
Any heart problem or heart murmur	___ Yes	___ No	Explain _____
Anemia or bleeding problem	___ Yes	___ No	Explain _____
Blood transfusion	___ Yes	___ No	Explain _____
Frequent abdominal pain	___ Yes	___ No	Explain _____
Constipation requiring doctor visits	___ Yes	___ No	Explain _____
Bladder or kidney infection	___ Yes	___ No	Explain _____
Bed-wetting (after 5 years old)	___ Yes	___ No	Explain _____
(Girls) Has she started her menstrual period?	___ Yes	___ No	Explain _____
(Girls) Are there problems with her periods?	___ Yes	___ No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	___ Yes	___ No	Explain _____
Frequent Headaches	___ Yes	___ No	Explain _____
Convulsions or other neurologic problems	___ Yes	___ No	Explain _____
Diabetes	___ Yes	___ No	Explain _____
Thyroid or other endocrine problem	___ Yes	___ No	Explain _____
Any other significant problem	___ Yes	___ No	Explain _____
Use of alcohol or drugs	___ Yes	___ No	Explain _____