KIDS FIRST PEDIATRIC SPECIALISTS

John F. Norton, M.D.
Deborah A. Hall, M.D.
Angella M. Talley, M.D.
Beth Sharp, FNP-BC
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1263 Hospital Dr. NW, Suite 180
Corydon, IN 47112
812-738-1200

5300 State Road 64, Suite 105
Georgetown, IN 47122
812-366-0012

Fax 812-738-1710

To Whom It May Concern:

We are pleased that you have chosen Kids First Pediatric Specialists as your pediatricians.

Our office hours are as follows:
Monday- Wednesday 7:30 A.M.-6 P.M
Thursday 8:30 A.M-6 P.M.
Friday 8:30 A.M.-4:30 P.M.

What we need from you:
Demographic forms (enclosed)
Medical records from your previous physician
Current immunization record
Insurance card
Photo I.D.

It is our policy that we require you to arrive ten minutes prior to your appointment time, or we will ask you to reschedule.

If you have any questions, please feel free to contact my office at (812) 738-1200 ext. 4404

Sincerely,

Jennifer Lowe
Office Manager

HCH Physician Practices

Patient Registration and Consent to Treat

Primary Care Physician:_____

Pharmacy: _____

Child's Name: _____ DOB: _____ Sex: Male Female
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Student: Yes No Name of School: _____
Is child considered Hispanic or Latino: Yes NO Primary Language:_____

Guarantor:_____ DOB: _____
(Person responsible for invoice)
Relationship: _____ SSN: _____
Employer: _____

Emergency Contact: _____ Relationship: _____
Phone: _____

Primary Insurance:_____
Subscriber's Name:_____DOB:_____
Relationship to Patient:_____SSN:_____Employer:_____
ID Number:_____ Group Number:_____

Secondary Insurance:_____
Subscriber's Name:_____DOB:_____
Relationship to Patient:_____ SSN:_____Employer:_____
ID Number:_____ Group Number:_____

Please list all siblings that are patients at Kids First Pediatrics.

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Parent/Guardian Signature: _____ Date: _____

PLEASE HAVE INSURANCE CARD AVAILABLE

Kids First Pediatric Specialists

1263 Hospital Dr. NW, Suite 180
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AUTHORIZATION FOR CONSENT TO TREAT A MINOR

Name of Minor: _____ Minor's Date of Birth: _____

I, _____, as the Parent/Legal Guardian of the above-named minor, do hereby authorize the Designated Individual(s) listed below (must be 18 years of age or older) to give consent for the above-named minor:

_____ _____ _____
(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

_____ _____ _____
(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

_____ _____ _____
(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

for the following Medical Treatments: **(CHECK ONE)**

☐ All surgical and medical treatment, including vaccinations, deemed necessary by the provider.

– OR –

☐ Only the surgical and/or medical treatment deemed necessary by the provider for the condition or symptoms listed below: **(SPECIFY CONDITION OR SYMPTOM)**

_____

_____

This authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature: _____ Date: _____
(must be signed by Parent or Legal Guardian)

VERBAL CONSENT WITNESSED BY: (Two KFPS associate/provider witnesses are required)

Signature: _____ Date: _____
(Witness #1 – KFPS associate/provider)

Signature: _____ Date: _____
(Witness #2 – KFPS associate/provider)

HCH Physician Practices

Authorization Signature Form for HIPAA

Please Print

Patient Name:_____

Date of Birth:_____

Your signatures on this form acknowledges receipt of this notice, and that you have been given the opportunity to review it and ask questions regarding its concerns.
Please designate below the individuals (i.e. family members, caregivers, power of attorney, etc) with whom we may discuss your care. Other than the entities listed in the Notice of Privacy Practice any individual not listed below will not be given information about your care without your permission.

_____

_____

_____

_____

_____

Patient Signature/Responsible party:_____Date_____

Witness:_____Date_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

KIDS FIRST PEDIATRIC SPECIALIST
1263 Hospital Drive, Suite 180 Corydon, IN 47112
(812)738-1200

Name of Patient:	**Social Security Number:**	**Address of Patient:**
		Street _____
Telephone Number: ( )	**Birthdate:** / **Age:**	City _____
		State Zip

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

FROM	Name of Organization or Person to RELEASE information: Street: City: State: Zip:
TO	Name of Organization or Person to RECEIVE information: Kids First Pediatric Specialists Fax#: (812) 366-0022 Street: 5300 State Road 64, STE 105 City: Georgetown State: IN Zip: 47122

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

- ☐ Continuing medical care
- ☐ Claim for reimbursement
- ☐ Litigation against third party other than [COVERED ENTITY], a [COVERED ENTITY] employee, or a physician
- ☐ Litigation against [COVERED ENTITY], a [COVERED ENTITY] employee, or a physician (*Specify*) _____
- ☐ At the patient's request _____
- ☐ Other (*Specify*) _____

I understand that this authorization can be revoked by me at any time by submitting a written request to _____
I understand that revocation will not apply if [COVERED ENTITY] has already released by information.
I understand that [COVERED ENTITY] cannot require me to sign this authorization as a condition for providing treatment of obtaining payment for same.
I understand that the material released as a result of this authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.
This authorization will expire as follows: NONE

INFORMATION TO BE RELEASED

Dates of treatment:	Type of treatment: ☐ Inpatient ☐ Emergency Room ☐ Outpatient

- ☐ Face Sheet
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Emergency Room Report
- ☐ Entire Record
- ☐ X-ray Reports (*Specify type or all*) _____
- ☐ Laboratory Reports (*Specify type or all*) _____
- ☐ HIV Results
- ☐ Other (Specify):
- ☐ Check here to request the information in electronic format (applies only to information we maintain in an electronic health record).

_____ _____
(Signature of Patient) (Date Signed)

_____ _____
(Signature of Other Authorized Person) (Relationship to Patient)

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative the spouse or adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self.

KIDS FIRST PEDIATRIC SPECIALISTS

John F. Norton, M.D. Deborah A.Hall, M.D.

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FX: 812-738-1710 FX: 812-366-0022

PATIENT PREFERENCES FOR WRITTEN AND ORAL COMMUNICATION

In general, the HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of personal health information. The individual is also provided the right to request confidential communications regarding their personal health information be made by alternative means, such as sending correspondence to the individual's office rather than their home. Please complete the following information so that we may provide your child's information to you in a confidential manner that is to your liking.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (check all that apply)

Home Telephone_____ Cell Phone_____

OK to leave a message with detailed information

OK to leave a message with another adult in the household (ex. Spouse, grandparent of your child, babysitter, etc.)

Leave message with call-back number only

Work Telephone_____

OK. To leave a message with detailed information

Leave message with call-back number only

Written Communication

OK to mail to my home address

OK to mail to my/office address

OK to fax to this number_____

Other Information

_____

_____ _____

Signature of Parent Date

New Patient Information

CHILD'S FULL NAME_____

DOB: _____ BIRTH WEIGHT: _____ LENGTH:_____

Has he/she ever spent the night in the hospital?

When: _____ Where: _____

Why: _____

Has your child had any of the following illnesses?

__Yes __No **Heart Disease**	__Yes __No **Seizures or Convulsions**	__Yes __No **Chickenpox**
__Yes __No **Allergies/Hay Fever**	__Yes __No **Frequent Ear Problems**	__Yes __No **Strep Throat**
__Yes __No **Anemia**	__Yes __No **Joint or Muscle Pain**	__Yes __No **Pneumonia**
__Yes __No **Problem Diarrhea**	__Yes __No **Stomach Problems**	__Yes __No **Diabetes**
__Yes __No **Bronchitis**	__ Yes __No **Problem Constipation**	__Yes __No **High Blood Pressure**
__Yes __No **Asthma**	__Yes __No **Urinary Problems**	__Yes __No **Medicine Allergy**

If any were checked YES please explain (ex: when, how often, family history of?)

_____

_____

Does your child see any specialists? _____ Yes _____No

If so, please list the name(s) of the specialist(s) and the reason.

_____

_____

How would you describe your child's appetite? _____Good _____Fair

Date last seen by a doctor? _____ Date last seen by a dentist?_____

QUESTIONS FOR PARENTS OF NEWBORNS ONLY

Did you have any problems during pregnancy?	_____ Yes	_____ No
Was the baby within 2 weeks of being on time?	_____ Yes	_____ No
Were there problems at delivery?	_____ Yes	_____ No
Did the baby go home with your form the hospital?	_____ Yes	_____ No
Have you had any miscarriages?	_____ Yes	_____ No

How do you feed your child? Breast? How often? _____

Formula? Brand? _____ Amount per day? _____

Kids First Pediatric Specialists
Historical Intake Form

Name_____ Date of Birth_____

*Medical Problems—Current and past medical problems affecting your child—such as allergies, eczema, etc

_____

*Allergies—Please list any known allergies and the child's reaction to the allergen

Medication(s)_____Reaction_____

Food(s)_____Reaction_____

Insects/Bee(s)_____Reaction_____

*Medication—List medication name(s), strength, and dosing. Check the appropriate box to the right. Include prescription and non-prescription medications and vitamins. Remember inhalers. Tell the nurse if there are other medications or write them in at the end of the form.

	As needed		As needed
1._____	[ ]	3._____	[ ]
2._____	[ ]	4._____	[ ]

*Social History

Child lives with _____

Pets/Animals Cat [ ] Dog [ ] Fish [ ] Chicken/Birds [ ] Farm Animals [ ] Other_____

Smoke Exposure None [ ] In-home [ ] Outside of Home [ ]

Water Source Public/City [ ] Well [ ] Cistern [ ]

Heat Source Electric [ ] Gas [ ] Indoor Wood Stove [ ] Outdoor Wood Stove [ ]

*Surgeries—Please include date or year of surgery if known.

Ear Tubes [ ] Date(s)_____ How many sets?_____

Tonsillectomy [ ] Date_____

T & A [ ] Date_____

Fracture Repair [ ] Date_____ Site_____ Outside pins [ ] Internal pins/plates [ ]

Oral Surgery [ ] Date_____

Other Surgeries_____ Date_____

*Hospitalizations (Overnight stay other than newborn) [ ] None

Reason_____ Date_____

*Therapy Services—List the service(s) that your child is currently receiving and who is providing the service(s). i.e. PT, OT, ST, DT

_____

*Family History—Please mark the problems on this list that have affected someone in the child's biological family. Indicate the relationship of that person to the child. List maternal or paternal. May go as far back as great-grandparents.

Acid Reflux (GERD) [ ] _____
Allergies [ ] _____
Anemia [ ] _____
Arrhythmia [ ] _____
Asthma [ ] _____
Cardiomyopathy [ ] _____
Crohn's Disease [ ] _____
Diabetes [ ] _____
Eczema [ ] _____
Gallbladder Issue [ ] _____
Heart Defect [ ] _____
Heart Disease [ ] _____
High Blood Pressure [ ] _____
High Cholesterol [ ] _____
Cancer [ ]

Kidney Disease [ ] _____
Lupus [ ] _____
Mental Illness [ ] _____
Migraines [ ] _____
MRSA (in same house) [ ] _____
Rheumatoid Arthritis [ ] _____
Seizures [ ] _____
Stroke [ ] _____
Sudden Death at age
less than 50 yrs [ ] _____
High Thyroid [ ] _____
Low Thyroid [ ] _____
Ulcerative Colitis [ ] _____
Urinary Reflux [ ] _____

Type_____ Relationship_____

Type_____ Relationship_____

Genetic Diseases/Mutations [ ]

Type_____ Relationship_____

Other Problems [ ] _____ Relationship_____

*Birth History

Weeks gestation_____ Vaginal [ ] or C-section delivery [ ]

Any complications with pregnancy or delivery?_____

Treated with IV antibiotics as a newborn? Yes [ ] No [ ]

If you are a new patient/family, how did you learn about our office? _____

Please return this form to the nurse or receptionist. Thank you for taking your time to help us.

Kids First Pediatric Specialists Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in minute amounts in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers and that you can perform as parents/caregivers. The recommended vaccines and the vaccine schedule are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

This said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky. The boy contracted smallpox and died at the age of 4, leaving Franklin with a lifetime of guilt and remorse. In his autobiography, Franklin wrote:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many parents have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating.

But such an attitude, if it becomes widespread, can only lead to tragic results. After publication of an unfounded accusation (later retracted), that MMR vaccine caused autism in 1998, many Europeans chose not to vaccinate their children. As a result of under-immunization, Europe experienced large outbreaks of measles, with several deaths from disease complications. In 2012, there were more than 48,000 cases of pertussis (whooping cough) in the United States, resulting in 22 deaths. Most victims were infants younger than six months of age. Many children who contracted the illness had parents

Continued on the next page _

INITIAL_____

who made a conscious decision not to vaccinate. In 2015, there was a measles outbreak in Disneyland, California (probably started by an infected park visitor who had traveled from the Philippines). The outbreak eventually spread to 147 people and, again, many were too young to have been vaccinated.

When you don't vaccinate, you take a significant risk with your child's health and the health of others around them. By not vaccinating, you also take selfish advantage of thousands of others who do vaccinate their children, thereby decreasing the likelihood that your child will contract a vaccine-preventable disease. We feel that refusing to vaccinate is unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will gladly explain the vaccine schedule. We will also help answer any questions you may have. However, should you have doubts, please discuss these with your healthcare provider in advance of your visit. In some cases, we may alter the schedule for medical reasons. We will not alter the schedule at the parents request without medical justification. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated. We will vaccinate according to the CDC schedule. While we will always recommend vaccines according to the CDC schedule, the Flu Vaccine and HPV Vaccine, are excluded from this policy. If your child(ren) is behind schedule, we will catch your child up based upon the CDC's catch-up schedule. We will not allow alternate catch-up schedules.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,

All of your healthcare providers at Kids First Pediatric Specialists:
John F. Norton, M.D.
Deborah A. Hall, M.D.
Angella M. Talley, M.D.
Beth Sharp, MSN, FNP-BC

Immunization Action Coalition · Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org
www.immunize.org/catg.d/p2067.pdf · Item #P2067 (8/16)

Initial_____

I acknowledge that I have received a copy of the Vaccine Policy Statement.

I understand that if I choose to not vaccinate my child from this point on, that Kids First Pediatric Specialists will only provide my child care for 30 days from this date.

If you choose to not vaccinate, please fill out a medical release form to be faxed to the provider of your choice, along with your child's medical records.

Please write out the name of your child along with date of birth below:

_____

_____ _____

Parent/Guardian Signature Date

KIDS FIRST PEDIATRIC SPECIALISTS
POLICIES AND PROCEDURES

Thank you for choosing Kids First Pediatric Specialists as your pediatrician. We are committed to providing your child with the best possible care. We want to make sure you have a clear understanding of our policies, as this is very important to our professional relationship.

INSURANCE

We do file insurance as a "courtesy" to our patients. While we are participating with most insurance companies, it is your responsibility to know prior to your appointment if our providers are participating with your insurance plan.

It is also your responsibility to know what your insurance plan benefits are (what is covered/not covered). Some insurance plans have copayments, deductibles, and/or coinsurance. Copayments are due at the time of service. This is per your insurance guidelines. If you do not have your copayment at time of service, you will be asked to reschedule.

Once insurance is filed and we receive a remittance advice back from them, any balances due by you will be sent out via a statement. We ask that you send in payment promptly to avoid us having to refer the account to an outside collection agency, in which additional agency fees may apply. If you are having financial problems, we ask that you contact our billing department to set up payment arrangements to keep your account current.

If you do not provide us with accurate insurance information for each visit, and within the timely filing limits set by your insurance company, you will be held responsible for any balances due. The same applies in situations where the insurance company has requested additional information from you. If the information requested is not received by you and the claim is denied, you will be responsible for all charges incurred.

Since insurance changes occur frequently, you will be required to present your insurance card at **each and every visit** to ensure that we have the most up to date policy.

If your insurance company requires your child to be assigned to a specific primary care provider and one of our providers is not listed as the primary care provider, you will be asked to reschedule the appointment until it is updated and confirmed.

Most insurance companies pay 100% for well child visits, but please note that if you bring your child in for a well visit and they are having an acute illness or problem, a sick visit may be charged in addition to the well visit, resulting in you being responsible for your copayment, deductible, and/or coinsurance.

If your child does not have health insurance, payment is due at time of service. We do offer a cash discount to patients without health insurance coverage. To receive the discount, the visit must be paid at the time of service.

We accept the following payment types: Cash, check, money order, Visa, MasterCard, and Discover.

RETURNED CHECKS

If a check is returned, there will be a $25.00 fee added to the account. The returned check fee and balance must be paid before any further services are rendered, and checks will no longer be allowed as a payment type for any future balances on the account.

MINOR AGE PATIENTS

We encourage that all patients be accompanied by an adult and that billing arrangements be made with our office ahead of time. If treatment is rendered, we resume, in good faith, that the parents or guardians are responsible for any and all charges that are incurred. We do ask that whomever may be bringing your child to an appointment be listed on the Medical Authorization form.

PREGNANCY

It is our policy that if we have a patient that becomes pregnant or marries, we ask that they seek care of an adult PCP. As a pediatrician, we treat only the child, not the parent, and the child.

FORMS

Please bring with you any form that needs completed for school, sports, daycare, etc. to your child's scheduled appointment. This will be completed at no charge, as part of the office visit. FMLA forms, or any other forms that need to completed outside of a scheduled appointment, do require a $20.00 fee to be paid in advance of the paperwork being filled out. This will not be billed to your insurance.

MEDICAL RECORDS

We will provide one copy of the patient's medical records upon request, at no charge, to be released to the parent or other physician's office. In accordance with the Indiana State Statute IC 16-39-9-4, Kids First Pediatric Specialists will provide additional copies of the records for the following fees.

- $15.00 for the first 10 pages of records.
- $0.25 for each additional page thereafter.
- An additional $10.00 rush fee may be applied to provide the records within 2 working days of the request.
- Notary fee $10.00

SICK APPOINTMENTS

These appointments are typically scheduled as same day appointments. Same day appointments may be scheduled with a provider other than your usual provider.

WELL CHECK APPOINTMENTS

These appointments are typically scheduled in advance. On some occasions, we may be able to accommodate scheduling a well visit same day, depending on availability. It is recommended that you schedule your child's next well visit appointment prior to leaving the office. Well checks will only be scheduled with your usual provider.

MEDICATION CHECKS

We ask that you schedule these appointments in advance to avoid potential problems with getting your child's medication(s) refilled.

MISSED APPOINTMENTS (NO SHOWS)

These are tracked and may result in dismissal from the practice. 3 no shows in a calendar year equals grounds for dismissal. If you know you are not going to be able to make it to your child's appointment, please call to cancel and/or reschedule. We do understand that there may be times when you cannot make it to an appointment due to emergencies or obligations for work or family. However, when you do not call and cancel your child's appointment, this may prevent another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule your child for a visit, due to a seemingly "full" appointment schedule.

CANCELLATIONS

We ask that you try to give our office as much advance notice as possible when cancelling an appointment. We do understand that there may be times when you must cancel an appointment due to emergencies or obligations for work or family. However, when you do not give an advance notice, this also may prevent another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel with advance notice and we are unable to schedule your child for a visit, due to a seemingly "full" appointment schedule.

LATE POLICY

If you are more than 10 minutes late for your child's appointment, you will be asked to reschedule the appointment. New Patients are asked to be at their appointment 10 minutes prior to their appointment time. 10-minute late policy applies according to the time you are asked to be at our office.

TELEPHONE MESSAGES

Please note that it may take up to 24 hours to receive a call back on a message that was left for the provider. In most situations, messages are returned at the end of the day, after all patients have been seen.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We appreciate your understanding and patience. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

I have read and understand the above policies and procedures of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____

Patient Name & DOB

_____ _____

Parent/Guardian Signature Date