

Oconee Pediatrics
15579 Wells Highway Seneca, SC 29678
Telephone: 864-882-7800—Fax: 864-882-5908
Frank A. Stewart, DO Beatriz Gil-Stewart, D.O.
Branden Boatwright, FNP Catherine Wilson, NNP
Rachel Ward, 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 first 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. We will contact you to set up your appointment.

_____ **Insurance Card or Cards (please note that the only Medicaid plans that we accept are: *Molina, First Choice, Humana and Blue Choice*)**

_____ **Immunization Record**

_____ **Bring all medications that they take on a daily basis or a list to your first visit.**

_____ **If you are not a parent and are a legal guardian, we must have a copy of the court order/safety plan and a copy of your identification.**

Please be advised that a parent or legal guardian must be present with the child to be seen on the first visit.

Thank you for the opportunity to care for your children!

Paper work may be dropped by the office, faxed to 864-882-5908, or emailed to oconeepediatrics864@gmail.com (if emailed or faxed, please call and confirm it was received)

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
RACHEL WARD, FNP MEREDITH UNDERHILL, FNP

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

Authorization To Use Or Disclose Protected Health Information

If not patient, relationship of legal representative to patient

PATIENT INFORMATION **PLEASE WRITE ALL INFORMATION ABOVE THE LINES!

LAST NAME	MALE <input type="checkbox"/>	FIRST NAME	MIDDLE NAME	PREFERRED NAME
	FEMALE <input type="checkbox"/>			

DATE OF BIRTH	SSN#	PRIMARY LANGUAGE
		YES <input type="checkbox"/> NO <input type="checkbox"/>

EMAIL ADDRESS	RACE/ETHNICITY	IS PATIENT OF HISPANIC ORIGIN?
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PRIMARY GUARDIAN'S INFORMATION

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

SECONDARY GUARDIAN'S INFORMATION

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

EMERGENCY CONTACT

NAME	CONTACT NUMBER	RELATION TO CHILD
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SIBLINGS-FULL NAMES AND DATES OF BIRTH:**INSURANCE INFORMATION **PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK****

INSURANCE COMPANY	FULL NAME OF SUBSCRIBER	DATE OF BIRTH
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GROUP NUMBER	POLICY NUMBER	SUBSCRIBER'S SS#
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PREFERRED PHARMACY:

NAME OF PHARMACY	LOCATION
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HOW DID YOU HEAR ABOUT OCONEE PEDIATRICS? ☺	HOSPITAL YOUR CHILD WAS BORN AT?
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Patient/Family Health History

Patients Name: _____

Date of Birth: _____

Today's Date: _____

Please help us to care for your child by providing us with a look at the health history of your child and immediate family members. Please circle yes or no to the questions and if the answer is yes, please provide us with a little detail in the space provided. (The provider will ask for more details if needed.) On the reverse side, please answer the same questions regarding the immediate family. Thank you for choosing Oconee Pediatrics to care for your child!

Your Child's Health History

1. Heart or Circulation	Yes	No	_____
2. Lung or Respiratory	Yes	No	_____
3. Liver, Gallbladder, Spleen	Yes	No	_____
4. Kidney or Urinary Tract	Yes	No	_____
5. Genitalia	Yes	No	_____
6. Brain or Nerves	Yes	No	_____
7. Muscles	Yes	No	_____
8. Bones or Joints	Yes	No	_____
9. Skin or Hair	Yes	No	_____
10. Blood Disorders	Yes	No	_____
11. Nutrition or Growth	Yes	No	_____
12. Behavior or Development	Yes	No	_____
13. Genetic or Inherited Disorders	Yes	No	_____
14. Problems with Pregnancy/Birth	Yes	No	_____
15. Surgeries	Yes	No	_____
16. Vision or Hearing	Yes	No	_____
17. Dental	Yes	No	_____
18. Medicine Allergies	Yes	No	_____
19. Recurrent Infections	Yes	No	_____
or Difficulty Resolving			
20. Environmental Allergies	Yes	No	_____

OVER PLEASE

Your Child's Immediate Family Health History
(Brother/Sister, Parents, Grandparents, Aunts/Uncles)

21. Heart or Circulation	Yes	No	_____
22. Lung or Respiratory	Yes	No	_____
23. Liver, Gallbladder, Spleen	Yes	No	_____
24. Kidney or Urinary Tract	Yes	No	_____
25. Genitalia	Yes	No	_____
26. Brain or Nerves	Yes	No	_____
27. Muscles	Yes	No	_____
28. Bones or Joints	Yes	No	_____
29. Skin or Hair	Yes	No	_____
30. Blood Disorders	Yes	No	_____
31. Nutrition or Growth	Yes	No	_____
32. Behavior or Development	Yes	No	_____
33. Genetic or Inherited Disorders	Yes	No	_____
34. Problems with Pregnancy/Birth	Yes	No	_____
35. Surgeries	Yes	No	_____
36. Vision or Hearing	Yes	No	_____
37. Dental	Yes	No	_____
38. Medicine Allergies	Yes	No	_____
39. Recurrent Infections	Yes	No	_____
or Difficulty Resolving			
40. Environmental Allergies	Yes	No	_____

41. Other _____

Family Information:

Mother's Name

Father's Name

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 PRIVACY FORM 2022

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☐ Appointment information☐ Billing 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 than 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 that 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

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. If you fail to provide us with the correct insurance information at the time of service, you will be responsible for the balance of your claim.

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 from patients can be considered fraud. Please help in upholding the law by paying your co-payment at each visit.

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.

MONTHLY BILLING STATEMENT

After your insurance company pays Oconee Pediatrics, you will receive a billing statement which indicates your balance due and/or deductibles due. These amounts are payable to Oconee Pediatrics. The balance amount is to be paid in full within 10 days of receipt of the billing statement. If you have questions about your account, please call 864-882-7800 and ask to speak with the insurance/billing manager.

INSURANCE

We participate in most insurance plans. If you are not insured by a plan we do business with or do not have insurance, payment in full is expected at each visit. If you are insured by a plan we do insurance with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Oconee Pediatrics does not file claims with any secondary insurance companies.

NON-PAYMENT

Partial payments will not be accepted unless otherwise negotiated with the billing department. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice. If this were to occur, you will be notified in writing that you have 30 days to find alternative medical care. During that 30 day period, providers will only be able to treat you on an emergency basis.

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 will result in discharge from the practice. A missed appointment is any appointment not canceled within 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 covered including well child visits, maximums, immunizations, etc. You will be billed and responsible for all non-covered services.

NEWBORN INSURANCE

In order for Oconee Pediatrics to file insurance for your newborn, a parent must add them to the insurance policy within 30 days of the date of birth. Once added, please notify our billing department in order to have the patient's charges filed in a timely manner. If insurance is not determined after 30 days from birth, the patient's account will be considered self-pay and the responsible party will be billed for the balance.

FORMS OF PAYMENT

Oconee Pediatrics accepts payments by cash, check, money orders, Visa, MasterCard, Discover, American Express, and debit cards bearing these logos. Payment is expected at the time of service.

**OCONEE PEDIATRICS HIPAA POLICY STATEMENT
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 May 16, 2022

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 your 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 your 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 your 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 or by email at oconeepediatrics864@gmail.com.