Bayou Pediatric Associates New Patient Form

_____ _____ _____

Last Name First Name Middle Name

_____ _____ Male or Female

Date of Birth Social Security Number (Circle one)

_____ _____ _____

Address Home Phone Number Cell Phone Number

_____ _____ _____ _____ _____

City State Zip Code Work Phone Number Alternate Phone Number

_____

Email Address

At Bayou Pediatric Associates we utilize electronic health records. The following information is required to create your child's chart. Thank you. Please mark an X next to what applies to your child.

Preferred Language	**Race**	**Ethnicity**
English	African American	Hispanic
French	Asian	Non-Hispanic
Spanish	Caucasian	
Vietnamese	Native American	
Other	Multi-Racial	

_____ _____ _____ _____

Mother's Name DOB Father's Name DOB

Has the patient's mother or father ever been a patient or a responsible party to another patient at Bayou Pediatrics? Yes ☐ No ☐

Please fill out the insurance information that applies to your family as listed below:

Primary Insurance _____ Policy Number _____
Card Holder Name _____ Social Security Number _____
Relationship to the Patient _____ Policy Holder DOB _____

Secondary Insurance _____ Policy Number _____
Card Holder Name _____ Social Security Number _____
Relationship to the Patient _____ Policy Holder DOB _____

Bayou Pediatric Associates Private Insurance Financial Agreement, Authorization of Treatment and Policy

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

- You are required to bring your child's insurance card, social security card and immunization record to all visits.
- I authorize treatment of my child/children and agree to pay all fees and charges for such treatment. It is agreed that payments will not be delayed because of any pendency of claim. I understand my benefits and am aware of what are covered and non-covered procedures. Co-payments, percentages and non-covered procedures will be paid at the time of service.
- All insurance companies under contract have agreed to be paid within thirty days of all correct claims. If the insurance company does not hold up to this agreement Bayou Pediatric Associates is no longer bound to the contract and the payment responsibility will shift to the patient. Bayou Pediatric Associates will however, help in resubmitting claims if necessary. Please be aware every six months your insurance company will send a questionnaire regarding your insurance if there is no response to the inquiry claims will not be paid and the patient will become responsible for the balance. During this time your insurance company considers your account to be frozen, any office visits that occur during this time will have to be paid in full by the patient/responsible party.
- In the event you have a private insurance policy and Medicaid we will only file the private insurance policy. Medicaid is never filed as primary when you have a private insurance policy. We do NOT file Medicaid as a secondary. You remain responsible for any co-pays, deductibles or percentages that the primary policy applies.
- 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.
- A parent or legal guardian must sign the child's permission form before immunizations can be given. NO EXCEPTIONS!
- We ask that you notify us if you are unable to make your appointment no later than one hour prior to the appointment time. If you are more than twenty minutes late for your appointment the appointment will be considered a no show.
- You should expect to spend one – two hours at the office for a thorough and complete 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 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 Tonsilitis\Sinusitis_____
Diptheria/Mumps/Meales/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 _____
Livers 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: _____

_____

PARENTAL PERMISSION CONSENT FORM

Date: _____

I, _____, _____
(NAME) (RELATIONSHIP)

Give permission for those listed below 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/children. The individuals listed below will have to show proper identification.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

I, _____, _____
(NAME) (RELATIONSHIP)

DO NOT give permission for anyone other than myself to give consent for my child/children.

- **If any of the above information changes it will be the responsibility of the parent/guardian named above to contact our office at 985-868-5440.**

_____ _____
Father of child signature Mother of child signature