## Bayou Pediatric Associates New Patient Form

Last Name First Na			Malo or Fomalo		Middle Name		
Date of Birth	Social Security Number		Male or Female (Circle one)				
Address		<del></del>	Home Pl	none Numb	er	Cell Pho	one Number
City	State	Zip Code	Work Ph	one Numbe	er	Alterna	te Phone Number
Email Address		<del></del>					
-		es we utilize electro				_	-
<u>-</u>		Thank you. Please	mark an X	ı		s to your	child.
Preferred Lang	uage	Race		Ethnicity			
English		African American		Hispanic			
French		Asian Caucasian	<u> </u>	INOI	n-Hispani	C	
Spanish		Native American					
Vietnamese Other		Multi-Racial					
Mother's Name	other's Name DOB		١	Father's Name			DOB
Has the nationt's	nother or	fathar avar baan a	nationt o	r a rosnonsi	hlo nartv	to anoth	or patient at
Bayou Pediatrics?		father ever been a	patient of	a responsi	bie party	to anoth	er patient at
·		information that ap	oplies to y	our family a	as listed b	elow:	
Primary Insurance				Policy Numl	ber		
Card Holder Name				Social Security Number			
Relationship to the	e Patient <sub>.</sub>			Policy Holde	er DOB		
Secondary Insurar	ice			Policy Numl	ber		
Card Holder Name				Social Security Number			
Relationship to the Patient				Policy Holder DOB			

#### Bayou Pediatric Associates Kidmed Policy, Agreement and Authorization of Treatment

Welcome to Bayou Pediatric Associates Kidmed Clinic. In order for our clinic to operate smoothly we have put into place the following policies.

- I authorize treatment for my child/children as recommended per the Kidmed Periodicity Chart and the Bayou Pediatric Physicians.
- You are required to bring your child's social security card and immunization record to each visit.
- A parent or legal guardian must sign the child's permission form before immunizations can be given. NO EXCEPTIONS!
- We will verify your child's Medicaid linkage and eligibility with each office visit. If your child is no longer eligible for Medicaid you will be offered to pay for the visit.
- We ask that you notify our office if you are unable to make your appointment. It is understood that a cancellation must be called in one hour prior to the appointment time or it will be considered a no show. If you do not call to reschedule your appointment it will be considered a no show. If you are more than twenty (20) minutes late for your appointment you will not be seen and your appointment will be rescheduled. After two (2) no shows we will no longer reschedule you Kidmed appointments.
- Medicaid does not pay all charges incurred. If a charge is not covered the patient will be responsible for
  the payment. Bayou Pediatric Associates does not know if a service is covered until the claim is returned
  due to ongoing changes in the Medicaid program. Bayou Pediatric Associates does know that therapeutic
  injections and splints are not covered. This charge will be collected at check out.
- If Medicaid denies charges stating patient has primary insurance the claims will have to be filed to the private insurance. If any charges are processed as patient responsibility, the patient will be responsible to pay these charges. We NOT file Medicaid as a secondary insurance.
- We utilize Electronic Health records. You have access to view your child/children's health record. Please
  visit: <a href="https://bpa.medtonsoftware.com/patientportal/login">https://bpa.medtonsoftware.com/patientportal/login</a>; please ask a member of our staff to aid you in
  creating your user name and password for this website.
- You should expect to spend approximately one to two hours for a thorough and complete Kidmed visit.
- We are now mandated to send out prescriptions electronically and it may take several hours for your pharmacy to process your prescriptions.
- Bags will be provided for dirty diapers, and should be disposed of at home. We cannot dispose of them in our clinic due to OSHA regulations.
- Due to privacy laws no videotaping or pictures are allowed in this office at any time. Also please refrain from using your cell phone when in our office.
- Due to HIPAA we do not fax medical records.
- There is a \$25 fee for copies of medical records.
- There is a \$50 fee for NSF payments.
- Only 2 adults are permitted in the examination rooms.
- No food or drinks are permitted in the office/examination rooms!
- We are proud to be a smoke free facility! Please refrain from smoke while at our offices.
- Bayou Pediatric Associates will no longer see patients whose parent/legal guardian refuses their required immunizations.
- I understand that if I use foul language on the phone or in person at Bayou Pediatric Associates I will be asked to find a new primary care provider.

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- For the well-being of my child/children I understand I may be dismissed for not following all policies and procedures of Bayou Pediatric Associates. If dismissed, Bayou Pediatric Associates will send a letter of dismissal and a new primary care provider must be chosen.
- Dress Code: Shirts and shoes must be worn at all times, except when asked to be removed by staff. Pants
  must be worn at waist level without underwear exposure. Clothing that depicts or promotes violence, sex
  acts, illegal drug use or profanity will NOT be permitted. Provocative or tight clothing that exposes breast
  or buttocks will NOT be permitted.

I understand and agree with the above policies. I also understand my responsibilities. Please understand these policies are made in consideration of the physicians, staff and patients. We appreciate your understanding and cooperation. Signature of Guardian Date **Bayou Pediatric Associates Notice of Privacy Practices Acknowledgment of Receipt** Effective Date: April 14, 2003 Please Review Carefully The Notice of Privacy Practices tells you how Bayou Pediatric Associates uses and discloses information about you. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you. , have been given a copy of Bayou Pediatric Associates Notice of Privacy Practices. Signature of Guardian Date Personal Representative Date

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# BAYOU PEDIATRICS AND ASSOCIATES, APMC REQUEST FOR ACCESS TO MEDICAL INFORMATION

Our Notice of Privacy Practices provides the information about our use of patient protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health information used to make decisions about them.

The practice will only include information used to make decisions about the patient. The practice may limit access to information generated only by this practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this request and notify the patient of our decision within 15 days of the request. If the request is approved, the practice will provide the requested information within 30 days or 60 days if such an extension is necessary. Reasonable cost may be charged for the request.

Patient	Date of Birth			
1	(Name)	(relationship to patient	) authorize	
to release a copy of medical reco	rds to:			
Name:				
Address:				
Telephone:				
Address:				
Extent of Authorization:				
a) I authorize the release of				
b) I authorize the release of	of the complete healt	th record with the exception of:		
Signature of patient or Guardian		 Date		
Printed Name				
Timed Hame				
I will pick up the copies				
Please mail copies to				

## <u>Bayou Pediatric Associates</u> Medical History and Family History Form

Name	DOB
Birth History	Medical History
Gestation Weeks	Recurrent Illnesses
Vaginal or C-Section Delivery	Chronic Illnesses
Hospital of Delivery	Seizures
Infant's Doctor	Recurrent Ear Infections
Birth Weight	Recurrent Tonsilitis\Sinusitis
Date of Discharge	Diptheria/Mumps/Meales/Rubella
Hearing Screening - Passed or Failed (Circle One)	Eczema
Surgical History	Social History
Adenoid removal	Any smokers that live in the home?
Tonsil removal	Pets in the home? What type?
Ear Tubes	How many people live in the home?
Circumcision	Birth to school age childcare? Private Sitter/Stay
	home parent or Daycare (circle one)
<b>Lead Poisoning Risk Assessment</b> age 6 mths – 5 yrs)	School age children? Attends school
Lives in or visits house built before 1960	/Homeschool/Not in school (circle one)
Lives in 1960 or earlier house being renovated	Tobacco use? (12 yrs and older)
Family or Playmate with lead poison	Recreations Drug use? (12 yrs and older)
Adult works with lead, pottery or ceramics	Alcohol Use (12 yrs and older)
Livers near battery recycling plant or lead industry _	Sexually Active (12 yrs and older)
Uses folk remedies that contain lead	
Lives near highway or heavy traffic	
Lives in house with lead pipes or shoulder joints	
Family History –Applies to Parents, Grand Parents,	Siblings, Aunts, Uncles and Cousins
Maternal History (Mother's Side)	Paternal History (Father's Side)
Allergies	Allergies
Arthritis	Arthritis
Asthma	Asthma
Cancer	Cancer
Diabetes	Diabetes
Elevated Cholesterol	Elevated Cholesterol
Heart Disease	Heart Disease
High Blood Pressure	High Blood Pressure
Sickle Cell Disease	Sickle Cell Disease
Thyroid Disease	Thyroid Disease
Any additional medical history, family history or co	ncerns:

### **PARENTAL PERMISSION CONSENT FORM**

Date:	
I,	
(NAME)	(RELATIONSHIP)
Give permission for those listed belo	ow to give consent for patient
Date of Birth	routine/standard procedures including but not limited to, blood
work, medication injections, swabs	and catherizations that may be performed during routine wellness or
sick visits. I also give permission for	those listed below to pick up prescriptions and receive medical
information concerning my child/ch identification.	ildren. The individuals listed below will have to show proper
Name:	Relationship:
	<del></del>
	<del></del>
l,	<i>-</i>
(NAME)	(RELATIONSHIP)
DO NOT give permission for anyone	other than myself to give consent for my child/children.
· · · · · · · · · · · · · · · · · · ·	tion changes it will be the responsibility of the parent/guardian
named above to contact ou	<u>ır office at 985-868-5440.</u>
Father of child signature	
rather of Ciliu Signature	iviotilei oi ciilla Signature