Stacy C. Davis M.D., P.C.

Pediatric and Adolescent Medicine

WELCOME SHEET

THANK YOU FOR SELECTING OUR HEALTHCARE TEAM. WE WILL STRIVE TO PROVIDE THE BEST POSSIBLE HEALTHCARE. PLEASE FILL OUT THE ENTIRE FORM AND SIGN IT. THIS IS TO INSURE THAT WE PROVIDE YOU WITH THE BEST SERVICE POSSIBLE. IF YOU NEED ANY ASSISTANCE, PLEASE ASK US AND WE WILL BE MORE THAN HAPPY TO HELP.

PATIENT INFORMATION

NAME: FIRST **MIDDLE** **LAST** **BIRTHDAY**

SOCIAL SECURITY #: MALE ☐ FEMALE ☐ HOME PHONE: ( )

RACE **PLEASE CHECK ALL THAT APPLIES:** ALT PHONE: ( )

IS THE PATIENT HISPANIC? YES☐ NO☐

☐ ASIAN
☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE AMERICAN OR ALASKAN NATIVE
☐ WHITE
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER
☐ NOT PROVIDED

ADDRESS: APT#: CITY: STATE: ZIP:

CHILD RESIDES WITH: **NEWBORNS ONLY:** /
LAST NAME AT TIME OF BIRTH **HOSPITAL/PLACE OF BIRTH**

ROUTINE PHARMACY

ADDRESS: CITY STATE

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN) A

NAME **MIDDLE** **LAST** **BIRTHDAY**

SOCIAL SECURITY #: MALE ☐ FEMALE ☐ RELATIONSHIP TO PATIENT:

ADDRESS:

APT#: CITY: STATE: ZIP:

DRIVER'S LICENSE#: STATE

EMPLOYER: EMPLOYER PHONE#: ( )

EMPLOYER ADDRESS:

PARENT OR GUARDIAN B

NAME **MIDDLE** **LAST** **BIRTHDAY**

MALE ☐ FEMALE ☐ RELATIONSHIP TO PATIENT: HOME PHONE: ( )

AUTHORIZED TO MAKE DECISIONS REGARDING THE PATIENT'S HEALTH? YES☐ NO☐

MAY WE INFORM THIS PERSON ABOUT YOUR CHILD'S GENERAL MEDICAL CONDITION, COURSES OF MEDICAL TREATMENT, AND DIAGNOSIS? YES☐ NO☐

EMERGENCY CONTACT ***someone other than the responsible parties***

NAME: **BIRTHDAY**

RELATIONSHIP TO PATIENT: MALE ☐ FEMALE ☐ HOME PHONE: ( )

ADDRESS: APT#: CITY: STATE: ZIP:

AUTHORIZED TO MAKE DECISIONS REGARDING THE PATIENT'S HEALTH? YES☐ NO☐

MAY WE INFORM THIS PERSON ABOUT YOUR CHILD'S GENERAL MEDICAL CONDITION, COURSES OF MEDICAL TREATMENT, AND DIAGNOSIS? YES☐ NO☐

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Stacy C. Davis M.D., P.C., may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Stacy C. Davis M.D., P.C. Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Stacy C. Davis M.D., P.C., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Stacy C. Davis M.D., P.C., 1450 Winter Street, Augusta, GA 30904.

Stacy C. Davis M.D., P.C., may call my home and /or cell phone and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Stacy C. Davis M.D., P.C. may mail to my home any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements and laboratory results. I have the right to request that Stacy C. Davis M.D., P.C., restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Stacy C. Davis M.D., P.C. to use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I revoke my consent, Stacy C. Davis M.D., P.C. reserves the right to dismiss me from the practice after proper written notice is given. If I do not sign this consent, Stacy C. Davis M.D., P.C., reserves the right to decline to accept me as a patient. This form is not alterable and any cross outs / changes are not acceptable.

GUARANTOR SIGNATURE _____ DATE

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OUR VACCINE PHILOSOPHY

Children should receive the recommended vaccines according to the guidelines provided by the AAP and the CDC. Vaccines are safe and effective in preventing diseases and health complications in children and young adults. Regular vaccinations help children ward off infections, and are administered as one of the safest and best methods of disease prevention.

Our practice follows the immunization guidelines recommended by the American Academy of Pediatrics (AAP). For information about these vaccines and the diseases they protect against, please visit http://www.aap.org/healthtopics/immunizations.cfm

For detailed informational sheets published by the Centers for Disease Control (CDC) please visit www.cdc.gov/vaccines/pubs/vis. The employees of this office are carrying out the direction and policies of Dr. Stacy C. Davis. If you should find problems with these policies or any other problems please report any problems to the office manager.

I have read and understand the Policies Form. I understand that violation of the policies could result in immediate termination form this practice.

GUARANTOR SIGNATURE_____DATE_____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT AND E-PRESCRIPTION INFORMED CONSENT FORM

The purpose of this form is to record acknowledgement of receipt of Privacy Notice, as required by the Health Information Portability and Accountability Act of 1996 (HIPAA). Should such acknowledgment be unobtainable, this form will document Stacy C. Davis M.D., P.C.'s good faith attempt to acquire such knowledge.

I acknowledge receipt of Stacy C. Davis M.D., P.C. Privacy Notice and Practices. I have read and understand these practices and my medical Protected Health Information privacy rights as stated in the company Notice materials.

We are pleased to offer a new feature to our patients. We can now automatically obtain your child's prescription history from e-Med Hx via Surescript and download the prescription information into your child's electronic medical chart. It will make it easier for you to share your child's medical history with us and give us the ability to provide you and your child with better, more efficient quality care.

In order to take advantage of this program, we will require your permission. Please complete as indicated below and return the form to the receptionist.

I GIVE permission to Stacy C. Davis M.D., P.C. to obtain my child's prescription history directly from e-Med Hx.

PATIENT: _____

GUARANTOR: _____ DATE: _____

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Pediatric and Adolescent Medicine

FINANCIAL AGREEMENT

Insurance

Your insurance policy is a contract between you and your insurance company. If insurance is available, we request that you present your card each visit. In accordance with the insurance contracts, we will expect full payment of your **co-payment, co-insurance, and/or deductible at the time of service.** We accept the following method of payment: CASH, CREDIT, and CHECK. There will be a $30.00 return fee for all insufficient items. If your insurance does not allow our fees in full, you are responsible for your balance unless we have a participation contract with you insurance carrier. Please note that our fees are reasonable and customary and allowed by most major insurance carriers.

Appointments will be rescheduled if co-payment is not paid at the time of service.

Medicaid and HMO Commercial Plans

Medicaid patients are expected to list Dr. Davis as PCP prior to appointment and to present their insurance cards at every visit. We will not verify eligibility information without the insurance card.

Returned Checks/ Collection of Delinquent Account

There is a $30.00 returned check fee assessed to all returned checks. The Guarantor will be notified by mail and have 15 days to make the payment. This payment must be made by cash, money order, or credit card. If payment is not received the check may be submitted to our collection agency or to the Magistrate for collections. All future visits will require payment by cash or credit card only.

The Guarantor will be responsible for additional expenses incurred in order to collect a delinquent account**. Delinquent accounts, where payments agreements have not been honored or made, will result in termination of the patient from the practice.** Termination letters will be sent by certified mail.

Laboratory Services

We use Labcorp for labs. Our staff will attempt to determine the lab your insurance covers, but it is ultimately **YOUR RESPONSIBILITY**, as the guarantor to the patient to know which lab your insurance carrier requires you to use. All lab charges not paid by the patient's insurance company will be billed to the guarantor and the balance due will be that of the guarantor.

Collections Acknowledgement

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also agree to be responsible for up to 50% collection fees, plus any, and all legal fees and court cost.

I have read the Financial Policy and I understand the policy.

GUARANTOR SIGNATURE_____ DATE_____

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OFFICE POLICY

We consider it an honor that you have chosen Stacy C. Davis, M.D., P.C. as your child/children's health care provider, and we will strive to meet your expectations. There are a large number of children needing medical treatment and we have established certain policies to help us provide quality care to as many children as possible. Thank you for your cooperation.

OFFICE ENVIRONMENT

The office of Dr. Stacy Davis is a family oriented environment.

To minimize the spread of germs and pest there is no eating or drinking in the office.

Parents are expected to supervise your child/children in the waiting rooms, outside, and in the restroom. Destructive activity and annoyances of other patrons will not be permitted and can result in dismissal from the practice.

Patients, Parents, or Guardians who use abusive language, profane language, or any form of disruptive behavior (In the presence of or by use of telephone) will not be permitted to have their children treated in this office.

Parents and patients are required to wear appropriate attire to the office.

APPOINTMENT POLICY

We ask parents not to bring other family members or friends to appointments due to limited waiting room space.

We see our patients by appointment and do our best within the limits of circumstances that we can control, to see our patients on time. We feel that patients deserve our attention during the appointment time we have reserved for them.

We will not see patients who arrive more than 30mins late; those appointments will count as a missed appointment.

At least 24hours notification is required for appointment rescheduling or cancellations, failure to notify the office will count as a no-show appointment.

Dr. Davis will only see two patients from the same house hold in one visit.

If you realize that you cannot come to your scheduled appointment, please let us know at least 24 hours before your child's appointment. If you are running late for your appointment please call ahead to let us know.

There is limited availability for 3:00 pm appointments for many school aged patients. We ask for your cooperation for those appointment times.

Three consecutive no-show appointments will result in dismissal from the practice for the entire family.

WALK-IN POLICY

We strongly discourage walk-in visits as this is unfair to our patients who have previously scheduled appointments and it interferes with our ability to deliver safe medical care in a timely manner to all of our patients.

We request that all patients call for an appointment before coming to our office. Same day appointments may be available.

There are very rare instances in which it is appropriate to come in before calling. A life threatening or potentially life-threatening situation is not one of these instances. Anytime a parent feels that a life threatening medical condition is present, the appropriate course of action is to immediately call 911.