PEDIATRICS
At Brookstone Centre

Check Physician of Choice:
- ☐ RICHARD MANSFIELD, D.O. FAAP
- ☐ AMY COOL, M.D. FAAP
- ☐ VERONICA MANKA, M.D. FAAP
- ☐ NEHA POTINI, M.D. FAAP
- ☐ TRINA WILLIAMSON, FNP
- ☐ _____

Today's Date _____

Child's Name _____ Date of Birth _____

Sex _____ Allergies _____

Address _____ City _____ State _____

Zip _____ Race _____

Emergency Contact Other Than Parents _____

Mother's Name _____ S.S.# _____

Address (if different) _____ City _____ State _____

Zip _____ Phone _____ Date of Birth _____

Employer _____ Address _____

Occupation _____ Work Phone _____

How long employed _____ Email _____

Father's Name _____ S.S.# _____

Address (if different) _____ City _____ State _____

Zip _____ Phone _____ Date of Birth _____

Employer _____ Address _____

Occupation _____ Work Phone _____

How long employed _____ Email _____

*Siblings _____ Date of Birth _____

Parents are: ☐ Married ☐ Living Together ☐ Seperated ☐ Divorced

If divorced, who is the Custodial Parent: ☐ Mother ☐ Father

Insurance Information (You must provide us with a copy of your current insurance card at every visit)

Insurance Company _____ ID# _____ Eff Date _____

Co-Pay $ _____ Name of Insured _____

Insurance provided through: ☐ Employer ☐ Private ☐ Other ☐ Self Pay

Name and full address of Employer _____

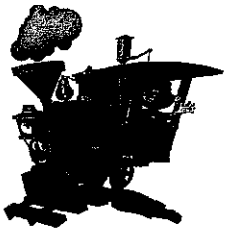
_____

Your preferred Pharmacy _____ Location _____

All Charges are the parent or guardian's responsibility. I hereby authorize Pediatrics at Brookstone Centre, PC to release information to insurance carriers concerning my or my child's illness and treatments and to assign all payments for services rendered. I understand that I am responsible for any amount not covered by insurance.

Signature _____ Date _____

Thank You for choosing us as your child's pediatrician!



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Child's Name _____ Date of Birth _____
Previous physician _____ Hospital delivered at: _____
History: Was the child premature? _____ If so, how many weeks? _____
Method of birth _____ Any complications of birth? _____
Birth weight _____ Length _____ Head Circumference _____
Is he or she currently on any medication? _____

Has he/she had any of the following:

Ear infections	yes	no	How many_____	Frequent sinus infections	yes	no
Seizures	yes	no		Frequent throat infections	yes	no
Diabetes	yes	no		Heart problems	yes	no
Heart murmur	yes	no		Bed wetting after age 6 years	yes	no
Pneumonia	yes	no		Asthma	yes	no
Seasonal allergies	yes	no		Allergies to medication	yes	no
Food allergies	yes	no		_____		

Has he/she had any of the following surgeries? Please provide dates of surgeries:
Appendectomy _____ Ear Tubes _____ Tonsils _____ Adenoids _____
Any other surgeries _____

Does anyone in the family have:

Allergies	yes	no	Diabetes	yes	no	Asthma	yes	no	Lung disease	yes	no
Cancer	yes	no	Tuberculosis	yes	no	High blood pressure	yes	no			
Seizures	yes	no	Thyroid disease	yes	no	Psychiatric disorders	yes	no			

School / Social History:
With whom does child live _____
Education level of parents. Less than high school High school College Post graduate
What school does he/she attend _____ Grade _____
How does your child perform in school? Academically _____ Conduct _____
Does he/she have a learning disability _____ Is he/she in special education classes _____

Developmental History:
At what age did he/she Sit alone _____ Crawl _____ Walk without assistance _____

Signature _____ Date _____

Reviewed _____ Date _____

Thank You for choosing us as your child's pediatrician!

Pediatrics at Brookstone Centre

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

Important: Do not sign this form without reading and understanding its contents.
Mark out and initial any Procedure and/or section of this form for which consent is not granted.

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures may be necessary. These Procedures are performed by the physician or an assistant for the physician.

While usually performed without incident, there are potential risks associated with each of these Procedures. It is not possible to list every risk for every Procedure and this form will therefore list the most common possible risks. It is important to note that a simple act such as taking a commonly used medication can rarely cause severe reactions that could lead to organ failure or even death.

If I have any questions or concerns regarding these procedures, I will ask my physician or his/her assistant to-provide me with additional information. The Procedures include:

- **Needle Sticks** such as shots, injections or intravenous lines to administer fluids or medications. Material risks include, but are not limited to, infection, infiltration (fluid from an IV leaking into the tissue), disfiguring scar, nerve damage with possible loss of limb function. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
- **Physical tests, assessments and treatments** such as internal body examinations, wound cleaning and wound dressing. Material risks include allergic reaction and infection. Apart from using modified procedures and/or refusal of treatment, no practical alternative exists.
- **Administration of medication** whether orally, rectally, topically, or through the eye, ear or nose. Material risks include, but are not limited to, allergic reaction, puncture and perforation. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
- **Drawing blood or bodily fluids with a needle or taking tissue samples (biopsy).** Material risks include but are not limited to infection, damage to joint or organ, nerve damage, and bleeding. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
- **Insertion of internal tubes** such as scopes, catheters, drainage tubes, etc. Material risks include but are not limited to internal injuries, bleeding, infection, allergic reaction, difficulty urinating after long term catheter placement. Apart from external collection devices or refusal of treatment, no practical alternative exists.

I understand that:

- The practice of medicine is not an exact science and that **NO GUARANTEE OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and /or result of any procedures; and
- The 'Healthcare Professionals participating in my care will rely on my documented medical history, as well as other information obtained from me, my family or others having knowledge about me, in determining whether to perform or recommend the Procedures, therefore, I agree to provide accurate and complete information about my medical history; and
- **I may be asked to sign additional required Informed Consent documents for specific procedures and tests.**

By signing this form:
I consent to **Pediatrics at Brookstone Centre**

- performing Procedures as they deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been\informed, in general terms, of the nature and purpose, the material risks and practical alternatives of the Procedures:

Signature of Patient (or other person authorized to sign):

_____

Printed Name of Patient _____DOB_____

Date signed: _____ Reason patient unable to sign

_____CHILD _____

Pediatrics at Brookstone, PC
Financial Policy

We would like to thank you for choosing Pediatrics at Brookstone Centre, PC as your child's doctors. As one of our patients, we would like to keep you informed of our current office and financial policies. We require an initial & a signature to document that you have read and understand these policies.

Payment
Payment is expected at the time of service. This is an insurance company rule. This includes co-payments or coinsurance for participating insurance companies. Pediatrics at Brookstone Centre, PC, accepts cash, personal checks, VISA, and MasterCard. There is a service charge of $35.00 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.
_____ Initials

Insurance
It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.
If your plan requires, you must name Pediatrics at Brookstone Centre, PC as your primary care physician prior to your first appointment. If Pediatrics at Brookstone Centre, PC physician is not named on your insurance as your primary care physician, your appointment will need to be rescheduled.

We do not file or bill any secondary insurance claims.

_____ Initials

Canceled Appointments
If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $20.00 for appointments that are not canceled at least 24 hours in advance.

_____ Initials

Office Fees/Charges
Due to the increasing amount of requests for specific paperwork to be filled out, we charge a fee for all paperwork that has to be completed by our physicians and nurses. The fees will be as follows: All letters that are requested to be sent to a physician's office, daycare, insurance company, etc. will be charged a $5.00 fee. All FMLA, government, court ordered, or social security oriented paperwork will be charged $10.00. All copies of medical records, upon receipt of a completed release of information form, will be charged as follows; CD $10.00 and a paper copy of the records will be $25.00. This fee does not apply if the records are being released to another physician.
_____ Initials

Prescriptions/Paperwork
Please request prescription refills during office hours and allow 3 business days for your request to be filled. Please allow us 7 business days to fill out other requested paperwork. Plan ahead to assure you have an adequate supply of medication for your child/children. Please note that these are business days and more days may be required if the physician is out of the office. We also have a refill line so you can call and leave a message for your refill needs. That number is 706-507-0636.

More Information
Please call if you have a question abut your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying you bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent children from receiving the care they need at the time they need it. If you need assistance, Please contact our billing department at 706-507-1457

_____ Signature of Parent/Guardian

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TRINA WILLIAMSON, FNP
EMILY BUTTS, CPNP-PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF

PROTECTED HEALTH INFORMATION

With my consent, Pediatrics at Brookstone Centre, PC may use and disclose protected health information (PHI) about my child to carry out **treatment, payment and healthcare operations (TPO).** Please refer to Pediatrics at Brookstone Centre, PC **Notice of Privacy Practices** for a more complete description of such use and disclosures.

I have the right as a parent or guardian to review the **Notice of Privacy Practices** prior to signing this consent. Pediatrics at Brookstone Centre, PC reserves the right to revise its notice of privacy practices at anytime. A revised notice of privacy practices may be obtained by forwarding a written request to Pediatrics at Brookstone Centre, PC privacy officer at 2001 Brookstone Centre Parkway, Columbus, GA 31904.

With my consent Pediatrics at Brookstone Centre, PC may utilize the following methods to contact me regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others. My preferred methods of notification are: (check all that apply), **text_____, email_____, voice mail_____.** It is my understanding that I am responsible for notifying the front office about changes in any of the demographic information, such as phone number, address, insurance.

With my consent, Pediatrics at Brookstone Centre, PC may mail to my home or other designated location any items that assist the practice in carrying our TPO, such as appointment reminder notes and patient statements as long as they are marked personal and confidential.

I have the right to request that Pediatrics at Brookstone Centre, PC restrict how it uses or disclose my child's PHI to carry out TPO, however, the practice is not required to agree to requested restrictions, but if it does, it is bound by this agreement.

By signing this form. I am consenting to Pediatrics at Brookstone Centre, PC use and disclosure of my child's PHI to carry out TPO. I also acknowledge receipt of the **Notice of Privacy Practices.**

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 do not sign this consent, Pediatrics at Brookstone Centre, PC may decline treatment to my child.

_____ _____

Signature of parent or guardian **Date**

_____ _____

Patient's Name **Print Patient's Name**

08/13

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Patient Information Consents

I understand that patient's health information is private and confidential. I have signed and reviewed **Pediatrics at Brookstone Centre's** PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION. I understand that **Pediatrics at Brookstone Centre** will confidentially protect my child's personal health information. The following defines additional situations which occur.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I,_____ parent or legal guardian of, :

_____

(Child's Full Name) (Child's Date of Birth)

Do hereby authorize the following individuals to accompany my children to medical appointments. This list includes anyone other than the child's custodial mother or father such as babysitters, step parents, grandparents, neighbors, friends of the family, siblings provided they are over the age of 18. I understand that only the child's custodial parents and those listed below will have authority to authorize treatment. It is the policy of this office that the adult presenting the child for treatment is responsible for payments of the patient portion of insurance at the time of service. Authorized individuals include: *(please print name and relationship)*

Name: **Relationship**

_____

_____

Please inform the above listed individuals to bring photo identification to appointments

We request that a custodial parent accompany the child to the initial visit appointment and to all checkups and ADHD appointments.

2001 BROOKSTONE CENTRE PARKWAY · COLUMBUS, GA 31904
PHONE (706) 571-9699 · FAX (706) 571-9565

AUTHORIZATION FOR TREATMENT OF UNACCOMPANIED MINORS

I,_____, parent or legal guardian

of:_____

my teenager (16 and above) authorize treatment in my absence. I acknowledge that I am responsible for payment of a fees related to this visit.

AUTHORIZATION TO LEAVE MESSAGES ON VOICE MAIL/MACHINES

I acknowledge that it is my right to refuse to authorize any detailed messages to be left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

YES, please leave me a message: _____ Date:_____

No, don't leave any specific messages:_____ Date:_____

AUTHORIZATION TO RELEASE PROOF OF IMMUNIZATION RECORD TO SCHOOLS OR DAYCARE SETTINGS AS REQUIRED BY LAW. In providing your signature below, the authorization covers all schools the individual child attends. This authorization remains in effect until cancelled by you. The authorization still requires that a parent call the office with the request to send the proof of immunization with an accurate fax number to an individual school and the specific contact person at the school. This information will be documented in the child's medical record.

_____ Date:_____

PEDIATRICS AT BROOKSTONE CENTRE, PC ELECTRONIC MEDIA POLICY

We invite you to check out our website: ***www.pediatricsatbrookstonecentre.com*** for forms and information about our practice. Please "like us" on our Facebook page. It is our policy not to comment on medical questions or symptoms posted on unsecured websites. Our employees are encouraged not to "like" parents or patients on their private social media sites. For specific concerns about service or other issues please contact the office manager at amy@pedsabc.com.