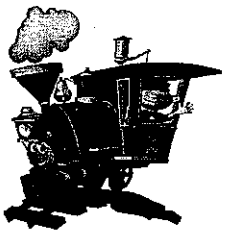


# PEDIATRICS
## At Brookstone Centre

RICHARD MANSFIELD, D.O
VERONICA MANKA, M.D
AMY COOL, M.D. FAAP
NEHA POTINI, M.D. FAAP
RANI CHEBROLU, M.D.
CHAD KRITZBERGER, M.D
TRINA WILLIAMSON, FNP-C
MAEGAN PHILLIPS, CPNP
ALLYSON MURDOCK, FNP-C

# Welcome to Pediatrics at Brookstone!

We are thrilled that you have chosen us to be your pediatric practice! We welcome the opportunity to build a lasting relationship with you and your family.

Our staff and doctors love the practice of pediatrics. We will do our best to earn your respect and trust, as well as create an environment that celebrates the fun and excitement of childhood.

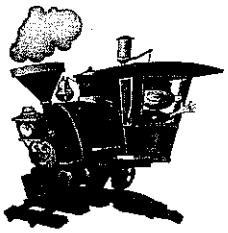
Below are a few reminders for any upcoming appointments.

- We do accommodate same day appointments, but please call early as these do fill up quickly.
- Please arrive On-Time. We understand that your time is valuable. We make every effort to see all of our patients on time. In order to provide you with prompt service, we need you to arrive 5-10 minutes prior to your scheduled appointment for every appointment. If you're more than 15 minutes late, you may be asked to wait or to reschedule your appointment.
- Please bring your insurance card to every appointment so that we may verify your coverage.
- We do offer night time and weekend call coverage. One of our nurses/physicians will be available to answer any and all questions. If you need to be seen we will advise you to be seen at the Pediatric Emergency Room located at Piedmont Hospital 710 Center St. Columbus, Ga
- Please make sure if you have a family member or friend that needs to bring your child to a sick appointment you have them listed as an authorized chaperone for the child/children.

We look forward to serving you and your family for years to come. If you have any questions or concerns please feel free to contact me.

Lynda Jones

Practice Manager 706-507-1481 lynda@pedsabc.com



# PEDIATRICS
## At Brookstone Centre

Check Physician of Choice:
- ☐ RICHARD MANSFIELD, D.O
- ☐ VERONICA MANKA, M.D
- ☐ AMY COOL, M.D. FAAP
- ☐ NEHA POTINI, M.D. FAAP
- ☐ RANI CHEBROLU, M.D.
- ☐ CHAD KRITZBERGER, M.D
- ☐ TRINA WILLIAMSON, FNP-C
- ☐ MAEGAN PHILLIPS, CPNP
- ☐ ALLYSON MURDOCK, FNP-C

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 _____

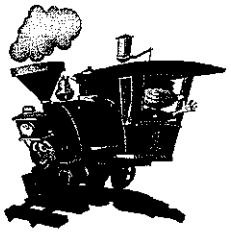
_____

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!**



# PEDIATRICS
## At Brookstone Centre

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.**

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 Parent/Patient (or other person authorized to sign):

_____

Printed Name of Patient _____DOB_____

Date signed: _____ Relationship to patient: _____

# 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 commercial 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 for appointments that are not canceled at least 24 hours in advance. The fees vary based on type of scheduled appointment.

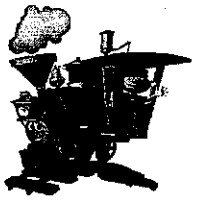
_____ Initials

**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 fee. Fees apply to the following: all FMLA, government, court ordered, or social security oriented paperwork. All copies of medical records, upon receipt of a completed release of information form, will be charged as follows; CD or USB will be $35.00 and a paper copy of the records will be $25.00. These fees may increase based on the size of the chart. 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



# PEDIATRICS
## At Brookstone Centre

## 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.

We recognize that the reproductive health is sensitive and protected. We will only use or disclose your PHI related to reproductive health (such as contraceptive care, fertility treatments, pregnancy, or abortion services) as allowed by law. Additional protections may apply under state law.

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**

4/25

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

PEDIATRICS
At Brookstone Centre

## Pediatrics at Brookstone Centre

## 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 lynda@pedsabc.com.

*PEDIATRICS AT BROOKSTONE CENTRE*
*5001 BROOKSTONE CENTRE PARKWAY*
*COLUMBUS, GA 31904*

**Patient Portal Consent**

**Parent Name:** _____ **Parent Phone Number:**_____

**E-Mail Address:** _____

**Children(s) Name and Date of Birth:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

We are now offering access to a patient web portal. This portal will allow you to access information from the medical records of all children listed. You can review a complete health information summary to include: Most recent physical date, upcoming appointments, historical visits, a summary of labs/medications, a problem list, allergy list, medication list and a complete immunization record along with direct messaging to the nurse.

By signing this form, you are solely responsible for anyone with access to this information. Once you are registered, you will receive an email or text to explain how to access this portal. You are giving Pediatrics at Brookstone Centre consent to upload your child's medical chart to the web portal. .

**Pediatrics at Brookstone Centre is offering you this for your convenience, this is not mandatory and in no way will your care be affected if you opt out.**

---

**Parent Signature:** **Date:**

Thank you,
Pediatrics at Brookstone Centre Physicians and Staff

**Website for portal access: https://brookstone.pcc.com/portal**