OCONEE PEDIATRICS
15579 WELLS HIGHWAY SENECA, SC 29678
PHONE: 864-882-7800 FAX: 864-882-5908
FRANK A. STEWART, D.O. BEATRIZ GIL-STEWART, D.O.
CATHERINE WILSON, DNP, NNP, FNP BRANDEN BOATWRIGHT, FNP
MEREDITH UNDERHILL, FNP

WELCOME TO OCONEE PEDIATRICS!

To become a new patient at Oconee Pediatrics, we need some important information from you.
Please use this checklist as a guide in preparing your information for us. Please help us avoid any delays in setting up your child's appointment by having all information completed when you bring it back to us.
Once you return it to our office, please allow 24 hours for us to process your paperwork before calling to set up an appointment.

What we will need:

___Insurance Card or cards (please note that the only Medicaid plans that we accept are: *Molina, First Choice, and Blue Choice*)
___Immunization Record

___List of your child's medication's that they take on a daily basis

___If you are not a parent and are a legal guardian, we must have a copy of the court order/safety plan

Please be advised that a parent or legal guardian must be present with the patient on the first office visit.

Thank you for the opportunity to take of your children!!

Oconee Pediatrics

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To: All parents/guardians and patients of Oconee Pediatrics
Regarding: Immunization Policy

At Oconee Pediatrics, your child's health is our number one priority! At each and every visit we will counsel you on what we believe to be the best treatment and preventative care possible for your child's health and well-being. One of the top preventative measures practiced in our office is immunizations. Immunizations are given at ages 2 months, 4 months, 6 months, 1 year, 15 months, 18 months, 2 years, 4 years, and boosters between the ages of 11 and 12 and 16 years of age. Our practice follows the requirements and recommendations of the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) for the recommended time on when to give immunizations. The recommended schedule is designed to immunize your child in a time frame that will give your child proper immunity from the disease. Any deviations from the schedule can put your child at risk.

Therefore, our practice does not participate in any forms of a modified immunization schedule and we do not accept or retain patients that do not immunize their children.

Please feel free to talk to one of our healthcare providers regarding immunizations. Also, for further immunization information, visit www.cdc.gov or www.aap.org.

Thank you and we look forward to taking care of your family!

Oconee Pediatrics

Oconee Pediatrics, PA
15579 Wells Highway
Seneca, SC 29678
Office: 864-882-7800 Fax: 864-882-5908

Authorization To Use Or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information described below:

_____ _____ _(___)_____
Patient Name **Date of Birth** **Contact Number**

The following individual or organization is authorized to make the disclosure (coming from)

_____

Telephone number _(____)_____ **Fax number**__(____)_____

This information may be disclosed to and used by the following individual or organization (going to)

_____

Telephone number _(____)_____ **Fax number**_(____)_____

Purpose of request: _____

The following information is to be disclosed: **PLEASE DO NOT FAX OVER 10 PAGES**

___Physician notes
___Lab results
___X-ray reports
___MRI scans
___Cardiac studies
___**COMPLETE MEDICAL RECORD INCLUDING RECORDS CONTAINED WITHIN FROM OTHER SOURCES**

__**Initials** I understand that the information in my record may include information relation to sexually transmitted diseases, Acquired Immunodeficiency Syndrome(AIDS), or infection with the Human Immunodeficiency Virus(HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

__**Initials** I understand that any disclosure of information carries potential for redisclosure and that the information then may be protected by federal confidentiality rules.

__**Initials** I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and I understand that the revocation will not apply to information already released based on this authorization.

__**Initials** I understand that authorizing the disclosure of this health information is voluntary.

__**Initials** I understand that I may inspect or obtain a copy of the information to be used or disclosed.

_____
Signature of Patient or Legal Representative

Date of release_____
Release expires 1 year from the above date

_____
If not patient, relationship of legal representative to patient

DATE_____ **WELCOME TO OCONEE PEDIATRICS!** **UPDATED 2018**

NEW PATIENT INFORMATION

PATIENT INFORMATION

LAST NAME	**FIRST NAME**	**PREFERRED NAME**	**MIDDLE INITIAL**
MALE__ FEMALE__			
DATE OF BIRTH	**SSN#**	**PRIMARY LANGUAGE**	
		YES	**NO**
EMAIL ADDRESS	**RACE/ETHNICITY**	**IS PATIENT OF HISPANIC ORIGIN?**	

PRIMARY GUARDIAN'S INFORMATION

LAST NAME	**FIRST NAME**	**RELATIONSHIP TO CHILD**
ADDRESS	**CITY & STATE**	**ZIPCODE**
GUARDIAN'S DATE OF BIRTH	**GUARDIANS SS#**	**BEST CONTACT NUMBER**
		NUMBER FOR TEXT MESSAGE REMINDERS

SECONDARY GUARDIAN'S INFORMATION

LAST NAME	**FIRST NAME**	**RELATIONSHIP TO CHILD**
ADDRESS (IF DIFFERENT)	**CITY& STATE**	**ZIPCODE**
GUARDIAN'S DATE OF BIRTH	**GUARDIAN'S SS#**	**BEST CONTACT NUMBER**
		ALTERNATE CONTACT NUMBER

EMERGENCY CONTACT

NAME_____ **CONTACT NUMBER**_____**RELATION TO CHILD**_____

SIBLINGS-FULL NAME'S AND DATES OF BIRTH:

INSURANCE INFORMATION ****PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK****

INSURANCE COMPANY	**FULL NAME OF SUBSCRIBER**	**DATE OF BIRTH**
GROUP NUMBER	**POLICY NUMBER**	**SUBSCRIBER'S SS#**

PREFERRED PHARMACY: _____ _____

NAME OF PHARMACY **LOCATION**

HOW DID YOU HEAR ABOUT OCONEE PEDIATRICS? ☺

DATE: _____

OCONEE PEDIATRICS
FAMILY MEDICAL HISTORY

PATIENT'S NAME: _____ **PATIENT'S DATE OF BIRTH:** _____

FAMILY INFORMATION

MOM'S NAME FIRST & LAST **DAD'S NAME FIRST & LAST**

FAMILY MEDICAL HISTORY

___ **FAMILY MEDICAL HISTORY DOES NOT APPLY. PATIENT IS ADOPTED/FOSTERED CHILD.** ***IF CHECKED, PLEASE COMPLETE BOTTOM PORTION WITH ANY*** **CONCERNS.**

HAS ANYONE IN YOUR CLOSE FAMILY (PARENTS, SISTER, BROTHER, GRANDPARENT, AUNT, UNCLE, ETC) EXPERIENCED THE FOLLOWING:

TUBERCULOSIS	**__NO**	**__YES**	**WHO**_____
DIABETES	**__NO**	**__YES**	**WHO**_____
THYROID PROBLEMS	**__NO**	**__YES**	**WHO**_____
ASTHMA	**__NO**	**__YES**	**WHO**_____
ALLERGY OR SINUS	**__NO**	**__YES**	**WHO**_____
SEIZURES	**__NO**	**__YES**	**WHO**_____
MENTAL RETARDATION	**__NO**	**__YES**	**WHO**_____
HEART ATTACK	**__NO**	**__YES**	**WHO**_____
HIGH BLOOD PRESSURE	**__NO**	**__YES**	**WHO**_____
BRONCHITIS	**__NO**	**__YES**	**WHO**_____
ALCOHOLISM	**__NO**	**__YES**	**WHO**_____
ULCERS	**__NO**	**__YES**	**WHO**_____
INTESTIONAL PROBLEMS	**__NO**	**__YES**	**WHO**_____
KIDNEY PROBLEMS	**__NO**	**__YES**	**WHO**_____
ANEMIA	**__NO**	**__YES**	**WHO**_____
CANCER OR LEUKEMIA	**__NO**	**__YES**	**WHO**_____
BLEEDING PROBLEMS	**__NO**	**__YES**	**WHO**_____
HEARING PROBLEMS	**__NO**	**__YES**	**WHO**_____
VISION PROBLEMS	**__NO**	**__YES**	**WHO**_____
ARTHRITIS	**__NO**	**__YES**	**WHO**_____
SICKLE CELL	**__NO**	**__YES**	**WHO**_____
PSYCHIATRIC ILLNESS	**__NO**	**__YES**	**WHO**_____

PLEASE LIST ANY OTHER MEDICAL HISTORY THAT YOU FEEL IMPORTANT TO SHARE:

_____

_____

OCONEE PEDIATRICS PRIVACY FORM **DATE:** _____

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

SHARING INFORMATION

Please check the information below that you authorize Oconee Pediatrics to release for the above named patient, and list who has permission to receive this information other than the patient's parents/legal guardians:

___Results of tests/x rays
___Billing information
___Appointment information
___Medical information/to include entire medical record

_____

Name of person that has permission to receive the above information / Relationship to patient

_____

Name of person that has permission to receive the above information / Relationship to patient

BRINGING PATIENT TO THE DOCTOR

List anyone who has permission to bring the above named patient to the doctor other that the patient's parents/legal guardians:

_____

Name of person Relationship to patient

_____

Name of person Relationship to patient

Please note, that any patient that presents to the office in attendance with an adult for medical services will not be turned away. It is the understanding of this practice if the child is in the care of the adult at the time they present for services, that the parent/legal guardian has entrusted the patient to them to obtain medical services.*

COMMUNICATION

I authorize Oconee Pediatrics to: (check all that apply) ____send text messages ____leave voicemails to/on the primary number listed on my account.

_____I authorize Oconee Pediatrics to send emails to the email address I have listed on my account.

I understand that it is my responsibility to keep my contact information updated at all times with Oconee Pediatrics.

RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time by sending notification to Oconee Pediatrics at 15579 Wells Highway, Seneca, SC 29678.I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective ongoing forward. I understand that information used or disclosed as a result of this authorization may result in re-disclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for our use and will continue to be protected by our privacy policy. I understand that I have the right to inspect or copy the protected health information disclosed as describe in this document. I can do this by written notification to: Oconee Pediatrics 15579 Wells Highway, Seneca, S.C. 29678. I understand that I have the right to refuse to sign this document.

I HAVE READ AND RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICE FOR OCONEE PEDIATRICS.

_____

Signature of Responsible Party **Date** **Relationship to Patient**

OCONEE PEDIATRICS PAYMENT POLICY/
RESPONSIBLE PARTY SIGNATURE FORM/CONSENT TO TREAT **DATE:** _____

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

RESPONSIBLE PARTY

The responsible party is the person who is financially responsible for the patient's account and who will receive all account statements to their address. By signing, I understand that I am the responsible party and will adhere to the requirements outlined in the policies to me for above listed patients as well as future patients registered in my name at Oconee Pediatrics.
Please note that we cannot set up multiple billing addresses in an account. *

_____

Name of responsibility party (print) **Relation to the patient**

WAIVER OF LIABILITY

_____ **(Initials)**
I understand that the treatment/service from the providers at Oconee Pediatrics, on the above listed patient, may not be a covered treatment/service or may not be covered at 100%. I agree to be personally and fully responsible for any balance due on my account.

PAYMENT POLICY

_____ **(Initials)**
Oconee Pediatrics is committed to providing the highest quality healthcare possible for our patients. Our pricing structure is representative of the usual and customary charges for our area.
Payment is expected, in full, at the time of service regardless of who brings the patient in for treatment. This includes deductibles, copays, and percentages. By collecting in full, at the time of service, we are able to keep our cost down and pass the savings along to you by not increasing our fees as frequently as most practices do. If you do not have a current insurance card and the insurance information we have on file is inactive, you will be asked to pay for the visit in full until such information can be obtained. By signing below, you are indicating that you are the responsible party and that you have read, understand, and agree to adhere to the payment policy of Oconee Pediatrics.
***** We cannot honor any special arrangements in court orders regarding the responsibility of payment for medical services. Payment is expected when services are rendered .*****

_____

Signature of Responsible Party **Date**

CONSENT TO TREAT

I give the providers of Oconee Pediatrics permission to diagnose and treat the patient listed above.

_____

Signature of Parent/Legal Guardian **Relation to Patient**

OCONEE PEDIATRICS HIPAA POLICY STATMENT
PRIVACY NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED BY OCONEE PEDIATRICS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ CAREFULLY.
EFFECTIVE: REVISED January 18, 2019

Under the HIPAA Privacy Regulations, Oconee Pediatrics and all similar health care providers are required by federal law to maintain the privacy of your child's protected health information (PHI) and will abide by the terms in the Privacy Notice. Please be advised that Oconee Pediatrics may use you child's PHI in rendering treatment to your child. For example, we are permitted to use your child's PHI in providing your child with medical care/treatment when your child visits our office or when we treat your child in a hospital or nursing facility. Under federal law, we may disclose your child's PHI to your or we can disclose your child's PHI to third parties for treatment. For example, if we refer your child to a specialist, we will forward your child's medical information to such specialists. We can disclose your child's PHI for payment purposes. For example, we will disclose your child's PHI to your insurance provider, your employer, Medicare, Medicaid, or other parties responsible for providing your child with health insurance coverage in order for Oconee Pediatrics to be reimbursed for our services rendered to your child. We will also use or disclose your child's PHI for health care operations. For example, we may use your child's PHI, when required by the Secretary of the US Department of Health and Human Services. Unless disclosure is required under federal/state law, or certain other exceptions, including law enforcement, we are prohibited from disclosing your child's PHI without your authorization. Our practice may use or disclose your child's PHI in accordance with the specific requirements of the HIPAA rules without Oconee Pediatrics needing to obtain your authorization if the information is.

1. Required by law
2. Required for public health purposes
3. Required disclosures about victims of abuse, neglect, or domestic violence
4. Required by a health oversight agency for oversight activities authorized by law
5. Required in the course of a judicial or administrative proceeding
6. Required for a law enforcement purpose to a law enforcement official
7. Required by a coroner or medical examiner
8. Required by an organ procurement organization for research, and
9. Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Additionally, if you are a member of the armed forces, Oconee Pediatrics is permitted to disclose your child's PHI without your consent if deemed necessary by appropriate military command authorities to assure an appropriate military mission. We may also contact you via mail or phone to remind you of appointments with our office or to discuss treatment alternatives. If, for any reason, you do not wish to be contacted via mail or phone, our office personnel will note your request in your chart. In the event our practice wishes to disclose you child's PHI to another entity besides those referenced above, we are required to obtain your authorization. We would seek to obtain your authorization if Oconee Pediatrics decided to release your child's PHI for reasons other than treatment, payment, or for our practice operations. For example, if we desired to participate in outside research or a drug study, we would need written authorization prior to being permitted to release your child's PHI to such outside research facility or drug manufacturer. If you provide us with an authorization, you have the right to revoke such authorization at any time by sending Oconee Pediatrics a written revocation. However, if we have already released such information pursuant to your authorization, the revocation will be effective for all future disclosures. Please be further advised that you have the ability to access, obtain a copy, inspect, and request amendment to your child's medical information that we maintain. Additionally, if you desire, Oconee Pediatrics can provide you with an accounting of all disclosures for treatment, payment, or healthcare operations and pursuant to authorization. If you have a dispute with our practice regarding the use of your child's PHI or a disclosure by Oconee Pediatrics and believe that you child's primary rights have been violated, please contact Oconee Pediatrics to file a complaint or you may contact the Secretary of Health and Human Services. We welcome feedback from our patients via mail, email, or telephone. Please understand that Oconee Pediatrics will not retaliate against you in any way for filing a complaint. Lastly, please be advised that you have the right to designate a personal representative or request restrictions on certain uses and disclosures of your child's PHI to carry out treatment, payment, or healthcare operations or disclosures by Oconee Pediatrics of your child's PHI to a family member, relative, or a close personal friend. However, we are not required by law to agree to your requested designation or restriction. If you request a copy of your child's PHI, you also have the ability to request that we send it to an alternative location and by alternative means. Additionally, if you have received this notice in an electronic format and you would like a paper copy, please contact Oconee Pediatrics Privacy Contact. Oconee Pediatrics reserves the right to amend this notice as revised. Notices will be posted on our website (www.oconeepediatrics.com) and in our office and provided to you upon request. Thank you and if you have any questions, please contact Oconee Pediatrics at 864-882-7800.

OCONEE PEDIATRICS PAYMENT POLICY

PROOF OF INSURANCE
All patients must complete our patient information packet before an appointment can be scheduled to see a provider. We must obtain a copy of your current, valid insurance card for proof of insurance. Insurance is verified prior to an appointment being scheduled. If you insurance information you present to us is not active, payment, in full, will be expected at the time of service.

CO-PAYMENTS AND BALANCE DUE
All co-payments and balance dues must be paid at the time of service. This includes deductible, copays, and percentages. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles, and percentages from patients, can be considered insurance fraud. Please help is in upholding the law by paying your part at the time of service.

CLAIMS SUBMISSION
We will submit your claims to your insurance provider and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If a claim needs to be refiled, we will do so, one time, as a courtesy granted that you have provided us with verification that your insurance is in an active status and that you have provided them with the information they have requested.

MONTLY BILLING STATEMENT
At Oconee Pediatrics, we collect in full at the time of service to help keep our billing costs at a minimum. By keeping these costs down, we pass the savings along to our patients by not having frequent fee increases as most practices do. It is understood that some services are covered in full by your insurance. For example, some companies pay for wellness exams yearly. In those cases, insurance will be filed. Should you insurance company not cover the service, payment will be expected upon receipt of your billing statement.

INSURANCE
We participate in most insurance plans. It is your responsibility to make sure we are in network with your plan. If you are not insured by a plan we participate with or you do not have insurance, payment, in full, is expected at each visit. We offer a 20% discount, at the time of service, for uninsured patients. To receive the 20% discount, the visit must be paid in full. We do not offer billing for these visits.

NON-PAYMENT
Partial payments will not be accepted unless otherwise negotiated with the billing department prior to the office visit. Please be aware that if a balance remains unpaid for greater than 90 days and no formal arrangements have been made with the billing department to settle the balance, your account may be cancelled.

MISSED APPOINTMENTS
In order to achieve the best appointment availability for our patients, we have a policy for missed appointments. Three missed appointments within a 12 month period may result in discharge from the practice. A missed appointment is any appointment not cancelled with 24 hours of the scheduled appointment. We understand the potential for unforeseen circumstances that can arise that may cause a late or missed appointment. If this happens, please call us as soon as possible so we can change your appointment status accordingly.

NON-COVERED SERVICES
Please be aware that some and perhaps all of the services you received may be non-covered or not considered reasonable or necessary by your insurance company. Since all insurance plans are different, please contact your insurance company or HR department for detailed information about what is covered or not prior to your visit.

NEWBORN INSURANCE
In order for Oconee Pediatrics to file insurance for your newborn, we will need their insurance information as soon as it becomes available. Most private insurance plans allow you less than 30 days to add your newborn to the policy. If your newborn will be covered by Medicaid, please contact them after leaving the hospital to ensure they have the information they need to activate you newborn's insurance. Until we receive proof of insurance on all newborns, the services will be billed to the guarantor. After 30 days of billing, payment in full will be expected.

FORMS OF PAYMENT
Oconee Pediatrics accepts payments by cash, check, credit card, and debit cards Payment is expected at the time of service.