

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: <https://bpa.medtonsoftware.com/patientportal/login>; 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.

- 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.

I, _____, have been given a copy of Bayou Pediatric Associates Notice of Privacy Practices.

Signature of Guardian

Date

Personal Representative

Date

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 _____

I _____ (Name) _____ (relationship to patient) authorize

_____ to release a copy of medical records to:

Name: _____

Address: _____

Telephone: _____

Address:

Extent of Authorization:

_____ a) I authorize the release of the complete health record

_____ b) I authorize the release of the complete health record with the exception of:

Signature of patient or Guardian

Date

Printed Name

____ I will pick up the copies

____ Please mail copies to _____

Bayou Pediatric Associates
Medical History and Family History Form

Name _____

DOB _____

Birth History

Gestation Weeks _____

Vaginal or C-Section Delivery _____

Hospital of Delivery _____

Infant's Doctor _____

Birth Weight _____

Date of Discharge _____

Hearing Screening - Passed or Failed (Circle One)

Medical History

Recurrent Illnesses _____

Chronic Illnesses _____

Seizures _____

Recurrent Ear Infections _____

Recurrent Tonsillitis/Sinusitis _____

Diphtheria/Mumps/Measles/Rubella _____

Eczema _____

Surgical History

Adenoid removal _____

Tonsil removal _____

Ear Tubes _____

Circumcision _____

Social History

Any smokers that live in the home? _____

Pets in the home? What type? _____

How many people live in the home? _____

Birth to school age childcare? Private Sitter/Stay home parent or Daycare (circle one)

School age children? Attends school /Homeschool/Not in school (circle one)

Tobacco use? (12 yrs and older) _____

Recreations Drug use? (12 yrs and older) _____

Alcohol Use (12 yrs and older) _____

Sexually Active (12 yrs and older) _____

Lead Poisoning Risk Assessment age 6 mths – 5 yrs)

Lives in or visits house built before 1960 _____

Lives in 1960 or earlier house being renovated _____

Family or Playmate with lead poison _____

Adult works with lead, pottery or ceramics _____

Lives near battery recycling plant or lead industry _____

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)

Allergies _____

Arthritis _____

Asthma _____

Cancer _____

Diabetes _____

Elevated Cholesterol _____

Heart Disease _____

High Blood Pressure _____

Sickle Cell Disease _____

Thyroid Disease _____

Paternal History (Father's Side)

Allergies _____

Arthritis _____

Asthma _____

Cancer _____

Diabetes _____

Elevated Cholesterol _____

Heart Disease _____

High Blood Pressure _____

Sickle Cell Disease _____

Thyroid Disease _____

Any additional medical history, family history or concerns: _____
