NORTH MARSHALL
PEDIATRICS

Medical Records Release Authorization

45 Medical Park Drive, Suite B
Guntersville, AL 35976

Phone: (256) 860-4100 ■ Fax: (256) 752-0026

PATIENT'S INFORMATION

Patient's Name: _____
Last First Middle

D.O.B.: _____/_____/_____ Age: _____ Sex: _____

RELEASE OF PATIENT INFORMATION

Please Select ONE: □ **Obtain Records From** □ **Release Records To**

Practice/Facility/Person	
Phone Number	**Fax Number**

Information to be Obtained or Released: ***(Ex: Entire Medical Record, Specific Date(s) of Services, Immunization Records, etc.)***

_____

_____

Purpose for Obtaining or Releasing Information:

□ Transfer to Another Pediatric Practice □ Personal Usage □ Moving out of Area

□ Transfer to Adult Practice □ Legal Usage □ Other: _____

I hereby authorize North Marshall Pediatrics, P.C., or the recipient listed above, to use or disclose protected health information regarding myself (if ≥ 14 years old)/my child's care and treatment. I understand that if the patient's medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release unless I specify otherwise. I understand information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by the HIPAA Rules. Obtaining or releasing the specified information to any person or entity not specified above is prohibited. Only the specified information from this practice can be legally released, and any information or record from another practice or facility must be obtained directly from them.

I understand have the right to revoke this authorization in writing at any time except to the extent that the practice has acted in reliance upon this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I agree to hold North Marshall Pediatrics, P.C. harmless and release them from any liability for any claims or actions, which may occur as a result of the obtained/released information. I understand that this authorization will expire twelve months from the date signed, and I understand I have a right to receive a copy of this request.

Please Select ONE:

□ I hereby state that I am the child's parent or legal guardian and have the legal right to make and or restrict healthcare decisions regarding this child, and that my parental authority has not been terminated or restricted by the courts. I also attest that this child is less than 14 years old and/or is physically/mentally handicapped and not able to sign this authorization for himself/herself.

□ I hereby state that I am the patient listed above and I am 14 years old or older.

_____ _____
Print Name of Patient/Parent/Legal Guardian Relationship to Patient

_____ _____/_____/_____
Signature of Patient/Parent/Legal Guardian Date Signed

NORTH MARSHALL PEDIATRICS

Patient Registration Form

Today's Date: ____/____/____

PATIENT'S INFORMATION

Patient's Name: _____
Last First Middle

D.O.B.: ____/____/____ Age: ____ Sex: ____ SSN: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Primary Phone Contact#: _____

Preferred Family Email Address: _____

****By consenting to these options, you are authorizing North Marshall Pediatrics, P.C. to utilize them to discuss the patient's medical information.**

Consent to Call: ☐ **Yes** ☐ **No** **Consent to Text:** ☐ **Yes** ☐ **No**

Consent to Portal: ☐ **Yes** ☐ **No** **Consent to Voicemails:** ☐ **Yes** ☐ **No**

MOTHER'S INFORMATION

Mother's Name/Legal Guardian: _____
Last First Middle

D.O.B.: ____/____/____ Age: ____ SSN: _____-_____-_____

Occupation/Employer: _____

Mother's Address (If Different): _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Work #: _____

FATHER'S INFORMATION

Father's Name/Legal Guardian: _____
Last First Middle

D.O.B.: ____/____/____ Age: ____ SSN: _____-_____-_____

Occupation/Employer: _____

Father's Address (If Different): _____

City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Card Holder's Name: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Card Holder's Name: _____ Relationship to Patient: _____

Tertiary Insurance Company: _____

Card Holder's Name: _____ Relationship to Patient: _____

PATIENT'S SIBLING INFORMATION

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

Name: _____

D.O.B.: ____/____/____ Age: _____ Sex: ____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship to Patient: _____

Phone #: _____ Cell #: _____ Work #: _____

2. Name: _____ Relationship to Patient: _____

Phone #: _____ Cell #: _____ Work #: _____

FEDERAL GOVERNMENT MANDATED INFORMATION

We are required to collect the following information for each patient. Please be sure to complete this section before returning the form.

Preferred Language (Please Select One):

- ▫ English
- ▫ Spanish
- ▫ Chinese
- ▫ Japanese
- ▫ Vietnamese
- ▫ Arabic
- ▫ Other: _____

Patient's Race (Please Select One):

- ▫ White
- ▫ Black/African American
- ▫ Native Hawaiian
- ▫ Asian
- ▫ American Indian/Native Alaskan
- ▫ Other Pacific Islander
- ▫ Other
- ▫ Unknown:
- ▫ Decline to Answer

Patient's Ethnicity (Please Select One):

- ▫ Latino/Hispanic
- ▫ Not Latino/Not Hispanic
- ▫ South African
- ▫ Mexican
- ▫ Puerto Rican
- ▫ Other:
- ▫ Unknown:
- ▫ Decline to Answer:

RECEIPT OF *NOTICE OF PRIVACY PRACTICES* WRITTEN ACKNOWLEDGEMENT INFORMATION

By signing below, I acknowledge I have received a copy of North Marshall Pediatrics, P.C.'s ***Notice of Privacy Practices*** in which the effective date of the Privacy Notice is 10/01/2022.

_____
Print Name of Parent/Legal Guardian

_____
Relationship to Patient

_____
Signature of Parent/Legal Guardian

_____/_____/_____
Date Received and Signed

NORTH MARSHALL PEDIATRICS

Child Health History Form

Patient's Name: _____
Last First Middle

D.O.B.: ____/____/____ **Sex:** ____ **Previous Pediatrician/Physician:** _____

School/Daycare: _____ **School Grade Level:** _____

Marital Status of Patient's Parents: □ Married □ Divorced □ Unmarried □ Separated □ Widow/Widower

Patient Lives With: □ Both Parents □ Mother □ Father □ Relatives □ Adoptive Parents □ Foster Parents
□ Other: _____

Patient's Pharmacy: _____

PAST MEDICAL/SURGICAL HISTORY INFORMATION

Do you have any developmental concerns about this patient? If so, please list: _____

Does the patient have any known birth defects? If so, please list: _____

Please check ALL that apply to this patient:

□ ADD/ADHD	□ Bed Wetting	□ Chronic Cough	□ Frequent Ear Infections	□ Poor Vision
□ Allergies Changes	□ Behavior Problems	□ Congenital Anomaly	□ Hearing Difficulties	□ Recent Weight
□ Anemia	□ Bladder/Kidney Infections	□ Constipation	□ Heart Murmur	□ Seizures
□ Anxiety Disorder	□ Blood in Stools	□ Diabetes	□ Joint Swelling	□ Thyroid Disorder
□ Asthma	□ Broken Bones	□ Diarrhea	□ Lazy Eye	□ Other
□ Autism /ASD	□ Cancer	□ Depression	□ Muscle Weakness	

Please list any and all serious accidents or injuries: _____

Please fill in if the patient has had any surgeries or hospitalizations:

Surgery/Hospitalization Date: _____/_____/_____ Reason: _____

Surgery/Hospitalization Date: _____/_____/_____ Reason: _____

Surgery/Hospitalization Date: _____/_____/_____ Reason: _____

PATIENT MEDICATION HISTORY INFORMATION

Is the patient allergic to any medications/immunizations?

Name of Medicine/Immunization: _____ Type of Reaction: _____

Name of Medicine/Immunization: _____ Type of Reaction: _____

Please list any and all prescriptions and over-the-counter medications the patient is currently taking, including dosages:

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY INFORMATION

Please circle and list all that apply:
(We ask that you limit the history to: Parents, Siblings, Grandparents & Aunts/Uncles ONLY)

Problems:	**Relationship to Patient:**	**Problems:**	**Relationship to Patient:**
ADD/ADHD	_____	Kidney or Bladder Disease	_____
Alcohol/Drug Abuse	_____	Lung Disease	_____
Asthma	_____	Intellectual Disability	_____
Autism/ASD	_____	Metabolic Disorders	_____
Birth Defects	_____	Neurologic Disease	_____
Blood Disorders	_____	Psychiatric Disorders	_____
Bone Disorders	_____	Seizures or Epilepsy	_____
Cancer	_____	Skin Disease	_____
Diabetes	_____	Smoker/Tobacco Use	_____
Heart Disease	_____	Stroke	_____
High Blood Pressure	_____	Thyroid	_____

Other: _____

Unexplained or Early Deaths in the Family: _____

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Parent Delegation Form

Patient's Name: _____
Last First Middle

D.O.B.: _____/_____/_____ Sex: _____

DELEGATION OF CARE

I, the undersigned parent/guardian of the patient listed above, authorize North Marshall Pediatrics, P.C. to deliver any necessary treatment or immunization(s) to my child when brought by myself or another responsible party or when alone (if ≥ 14 years old) during this and all subsequent visits. The necessary treatments may include, but are not limited to: medicines, immunizations, imaging, performance of procedures or other studies.

I, the undersigned parent/guardian of the patient listed above, authorize the following persons to present my child to North Marshall Pediatrics, P.C. for medical care in my absence and authorize them to sign for immunizations or any other treatments that are deemed necessary by North Marshall Pediatrics, P.C. and its personnel. The following persons are the ONLY people (other than the patient's biological parents or legal guardians) authorized to bring your child to the doctor's office. This delegation shall be valid until I withdraw my delegation of consent.

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

Name: _____ Phone #: (____) ____-_____ Relationship to Patient: _____

DELEGATION OF RECORDS/DEMOGRAPHIC INFORMATION

I permit North Marshall Pediatrics, P.C. to furnish any medical or demographic information requested by insurance companies with whom I have coverage or public agency which may be assisting in payment of the patient's care and/or any provider(s) referred to or any provider(s) referring this patient for treatment. I am aware that if I need limitations or restrictions on the patient's records, I am to inform North Marshall Pediatrics, P.C. immediately along with the necessary documentation.

I consent that North Marshall Pediatrics, P.C., and/or any affiliates or vendor, may call my home or other designated location and provided telephone numbers, and may 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.

DELEGATION OF PAYMENT

I hereby authorize payment directly to North Marshall Pediatrics, P.C. of benefits otherwise payable to me including major medical insurance and payment of medical benefits, but not to exceed the North Marshall Pediatrics, P.C. charges for these services. I understand that I am financially responsible to North Marshall Pediatrics, P.C. for charges not covered by this assignment, including all co-pays, deductibles, co-insurance and/or unpaid balances not covered by insurance regardless of marital status. Therefore, I acknowledge that regardless of insurance coverage, I am responsible for my account, and my account to be paid within 30 days. I understand that if this account is referred to an attorney, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection and enforcement, including attorney fees. I also authorize that refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

By signing this form below, I certify that I am the authorized parent or authorized agent/guardian of the patient and knowledgeable to furnish the information requested above.

_____ _____
Print Name of Parent/Legal Guardian Relationship to Patient

_____ _____/_____/_____
Signature of Parent/Legal Guardian Today's Date

NORTH MARSHALL
PEDIATRICS

Our Office's Policies

OFFICE HOURS AND EMERGENCIES

Our office hours are Monday through Friday from 8:00am to 5:00pm. We are closed for lunch from 12:00pm to 1:30pm.

Holidays: Our office is closed for all major holidays, such as: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, the day after Thanksgiving Day and Christmas Day. Depending on the day of the week the holiday falls, our office may be closed additional days.

Emergencies/After Hours: If you have a medical emergency, please call 911 or take your child to the nearest emergency room. If you would like to speak with our on-call after hours service regarding a true, urgent medical issue, please call our office at: (256) 860-4100 and press option 1.

APPOINTMENT POLICIES

In order to provide timely service to our patients, we prefer that you call and schedule appointments, as we are not a walk-in clinic. Our providers and staff do their best to stay on schedule as much as possible; however, delays and emergencies do happen and we ask that you be considerate of those delays or emergencies.

Punctuality is appreciated. We ask that you arrive on-time to your scheduled appointment in order to further assist our providers and staff with staying on schedule. If you are more than 15 minutes late for your scheduled appointment, the system will remove you from our schedule. Depending on the availability of our schedule, we will attempt to reschedule your appointment for the first available appointment. If you know that you are going to be late for your appointment, please call ahead so that you may be able to keep your appointment time. However, if you know you are unable to keep your appointment, we ask that you call at least 24 hours in advance to cancel.

Well Child Visit Appointments: In order to keep your children healthy, it is important to bring them in for regular/annual checkups. We recommend that you call at least 1 week in advance of needing your well child appointment so you may choose the appointment date and time that best fits your schedule and needs.

Sick Child Visit Appointments: We make every effort to schedule appointments for your sick child or children on the same day you call our office. To increase your chances of getting a same day appointment, call as early as possible due to appointment availability being slim during influenza and winter months. We ask that if you are making an appointment for multiple sick children, please call ahead so that we may accommodate you appropriately. Without a scheduled appointment, you will be seen at our first available appointment time, which may mean a longer wait time or may require you to return for a later appointment time that day.

Nurse Visit Appointments: You may call our office at any time to schedule a nurse visit for the following type of appointments: immunizations, weight checks, TB skin tests, allergy injections, etc. Our nurse schedule is always available for appointments during our office hours.

New Patient Appointments: We ask that you arrive 15-20 minutes prior to your scheduled appointment time. This is to allow you enough time to fill out the necessary paperwork and to help the providers and staff stay on schedule. Please be sure to bring with you your insurance card, shot record and any other records or information with you for your appointment. For newborns, please be sure to bring any discharge paperwork from the hospital to your first appointment.

Established Patient Appointments: Please try to arrive 5-10 minutes prior to your scheduled appointment. Always remember to bring your insurance card with you to every appointment. It is important to let our office know of any changes to your insurance, address, phone numbers or pharmacy as soon as possible.

NO-SHOW POLICY

Our office understands that situations arise in which will cause you to miss your scheduled appointment. However, if you do not call and cancel your appointment, you may be preventing another child from getting a much needed appointment. Therefore, our office has a "No Show Policy" in order to enable patients to have every opportunity to schedule an appointment.

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of your scheduled appointment will be recorded in your medical record as a "no-show." Patients with 3 OR MORE "no-shows" will run the risk of being dismissed from North Marshall Pediatrics, P.C.

INSURANCE POLICY

We accept MOST insurance plans. However, if you have a question regarding a particular insurance plan, please contact our billing department.

It is important to bring your current insurance card with you to every appointment. As a courtesy to our patients, we will submit your claims but we must have the most accurate information to do so. Please remember to inform our office if your insurance information has changed. If we do not have the correct or current insurance information, it could result in you receiving a bill from our office.

For Newborns, it is highly recommended that your insurance provider be contacted as soon as possible after your newborn arrives. Most health plans allow you 30 days to add your newborn to your insurance policy. After 30 days, if the newborn is not listed under the insurance policy, you may be responsible for all charges. If you have Medicaid, please bring the "Unborn" Medicaid paper with you as that paper will have the newborn's Medicaid number until you let Medicaid know that your baby has been born.

FINANCIAL POLICY

Our office accepts cash, check and all major credit cards.

You will be responsible for charges not covered by your insurance policy/policies, including all co-pays, deductibles, co-insurances and/or unpaid balances regardless of marital or custody status. If you have a co-pay, a deductible, a co-insurance or an overdue balance, we will collect in full at the time of service. Our office cannot be involved in payment disputes between parents. If you are a self-pay patient for a visit, please be sure to have your payment available at the time of your visit in order to be seen on that day.

We have a $30 returned check fee for all returned checks. You will then be responsible for paying the $30 fee along with the amount of any returned checks within 10 days of the notice from our office or further action will be taken.

If you are needing a printed copy of your child's medical records for yourself, there is a form to be filled out along with a $6.50 fee that is due before those records can be printed and available to you.

PRESCRIPTIONS & PAPERWORK "PICK-UP" POLICIES

In order for our providers to timely and appropriately care for the patients in the office, any prescription refill requests (that require being picked up in our office) or paperwork requests will be available for pickup **24 business hours** after your request has been made. For example, if you call and request a refill for your child's ADHD medication on Friday at 3:00pm, the prescription will not be available for pickup until the following Monday at 3:00pm.

Prescriptions: All prescription refill requests can be made by calling our nurse lines. Please do not wait until your child's last dose of medicine to call and request a refill.

Paperwork: All paperwork (sports physicals, school medication forms, daycare forms, blueslips, etc) that need a provider's signature may be dropped off at our office during normal office hours. However, we ask that you fill out all of the patient's direct information on those forms prior to leaving it with our office. Our providers will need that specific information before they will be able to fill out the medical portion of the paperwork.

Medical Records (Copies): Our office can provide you a copy of your child's medical records for yourself after a Medical Records Release Authorization Form has been signed, along with a $6.50 printing fee. Medical records can also be sent free of charge to another clinic, specialist, attorney, etc. once a Medical Records Release Authorization Form has been signed.

VACCINE POLICY

We at North Marshall Pediatrics, P.C. are pleased you have chosen us to be the primary care provider for your child's health care needs. We are committed to seeing your child grow up as healthy as possible and reach their given potential.

Our office views immunizations as a huge benefit in preventing serious, potentially fatal diseases and in saving lives. Vaccinating children and young adults may be the single most important health-promoting intervention our office performs as health care providers. We believe that all children and young adults should receive all of the recommended vaccines according to the immunization schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

If you are not comfortable with our immunization schedule, we will ask you to find another medical home for your child in order to protect our other patients who may not yet be eligible for vaccines due to age or medical condition.

TELEPHONE CALLS POLICY

If you do not need to make an appointment and you have medical questions, you may call our nurse lines. When leaving a message on the nurse line, please include the following information: the child's name, the child's date of birth, the reason for the call and the best phone number to contact you. Please remember that our main responsibility is to those patients who are currently in the office. Even though our nurses are busy with the patients in the office, they strive to return phone calls as quickly as possible throughout the day. Calls before lunch will be answered before the office closes for lunch, and calls made after lunch may not be returned until clinic is over. If you feel as though you cannot wait for a nurse to call you back, please call our office and schedule an appointment.

It is important to remember that our office will not print out a school excuse for your child without first seeing the child in our office for that particular illness/reason. Please contact the nurse line if you have any questions about school excuses.

You may also send a message to our nurses through our Patient Portal. Contact our office to find out more information!

By signing below, you acknowledge that you have received, read and understand/comply North Marshall Pediatrics, P.C.'s office policies.

_____
Print Name of Parent/Legal Guardian

_____
Relationship to Patient

_____
Signature of Parent/Legal Guardian

_____/_____/_____
Today's Date