Pediatrics Plus

Patient Information

Patient Name: _____ DOB: _____

Sex: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____ City: _____

Patient lives with: (circle one) Both Parents Mother Father Other _____

Mother's Name: _____ Phone: _____

Email: _____ DOB: _____

Employer: _____ Occupation: _____

SSN: _____

Father's Name: _____ Phone: _____

Email: _____ DOB: _____

Employer: _____ Occupation: _____

SSN: _____

Primary Insurance: _____ Policy No: _____

Secondary Insurance: _____ Policy No: _____

Medical History

Patient Name: _____ DOB: _____ Date: _____

Past Medical and Surgical History. Please list date of surgery.

_____

_____

_____

Family Medical History:

_____

_____

_____

Are you allergic to any medications?

_____

_____

List of Current Medications:
Drug Name: Dosage: Reason Prescribed:

_____

_____

_____

_____

_____

Do you smoke? _____ Yes _____ No Former _____
How many packs per day? _____

Do you drink? _____ Yes _____ No How many drinks per week _____

Patient Consent:
To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I will inform the Nurse Practitioner and staff at the next appointment without fail.

Signature: _____ Date: _____

Relationship to Patient: _____

Acknowledgement of Notice of Privacy (HIPAA) and
Consent to Use/Disclose Health Information

I acknowledge that I have received a copy of Pediatrics Plus Privacy Practices. I understand that as a part of my healthcare, Pediatrics Plus originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among they health professionals who contribute to my care
- A means of which insurance companies can certify that services billed were actually provided
- A source of information for applying my diagnosis and surgical information to my bill
- A tool for routine health care operations, such as assessing quality and reviewing the competence of the healthcare professionals

Before signing this form, you should understand the following:

-By signing this form, I authorize the use and/or disclosure of my protected health information.

-I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.

-I authorize the release of any medical or other information necessary to process the insurance claim resulting from this service. I also request payment of government insurance claim resulting from this service. I also request payment of government benefits either to myself or to the party who accepts assignment below.

- I understand that I have a right to revoke this authorization at any time. My revocation is to be in writing. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

- I understand that I do have the right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. Section 164.524).

- I give consent to Pediatrics Plus to examine and treat me/my child as deemed appropriate by the Providers for the period of **07/15/2024 – 12/31/2024**.

-The following parents/guardians/representatives are allowed to bring my child to Pediatrics Plus.

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Patient, Parent, Guardian, or Representative Signature Date

_____

Patient Name Date of Birth

Pediatrics Plus

7215 S Siwell Road, Suite B
Byram, MS 39272
Phone: 601-769-1140 Fax: 601-769-1141

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

Patient Name: _____ **DOB:** _____

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for _____ (print name of condition – e.g., ADHD, pain, anxiety, etc.)

The goals of this medicine are:

_____ to improve my ability to work and function at home.
_____ to help my _____ (print name of condition – e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell, or trade by medicine. I will nt take anyone else's medicine.
2. I will not increase by medicine until I speak with my doctor or nurse.
3. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
4. I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
5. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
6. I agree to give blood or urine sample, if asked, to test for drug use.

Refills:

Refills will be made only during regular office hours – Monday through Thursday, 8:00AM-5:00PM and Friday 8:00AM-12:00noon. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to Primary Care for my refill until I am called by the nurse. I must keep track of my medications. No early or emergency refills may be made.

Prescriptions form Other Doctors:

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy:

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement:

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities:

As your provider, I agree to perform regular checks to see ho well the medicine is working. I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

_____

Patient's signature

_____

Date

_____

Provider signature

_____

Witness signature

This document has been discussed with and signed by the Provider and patient. (A signed copy should be sent to the medical records department and a copy given to the patient.)

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Stephanie O. Boydston, FNP-C

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

I hereby authorize the release of medical information of **all** records listed below:

-Outpatient Records	-Immunizations Records	-ER Visit Date:
-Referrals to:	-Lab/Pathology Reports	-Operative Reports
-Hospitalization Dated:	-Newborn Records	-All Medical Records

Date(s) being requested: _____
From: _____ to Pediatrics Plus

From Pediatrics Plus to _____

THIS AUTHORIZATION SHALL BE VALID FOR 90 DAYS FROM THE DATE SIGNED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANT TIME. I HEREBY RELEASE PEDIATRICS PLUS FROM THIS MEDICAL INFORMATION. PLEASE NOTE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

Signature of Parent / Patient_____ Date: _____

Relationship: _____ Witness: _____

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PRIVACY PRACTICES

How We Collect Information About You

Pediatrics Plus and its employees and volunteers collect data through a variety of means including by not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do with Your Information

Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information

Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between HHSN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need. This is including, but not limited to, or to obtain or purchase any type of medical supplies, devices, medications, or insurance.

If you apply or attempt to apply to receive assistance through us an provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or unwilful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect:

We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.pediatricspluscare.com) that simply records the number of visitors and no other data. We do not use some affiliate programs that may or may not capture traffic date through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes and other sources:

Any pictures, stories, letters biographies, correspondence, or thank you notes to us become the exclusive property of Pediatrics Plus. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for the use of this information (photos, addressed, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying and requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.