TLC Pediatrics, PLLC
955 Carolyn Lane
Conway, AR 72034

Phone: (501)327-2444
Fax: (501)327-2443

Patient Information

Child's Name _____
Last Name First Name Middle Name

Sex _____ Age _____ Birthdate_____ Social Security # _____ Nickname _____

Mailing Address _____
Street/Apt. City State Zip

Home Phone Number_____ Email: _____
Ethnic Group: _____ Declined (_____)
Race: American Indian or Alaska Native: _____ Asian: _____ Black or African American: _____ White: _____
Native Hawaiian/Other Pacific Island _____ Other: _____ Declined (_____)

Family Information

Child's Legal Guardian(s) _____

Father's Name_____ Mother's Name _____

Address _____ Address _____

_____ _____

Home Phone _____ Cell Phone _____ Home Phone _____ Cell Phone _____

Employer _____Work #_____ Employer _____Work #_____

SS # _____ Birthdate _____ SS# _____ Birthdate _____

Does this person carry insurance coverage for this child?
_____YES _____ NO

Does this person carry insurance coverage for this child?
_____ YES _____ NO

Siblings who are seen in this office: If you need more room check here _____ and continue on the back.

_____ _____
Name Date of Birth Name Date of Birth

Insurance Information

Plan Name _____ Phone Number _____

Policy ID # _____ Group # _____

Address _____

Secondary Insurance Plan Name _____ Policy and Group # _____/_____

Address _____ Phone Number _____

Is the child covered by Medicaid (ARkids A/B)? _____ Yes _____ No Medicaid # _____

Emergency Contact

In case of emergency, whom should we contact?
Name _____ Relationship _____ Phone # _____

Insurance and Payment Authorization

I, the responsible party of above child, assign all insurance benefits to TLC Pediatrics, PLLC. I agree that I am responsible for all charges regardless if paid by insurance or not. I authorize TLC Pediatrics, PLLC and its providers to release all necessary information to secure the payment of benefits. I have authorized the use of this signature on all insurance submissions.

_____ _____
Signature of Responsible Party Date

Initial History Questionnaire

TLC Pediatrics, PLLC, 955 Carolyn Lane, Conway, AR 72034

Phone 501-327-2444 Fax 501-327-2443

Patient's Name: _____ Date of Birth: _____ Age: _____

Form Completed By: _____Relationship: _____Today's Date: _____

Household- Please list all those living in child's home and their relationship to child.

Name	Relationship	Birth Date	Health Problems

Birth History Check here if birth history not known. ( )

Birth weight _____Ibs ___oz Was the baby born at term? ( ) Yes ( ) No How many weeks? _____

List any complication during pregnancy or after delivery. _____

_____

During pregnancy, did mother: Use tobacco ( ) Yes ( ) No Drink Alcohol ( ) Yes ( ) No

Use drugs or medications: ( ) Yes ( ) No Explain: _____

Was the delivery: ( ) Vaginal ( ) C-Section If C-Section, why? _____

Was the baby breast-fed initially? ( ) Yes ( ) No If yes, how long? _____

Patient's Medical History –Please list below.

Serious illnesses or medical conditions: ( ) none _____

_____

Surgeries: ( ) none _____

Hospitalizations: ( ) none _____

_____

Allergies to medicines or drugs: ( ) none _____

(Continued on back)

Does your child have, or has your child ever had any of the following?

	Yes	No	Explain
Chickenpox			
Frequent ear infections			
Hearing problems			
Vision problems			
Asthma/wheezing/pneumonia			
Heart problems			
Urinary tract infections (UTIs)			
Snoring			
Seizures			
High blood pressure			
Fractures/concussions			
Use of alcohol/tobacco/drugs			
ADHD/depression/mood problems			
Developmental delay			
(For girls) Problems with periods			
Pregnancy			

List any other significant health problems for this child. _____

_____

Biological Family History

Have any family members had any of the following?

	Yes	No	Who (explain)
Asthma			
Childhood hearing loss			
Tuberculosis			
Heart disease (before 55 years old)			
High cholesterol (on medications)			
Anemia/bleeding disorder			
Mental illness			
Tobacco use			
Alcohol/drug use			
Liver or kidney disease			
Epilepsy or seizures			

List any other significant health problems of family members. _____

_____

Signature of person completing this form. _____

Revised 9/27/10

TLC Pediatrics, PLLC Policies

Payment Policy: All co-pays, co-insurance, and deductibles are due at the time of service. We accept cash, check, Visa and Mastercard.

Your Insurance Card: Remember to bring your current insurance card to EVERY appointment. We will submit your claim but we must have accurate information to do so.

Deductibles: If you have a deductible, please be aware that we will collect in full the contracted rate at the time of service. Once you have met your deductible for the year, you may bring in proof and we will make a note in the computer that you have met your deductible for the remaining year with that insurance company.

Unpaid Accounts: If your account is not paid in a timely manner or payment arrangements are not kept, we will assign your account to a credit bureau.

Insurance Guidelines: Physicians are required to follow basic CPT and ICD-9 guidelines when determining how to code services. They must code your visit based upon what services were provided and cannot take into account particular health plan benefit designs. Consequently, we are unable to switch the visit reason and diagnosis in order for a claim to be covered by your insurance. If you think an error has occurred on your account, please contact the billing office immediately.

Newborns: You should contact your insurance company as soon as possible after your child has been born. Most health plans allow 30 days to add your newborn to your insurance plan.

Appointments: If you are unable to keep your appointment, please call at least 24 hours in advance to cancel. If you have additional sick children, please call to schedule a separate appointment for each child. Missing appointments may result in charges for the office visit and/or dismissal from the clinic.

_____ _____

Patient Name Parent /Guardian Signature

_____ _____

Date of Birth Date

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, parent/guardian of _____, have received a copy of TLC Pediatrics, PLLC's Notice of Privacy Practices.

_____ _____
Patient Name Parent / Guardian Signature

_____ _____
Date of Birth Signature Date

Medical Information Release

In accordance with HIPAA guidelines, TLC Pediatrics, PLLC is authorized to release my child's medical records to or discuss my child's medical care with the following:

Name	Relationship	Contact Number

_____ _____
Parent/Guardian Signature Date

_____ (initial) I authorize the above individual(s) to bring my child for evaluation and treatment. I understand that anyone that brings my child in is responsible to pay all applicable charges at the time of service. Please list anyone that is on the above list whom you do **not** give permission to bring the child in for evaluation and treatment.

_____

_____

_____

HIPAA GENERAL CONSENT

I hereby give my consent for TLC Pediatrics, PLLC to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in TLC Pediatrics, PLLC's Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

- I understand that I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.
- I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.
- I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.
- I understand that I have the right to revoke my consent; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

_____	_____
Patient - Printed Name	Patient – Signature (if age 18 or older)
_____	_____
Patient's Date of Birth	Parent/Guardian Signature
_____	
Date	

TLC Pediatrics, PLLC
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 provides you with information on the steps this Clinic has taken to protect the privacy of your Protected Health Information. It also describes some of the privacy rights you have and how you can exercise those rights. Please read this carefully. If you have any questions, please ask the receptionist if you can speak with Lindsey Dill at (501) 327-2444, who is our Privacy Official. Our Privacy Official can answer any questions you may have concerning this Notice.

Your Protected Health Information is that information that is created or received by this Clinic, transmitted by electronic form or maintained in any medium, that identifies you or could reasonably identify you, and relates to your past, present, or future:

1.) physical or mental health or condition;
2.) your health care treatment; or,
3.) the payment of your health care services.

I. USES AND DISCLOSURES:

A. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's consent form:

1.) Treatment.

In order to adequately provide for your health care needs, your PHI will be used and disclosed within the Clinic by the Clinic's employees and independent contractors as necessary to treat, evaluate, and provide you with health care services. This may also include the need for us to obtain PHI from your previous health care providers in order for us to treat you properly.

2.) Payment.

To receive payment for our services, the Clinic will have to disclose certain PHI to your Health Plan or Insurer. This could require disclosure prior to treatment to obtain pre-certification from your Insurer to perform a procedure or it could be a post treatment disclosure to obtain payment for the services provided. Your Insurer also has a right to demand access to your records to determine eligibility for making pre-existing condition determinations or for conducting quality control inspections. PHI may also be disclosed to comply with workers compensation laws and similar programs. The Clinic may also use and disclose limited PHI to consumer reporting agencies relating to collection of payments owed to the Clinic.

3.) Clinic Operations.

To ensure the proper functioning of our clinic, it may be necessary from time to time that certain PHI be used and disclosed. For example, we may use a sign-in sheet at the front desk to keep track of which patients have arrived. We may call out your name when it is time for you to come back to an exam room. Our employees and independent contractors may have to access our medical records for certain business operations. Our clinic may allow high school, college, or medical school "shadow" students in the clinic and they may be exposed to certain PHI.

4.) Referrals.

In order to effectively refer you to another physician, we will have to release certain PHI to that physician to assist that physician in your treatment and to make the necessary appointment.

5.) Consultations.

There may be occasions where the Clinic may desire to consult another professional about your treatment to get a second opinion. In those situations, the Clinic will always attempt to maintain your privacy to the maximum extent possible, recognizing that it may not always be an option.

6.) Business Associates.

As part of our business operations, we have to enter into agreements with third parties to assist us. These third parties can be accountants, computer consultants, transcriptionists, etc. These third parties may have to access certain PHI. Prior to any of our Business Associates having access to PHI, they will sign an agreement that requires them to have procedures in place to protect the privacy of your PHI.

B. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your opportunity to orally assent or object:

1.) Family Members of Individuals Involved in Your Care.

This Clinic may use and disclose PHI to your family members or other individuals who are involved in your care when the Clinic believes it is necessary to provide your location, general health condition, and in the case of your death. An example might be if you needed a ride home, we might contact a relative to provide you a ride.
You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

2.) Faculty Directories.

We may use PHI to maintain a listing of the name, location, general condition, and religious affiliation of individuals in our facilities and disclose it to religious personnel and to others who specifically request the information by identifying the individual by name. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

3.) Release of Immunization Records to Schools

The Clinic may release immunization records directly to schools with only an oral authorization from a parent or person acting in the place of a parent.

C. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) without your consent, authorization, or opportunity to assent or object:

1.) Legal Obligations.

This Clinic will use and disclose PHI when legally required. If this situation occurs, we will notify you and we will limit the PHI to the minimum necessary to comply with the law. Some examples are as follows: court orders, subpoenas, reporting suspected abuse or neglect, reporting adverse results to the Food and Drug Administration, reporting exposures to communicable diseases, certain criminal activity, and military activity.

2.) Inmates.

If you are an inmate, this clinic may use or disclose PHI to the facility and correctional officers when appropriate.

3.) Emergencies.

In an emergency treatment situation, our Clinic may use or disclose PHI. Our Clinic's health care professional will obtain your consent as soon as practicable following the emergency.

4.) Communication Barrier.

If there is a substantial communication barrier, this Clinic may use or disclose PHI for treatment, payment, or health care operations when circumstances would infer consent.

D. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's Authorization form:

Other uses and disclosures of your Protected Health Information that do not fit into one of the above categories shall only be allowed upon your signing one of our Clinic's specific authorization forms. An example of when this may be necessary is if you would want our Clinic to release your medical records to your employer. You would need to come in and complete a specific authorization for us to disclose your PHI to your employer, unless of course your employer is your health insurer. If your employer is your private health insurer, then it would have access to your medical records through your consent form.
You have the right to revoke any authorization, however, the revocation will not be effective to the extent the Clinic has relied on it.

E. Certain disclosures cannot be made without your specific authorization.

1.) Psychotherapy notes.

Most uses and disclosures or psychotherapy notes are prohibited unless you specifically authorize their release.

2.) Sale of PHI.

The sale of PHI occurs when the Clinic makes a disclosure of PHI and directly or indirectly receives remuneration from the recipient in exchange for the PHI.

3.) Use of PHI for Marketing.

The Clinic may use PHI for marketing purposes.

F. Additional disclosures include:

1) Use of PHI for Fundraising.

PHI may be used for fundraising purposes. You have the right to opt out of receiving such communications by contacting the Privacy Official.

2) Disclosure of PHI to a Plan Sponsor.

PHI may be disclosed to a plan sponsor, in cases of a group health plan, health insurance, or HMO.

3) Disclosure of PHI for Underwriting Purposes.

PHI may be disclosed for underwriting purposes, in which case PHI that is genetic information will be excluded from such disclosure.

II. RIGHTS

A. Right to Request a Restriction of Uses and Disclosures.

You have the right to notify our Privacy Official in writing that you request a restriction on our use and disclosure of your Protected Health Information. Our clinic does not have to grant your request and we can condition treatment on your willingness to consent to our uses and disclosures of your Protected Health Information. We will notify you in writing whether we will grant or deny your request. If your request is granted, we may choose, at a later date, to deny continuing the restriction and if so, we will notify you in writing of that decision.

B. Right to Request Confidential Communications.

You have the right, by making a written request, to request that all our communications with you concerning your Protected Health Information be confidential.. Your request must tell us how or where you wish to be contacted. We are required to accommodate only reasonable requests. We cannot ask you the reason for such a request.

C. Right to Inspect and Copy.

You have the right, by making a written request, to inspect and copy your Protected Health Information. There are a few exceptions to this rule. We must approve or deny your request within 30 days, although a onetime 30 day extension is allowed.
In the case of a denial, we will provide you with an explanation for the denial.
We will charge a reasonable fee for copying, preparation, and postage (if mailed to you), which must be prepaid. If the Clinic has electronic medical records, you also have the right to request that your PHI be provided to you in an electronic format.

D. Right to Amend.

You have the right, by making a written request, to request that we amend your Protected Health Information that we created. If you make such a written request, we will act on your request and respond in writing within 60 days. Should your request be denied, an explanation will be provided. You will have the right to appeal any denial to amend PHI.

E. Right to Receive an Accounting.

You have the right, by making a written request, to request that we provide you with an accounting of our disclosures of your Protected Health Information. The accounting will be provided within 60 days of the request. Standard disclosures are not included in the accounting. Examples of standard disclosures would be disclosures to you, for treatment, payment, and health care operations. The first accounting in a 12 month period is free. Any subsequent request for an accounting in the same 12 month period will result in a reasonable, cost-based fee.

F. Right to Receive Copy of Notice.

You have a right to receive a paper copy of our Notice of Privacy Practices. You may pick one up in our waiting room.

G. Right to File a Complaint.

The law requires us to comply with HIPAA and our Notice of Privacy Practices. If you feel we are not in compliance, you have the right to file an anonymous complaint with our office.

We have an anonymous drop box in our waiting room. You also can file a complaint by notifying our Privacy Official in writing. We will not retaliate in any manner due to a complaint. We value your opinion. You also have a right to file a complaint with the Secretary of the Department of Health and Human Services, who is charged with enforcement of this regulation.

H. Right to Restrict Release of PHI for Certain Services.

You have the right to restrict the disclosure of information regarding services, treatment or other items for which you have paid in full or on an out of pocket basis. This information can be released only upon your written authorization.

I. Right to Be Notified in Case of a Breach of PHI.

You have the right to be notified of any breach of your unsecured PHI.

III. DISCLOSURE STATEMENTS

A. This Clinic intends to use and disclose Protected Health Information in the additional following ways, on which treatment is conditioned:

1.) To have you sign in on a sign in sheet;
2.) To allow our staff to call out your name when it is time for you to come back for an exam, treatment, or consultation;
3.) To send out reminders of appointments;
4.) To provide alternative treatment information;
5.) To leave messages on voice mail systems with appointment reminders; and,
6.) To contact you at the phone numbers you provide and leave messages to reschedule appointments or to leave lab results.

B. The Law requires this Clinic have privacy protections for Protected Health Information and to give you Notice of its legal responsibilities to individuals.

C. This Clinic has to follow the terms and conditions contained in its Notice of Privacy Practices.

D. The Clinic retains the right to make retroactive changes to its Notice of Privacy practices. This means that if the Clinic changes its Notice of Privacy Practices and thus changes its Privacy Practices and Procedures it can and will apply those changes to Protected Health Information it received, obtained, and created prior to those changes if it chooses and states so in the Notice.

E. Any individual who would like a copy of any revised Notices of Privacy Practices shall submit such a request in writing to the Privacy Official whose name is listed on the first page of this Notice.

F. This Notice is effective this the 28th day of July, 2010.