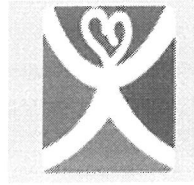


PEDIATRIC CARDIOLOGY OF MONTGOMERY

Barton B. Cook, M.D., F.A.C.C.
Gerardo S. González, M.D., F.A.C.C.



239 Mitylene Park Drive
Montgomery, AL 36117
Phone: 334-612-2111
Fax: 334-612-2166
Facebook.com/Pediatric Cardiology Montgomery

Lynn Todd, Administrator
Email: lynn@psm239.com
www.childrensheartdoc.com

PATIENT _____ DOB _____ AGE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PATIENT'S SOCIAL SECURITY NUMBER _____
SEX _____ RACE _____ HISPANIC _____ NON-HISPANIC _____
PATIENT'S PHYSICIAN _____

PARENT/GUARDIAN INFORMATION

NAME OF MOTHER/GUARDIAN _____
ADDRESS, IF DIFFERENT FROM PATIENT _____
MOTHER'S SOCIAL SECURITY# _____ DOB _____
MOTHER'S/GUARDIAN'S EMPLOYER _____
MOTHER'S WORK# _____ HOME# _____
CELL PHONE# _____

NAME OF FATHER/GUARDIAN _____
ADDRESS, IF DIFFERENT FROM PATIENT _____
FATHER'S SOCIAL SECURITY # _____ DOB _____
FATHER'S/GUARDIAN'S EMPLOYER _____
FATHER'S WORK# _____ HOME# _____
CELL PHONE# _____

PERSON REPOSIBLE 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 ANY 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:

Primary Insurance Company: _____

Policy Holder: _____ DOB: _____

Policy Holder Phone#: _____ Work#: _____

Policy# _____ Group# _____

Secondary Insurance Company: _____

Policy Holder: _____ DOB: _____

Policy Holder Phone#: _____ Work# _____

Policy# _____ Group# _____

PAYMENT POLICIES:

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

WE WELCOME VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, 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 ATTORNEY FEES AND/OR COST OF COLLECTION.

DATE: _____

Responsible party signature/Relationship to patient

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Patient's Name: _____

Patient HIPAA Release Form

The Health Insurance Portability & Accountability Act (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential.

A copy of this policy is available to you at your request

The Doctors and Staff of Pediatric Cardiology of Montgomery, L.L.C. may release information on my child's health to the following individual's:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Pediatric Cardiology of Montgomery will call/text you to remind you of your appointment unless directed not to by you. On caller ID, any calls from us will register. Please check one:

- Do Not call/text me at all
- Call/text me and leave a message on voicemail

EXPRESS PRIOR CONSENT TO CALL PHONE:

I, _____ give Pediatric Cardiology of Montgomery, its 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/parent, and treatment refused as permitted
- Consent added to the patient's medical 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 of Activities: _____

	YES	NO
Does patient smoke		
Does patient drink alcohol		
Does patient use recreational drugs		
Does patient drink caffeine		

Number per day _____
 Amount per day _____
 Amount per day _____
 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		
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		
39. Weight loss		
40. Wheezing		
41. Other _____		

PEDIATRIC CARDIOLOGY OF MONTGOMERY

Biological family history pertaining to the **PATIENT**

(Mom, Dad, Siblings, Grandmother/Grandfather, Aunt/Uncle, Niece/Nephew, and 1st cousins)

Does any family members have/had any of the following?

Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Deafness	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Heart Attack	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Heart Birth Defect	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Heart Surgery	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
High Blood Pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
High Cholesterol	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Irregular Heartbeat	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Mitral Valve Prolapse	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Murmur	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Pacemaker	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Sudden Death	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____
Thyroid	<input type="checkbox"/> yes	<input type="checkbox"/> no	Mother side or Father side or Both:	Which family member's: _____

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 and 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