PEDIATRIC CARDIOLOGY OF MONTGOMERY
Barton B. Cook, M.D., F.A.C.C.
Gerardo S. Gonzalez, M.D., F.A.C.C.

Fran Jackson, Administrator
Email: *fjackson@psm239.com*

239 Mitylene Park Drive
Montgomery, AL 36117
Phone: 334-612-2111
Fax: 334-612-2166
childrensheartdoc.com

PATIENT:_____ DOB:_____ AGE:_____
ADDRESS:_____
CITY_____ST_____ZIP_____
PATIENT'S SOCIAL SECURITY NUMBER:_____
HOME PHONE:_____ SEX:_____ RACE:_____
REFERRING M.D.:_____FAMILY PHYSICIAN:_____
DO YOU HAVE AN ANSWERING MACHINE?_____ IF YES, WHEN NEEDED MAY WE LEAVE A MESSAGE ON YOUR MACHINE?_____
E-MAIL:_____ MAY WE E-MAIL YOU?_____

PARENT/GUARDIAN INFORMATION

NAME OF MOTHER/GUARDIAN:_____
ADDRESS, if different from patient:_____
MOTHER'S SS #:_____ DOB:_____
MOTHER'S/GUARDIAN'S EMPLOYER:_____
MOTHER'S WORK #:_____ HOME #:_____
CELL PHONE #:_____

NAME OF FATHER/GUARDIAN:_____
ADDRESS, if different from patient:_____
FATHER'S SS #:_____DOB:_____
FATHER'S/GUARDIAN'S EMPLOYER:_____
FATHER'S WORK #:_____ HOME #:_____
CELL PHONE #: _____

PERSON RESPONSIBLE FOR BILL:_____ RELATIONSHIP:_____

IF YOU ARE **LEGAL GUARDIAN**, WE WILL NEED A COPY OF THE COURT ORDER. WE WILL NOT BE ABLE TO SEE THE PATIENT WITHOUT THIS LEGAL DOCUMENT. IF YOU HAVE QUESTIONS REGARDING THIS, PLEASE CALL OUR OFFICE PRIOR TO THE APPOINTMENT.

PHARMACY NAME:_____LOCATION:_____
PHARMACY PHONE:_____

NAME, ADDRESS, PHONE NUMBER **AND RELATIONSHIP** OF A PERSON NOT LIVING IN YOUR HOME THAT MAY BE CONTACTED IN CASE OF AN EMERGENCY:_____
_____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY:_____

ADDRESS:_____

POLICY HOLDER:_____ DOB:_____

POLICY HOLDER ADDRESS:_____

POLICY HOLDER PHONE #: HOME:_____ WORK:_____

POLICY HOLDER EMPLOYER:_____

POLICY #:_____ GROUP #:_____

PAYMENT POLICIES:

ALL CO-PAYS FOR VISITS AND TESTS ARE DUE AT THE TIME OF SERVICE. IF YOU WILL BE UNABLE TO DO SO, PLEASE CONTACT OUR BUSINESS OFFICE BEFORE YOUR APPOINTMENT DATE.

WE WELCOME VISA, MASTERCARD, CHECK OR CASH TO PAY THESE IN FULL.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED BY THIS CLINIC. I ALSO UNDERSTAND THAT IF PAYMENT IS NOT MADE, THAT I WILL BE RESPONSIBLE FOR ANY/ALL COLLECTION AGENCY FEES (33.33%), ATTORNEY FEES AND/OR COURT COSTS, IF SUCH BE NECESSARY.

My Co-pay amount is: $_____

DATE:_____ _____

Responsible party signature/Relationship to patient

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Patient Consent to the Use and Disclosure of Medical Records for Treatment, Payment, or Healthcare Options

I, _____, understand that as part of my healthcare, Pediatric Specialists of Montgomery originates and maintains paper and/or electronic records describing my health, symptoms, examination and test results, diagnoses, treatment and any plans for future health care treatment. I understand that this information serves as:
(1) A basis of communication among the many health professionals who contribute to my care (2) A source of information for applying my diagnosis and surgical information to my bill (3) A means by which a third-party payer can verify that services billed were actually provided, and (4) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professions.

I understand and have been provided with a *Notice of Privacy Policies* that provide a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
(1) The right to review the notice prior to signing this consent (2) The right to reject the use of my health information for directory purposes, and (3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

In addition to myself, I consent to the following adult individuals to have access to my medical records: (please give full name and address) (athletes should consider their coaches and trainers)

_____

_____

I understand that Pediatric Specialists of Montgomery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pediatric Specialists of Montgomery reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information

By my signature below I acknowledge that I have received the Privacy Notice of Pediatric Specialists of Montgomery, L.L.C. I understand that the physicians and staff of Pediatric Specialists of Montgomery, L.L.C. WILL NOT discuss my health information with my family or friends unless I expressly authorize them to do so. This authorization may be revoked at any time by me in writing. I hereby authorize the physicians and staff of Pediatric Specialists of Montgomery to convey information about my health to the following people:

Name: _____ Relationship _____

Name: _____ Relationship _____

Pediatric Specialists of Montgomery will call your home telephone to remind you of your appointment unless directed not to by you. If you have caller ID any calls from us will register. Please check one:

- ☐ Do NOT call me at all.
- ☐ Call me and leave a message on my answering machine/ voicemail if there is no answer
- ☐ Call me but do NOT leave a message on my answering machine/ voicemail.

EXPRESS PRIOR CONSENT TO CALL CELL PHONE:
I, the undersigned, give Pediatric Specialists of Montgomery , it's employees, and/or agents express prior consent to contact me at any/all phone numbers, including cell phone numbers, (by phone call or text message), for the purpose of insurance, treatment, and payment.

_____
Patient's Signature/Parent/Guardian

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____

PEDIATRIC CARDIOLOGY OF MONTGOMERY
New Patient Questionnaire – Patient Information

Patient's Name: _____ **DOB:** _____
Drug Allergies: _____

Current Medications:	Strength	Dose	How Often	Reason
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

List all overnight hospital stays and surgeries with dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Grade patient is in: _____ **Daycare/School Name:** _____

Primary Caregiver _____ **Number of Brothers** _____ **Number of Sisters** _____

List Activities: _____

	Yes	No	
Does patient smoke:			Number per day: _____
Does patient drink alcohol:			Amount per day: _____
Does patient use recreational drugs:			Amount per day: _____
Does patient drink caffeine:			Amount per day: _____

	Yes	No
1. Allergies		
2. ADD/ADHD		
3. Anemia		
4. Asthma		
5. Blue fingers/lips		
6. Chest pain		
7. Clotting disorders		
8. Cough		
9. Contacts/glasses		
10. Depression		
11. Diabetes		
12. Dizziness		
13. Easily tired		
14. Frequent urinary infections		
15. Headaches		
16. Hearing loss		
17. High blood pressure		
18. High cholesterol		
19. Irregular heartbeat		
20. Joint Pain		

	Yes	No
21. Kidney disease		
22. Loss of appetite		
23. Mental illness		
24. Mitral valve prolapse		
25. Murmur		
26. Nausea		
27. Nervousness/Anxiety		
28. Pacemaker		
29. Palpitation		
30. Passing out		
31. Pregnancy		
32. Rapid breathing		
33. Rashes		
34. Recent fever		
35. Seizures		
36. Sickle cell		
37. Thyroid disease		
38. Weight gain/loss		
39. Wheezing		
40. Other _____		

PEDIATRIC CARDIOLOGY OF MONTGOMERY
New Patient Questionnaire – Familial Medical History

Please fill out according to the relationship to the patient. ONLY check boxes that apply

	Sibling	Mother	Maternal Aunt	Maternal 1st cousin	Maternal Grandfather	Maternal Grandmother	Maternal Uncle	Father	Nephew/ Niece	Paternal Aunt	Paternal 1st Cousin	Paternal Grandfather	Paternal Grandmother	Paternal Uncle
Bypass Surgery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deafness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Birth Defect	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irregular Heartbeat	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Murmur	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pediatric Specialists of Montgomery, LLC

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.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your healthcare.

Our Duties. We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are also required to follow the terms of the Notice currently in effect.

How We May Use And Disclose Health Information About You. We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We will use and disclose your health information while providing, coordinating or managing your health care. For example, information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will put in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We may also provide other healthcare providers with your information to assist them in treating you.

Payment: We will use and disclose your medical information to obtain or provide compensation or reimbursement for providing your healthcare. For example, we may send a bill to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. As another example, we may disclose information about you to your health plan so that the health plan may determine your eligibility for payment for certain benefits.

Health Care Operations: We will use and disclose your health information to deal with certain administrative aspects of your healthcare, and to manage our business more efficiently. For example, members of our medical staff may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. We may disclose your health information to our business associates so they can perform the job we've asked them to do. However, we require business associates to take precautions to protect your health information.

Notification of Family: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition.

Communication with Family: We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

Research: Consistent with applicable law we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Director, Coroner, and Medical Examiner: Consistent with applicable law, we may disclose health information to funeral directors, coroners, and medical examiners to help them carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may use certain information for purposes of raising funds.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events, product defects, or post-marketing surveillance information to enable product recalls, repairs or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse and neglect.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Health Oversight: In order to oversee the healthcare system, government benefits programs, entities subject to governmental regulation and civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversight activities authorized by law, such as audits and civil, administrative or criminal investigations.

Court Proceeding: We may disclose your health information in response to requests made during judicial and administrative proceedings, such as court orders or subpoenas.

Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care: (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Threats to Public Health or Safety: We may disclose or use health information when it is our good faith belief, consistent with ethical and legal standards, that it is necessary to prevent or lessen a serious an imminent threat or is necessary to identify or apprehend an individual.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Other Uses: We may also use and disclose your personal health information for the following purposes:

- To contact you to remind you of an appointment for treatment;
- To describe or recommend treatment alternatives to you;
- To furnish information about health-related benefits and services that may be of interest to you;
- For certain charitable fund raising purposes.

Prohibition on Other Uses or Disclosures. We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you may revoke the authorization by writing to the contact person listed below. Understandably, we are unable to take back any disclosure we have already made with your permission.

Individual Rights. You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and healthcare operation. We are not required to agree to these requests. To request restrictions, please send a written request to the address below.
- To receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the address below, and tell us how or where you wish to be contacted.
- To inspect or copy your health information. You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed healthcare professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if:
  The information was not created by us, unless the person that created the information is no longer available to make the amendment,
  The information is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy, or is accurate and complete.
- To receive an accounting of disclosures of your health information. You must submit a request in writing to the address below. Not all health information is subject to this request. Your request must state a time period, no longer than 6 years and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically). The first accounting your request within a 12-month period is free. For additional accountings, we may charge you the cost of providing the accounting. We will notify you of this cost and you may choose to withdraw or modify your request before charges are incurred.
- To receive a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically. You must submit a request for a paper notice in writing to the address below. All requests to restrict use of your health information for treatment, payment and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed below.

Fees for copying of medical records is as follows:

$5.00 administrative charge
$1.00 per page of the first 25 pages
$.50 per page above that.

Complaints. If you believe that your privacy rights have been violated, a complaint may be made to our privacy officer at 334-612-2111 or the address listed below. You may also submit a complaint to the Secretary of the Department of Health and Human Services at The Office of Civil Rights, The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. 202-619-0257 or toll free at 877-696-6775. We will not retaliate against you for filing a complaint.

Contact Person. Our contact person for all questions, requests or for further information related to the privacy of your health information is:
Fran Jackson, Privacy Officer: 239 Mitylene Park Dr., Montgomery, AL 36116. 334- 612-2111.

Changes to This Notice. We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.

Notice effective: April 1, 2003