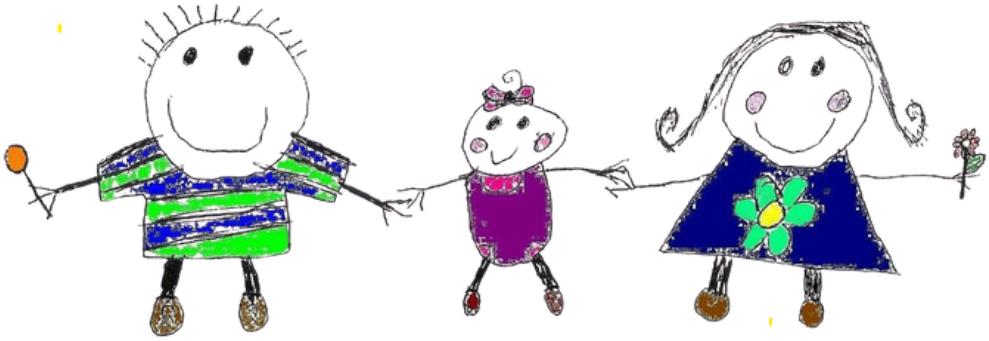
OCONEE PEDIATRICS



15579 Wells Highway, Seneca, SC 29678
Phone: 864-882-7800
Fax: 864-882-5908
Frank A. Stewart, D.O. Beatriz Gil-Stewart, D.O.
Branden Boatwright, F.N.P. Catherine Wilson, D.N.P.
Rachel Ward, F.N.P. Meredith Underhill, F.N.P.

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 Vaccine Policy

Vaccines no longer required to be a patient at Oconee Pediatrics !
Please read full statement.

We understand that due to recent political and social media input, many parents have become more hesitant to have their children vaccinated.
As an advocate for your child, we will always recommend what we know to be best for your child in all aspects of their medical care. This information comes from years of experience, knowledge, training, and on going continuing medical education.
With that being said, we will always recommend that your child be vaccinated with the AAP/CDC recommended vaccines but will no longer require you to vaccinate your child to remain in our practice.

When a decision is made to not vaccinate your child, a declination form **WILL BE REQUIRED** at **EVERY** visit where your child would be offered the AAP/CDC recommended vaccines. This form simply states that you have been offered the vaccines and also have been informed and understand the risks of not vaccinating your child. It also states that at any time you change your mind and decide you would like your child vaccinated, you can do so. **Should you choose to do a delayed vaccine schedule for your child, please note that any vaccine related visit is considered an office visit and your child will need to be seen by a provider.**

Should you have any questions, please feel free to call and talk to our staff.

As always, your child's healthcare is our top priority!!

Oconee Pediatrics, PA
15579 Wells Highway Seneca, SC 29678
Office: 864-882-7800 Fax: 864-882-5908 oconeepediatrics864@gmail.com

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)

_____

Facility Practice Name

_____ _____

Telephone Number **Fax Number**

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

_____

Facility Practice Name

_____ _____

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 INCLUDNG RECORDS CONTANED 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.

_____ _____

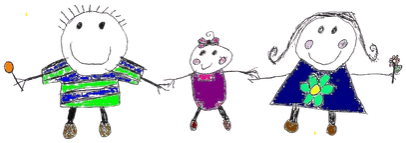
Signature of Patient or Legal Representative Date of release

Release expires 1 year from the above date

_____

If not patient, relationship of legal representative to patient

Chart #: _____



OCONEE PEDIATRICS

New Patient Information 2026

PATIENT INFORMATION

First Middle Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female SSN: _____

Address: _____

City: _____ State: _____ ZIP _____

Is Patient of Hispanic Origin?: ◯ Yes ◯ No Primary Language: _____

Preferred Pharmacy: _____ Race: _____

PRIMARY GUARDIANS INFORMATION ****REQUIRED INFORMATION****

First Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP _____

Guardians DOB: _____ Guardians SSN: _____

Relationship to child: _____

Cell Phone: _____ Email: _____

SECONDARY GUARDIANS INFORMATION

First Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP _____

Guardians DOB: _____ Guardians SSN: _____

Relationship to child: _____

Cell Phone: _____ Email: _____

EMERGENCY CONTACT: _____ Cell Phone: _____

INSURANCE INFORMATION

◯ Primary Insurance ◯ Self Pay ◯ Secondary Insurance

Name of Insurance Company: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Subscribers SSN: _____

Name of Secondary Insurance /Number: _____

SIBLINGS -NAME AND DOB

_____ _____

_____ _____

How did you hear about Oconee Pediatrics? _____

Initial History Questionnaire

PATIENT NAME: _____ **DOB** _____

AGE: _____ **SEX:** _____ **FORM COMPLETED BY:** _____

GENERAL

Do you consider your child to be in good health? ◯ **Y** ◯ **N** **EXPLAIN:** _____

Does your child have any special health care needs? ◯ **Y** ◯ **N** **EXPLAIN:** _____

Has your child ever been hospitalized? ◯ **Y** ◯ **N** **EXPLAIN:** _____

is your child allergic to medicine or drugs? ◯ **Y** ◯ **N** **EXPLAIN:** _____

BIRTH HISTORY

Birth weight: _____

◯ Full-term ◯ Preterm _____Weeks ◯ Post-term _____Weeks

Delivery: ◯ Vaginal ◯ Cesarean Reason: _____

Any complications during birth or after birth: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?_____

During pregnancy, did the mother:

Take prenatal vitamins?	Yes	No
Smoke or use e-cigarettes?	Yes	No
Drink alcohol?	Yes	No
Use marijuana?	Yes	No
Use illicit drugs?	Yes	No
Take other medications?	Yes	No

If yes, please list: _____

Blood type mother: _____ Blood type baby: _____ _____

Mother's lab results:

Hep B : _____ HIV : _____Group B streptococcus (GBS):_____

After birth, did the baby get:

Vitamin K shot : _____ Erythromycin eye Ointment : _____Hep B shot:_____

How was baby fed?

Bottle formula : _____ Bottle breast milk :_____Breastfed:_____ How long was baby breastfed?_____

Did baby go home with biological mother from hospital after birth?

Yes : _____ No: _____ Explain: _____

SOCIAL HISTORY

Does the child live with both biological parents?

Yes : _____ No: _____ Explain: _____

Please list all those living in the child's home.

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Initial History Questionnaire of Child

PATIENT NAME: _____ **DOB** _____

AGE: _____ **SEX:** _____ **FORM COMPLETED BY:** _____

PAST MEDICAL HISTORY OF CHILD

Has your child ever had any of the following problems?

Adopted or in foster care please check one and skip to Privacy Form

◯ **ADOPTED** ◯ **FOSTER CARE**

CONDITION	Y	N	EXPLAIN
EYE PROBLEMS, CATARACTS, OR RETINOBLASTOMA			
VISION IMPAIRMENT OR CONCERNS			
NASAL ALLERGIES (DUST,PET, ENVIROMENTAL)			
FREQUENT EAR INFECTIONS			
HEARING LOSS OR CONCERNS			
MULTIPLE CAVITIES OR PROBLEMS W/TEETH			
FREQUENT COLDS OR SORE THROATS			
ASTHMA, WHEEZING, OR BREATHING PROBLEMS			
BRONCHITIS, BRONCHIOLITIS, OR PNEUMONIA			
HEART MURMUR OR OTHER HEART PROBLEMS			
HIGH BLOOD PRESSURE			

PAST MEDICAL HISTORY OF CHILD CONTINUED

CONDITION	Y	N	EXPLAIN
FREQUENT STOMACH PAIN			
CONSTIPATION NEEDING MEDICAL TREATMENT			
FOOD ALLERGIES OR INTOLERANCE			
FEEDING ISSUES OR UNDERWEIGHT			
OVERWEIGHT OR OBESITY			
URINARY TRACT INFECTIONS			
BED-WETTING (AFTER 5YR OLD)			
KIDNEY, URETER, OR BLADDER PROBLEMS			
SERIOUS INJURIES OR FRACTURES			
BONE, JOINT, OR MUSCLE PROBLEMS			
FREQUENT HEADACHES OR DIZZINESS			
CONCUSSION OR HEAD INJURY			
CONVULSIONS, SEIZURES, OR NEUROLOGICAL ISSUES			
SLEEP PROBLEMS OR SNORING			
SKIN RASHES, ECEZMA, OR HIVES			

PAST MEDICAL HISTORY OF CHILD CONTINUED

CONDITION	Y	N	EXPLAIN
BLOOD TRANSFUSION			
HIV OR AIDS			
CHICKENPOX OR ZOSTER (SHINGLES)			
DEVELOPMENTAL DELAYS (SPEECH OR MOTOR)			
SCHOOL PROBLEMS OR LEARNING DIFFICULTIES			
ADHD OR BEHAVIORAL CONCERNS			
ANXIETY, DEPRESSION, OR MOOD PROBLEMS			
TOBACCO, ALCHOL OR DRUG USE			
EXPOSURE TO FAMILY VIOLENCE			
SEXUALLY TRANSMITTED INFECTIONS			
FEMALES: ISSUES WITH PERIODS			
AGE OF FIRST PERIOD:			
ACNE			
THYROID OR OTHER ENDOCRINE PROBLEMS			

PAST MEDICAL HISTORY OF CHILD CONTINUED

CONDITION	Y	N	EXPLAIN
DIABETES			
METABOLIC/GENETIC DISORDERS			
ANEMIA OR BLEEDING PROBLEMS			
CANCER OR CHEMOTHERAPY			
BONE MARROW OR ORGAN TRANSPLANT			

IMMEDIATE FAMILY HISTORY OF CHILD

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions?

CONDITION	Y	N	WHO
ANEMIA OR BLEEDING PROBLEMS			
ASTHMA			
ALLERGIES			
ALCOHOL USE PROBLEMS			
BED-WETTING (AFTER AGE 10YRS)			
CANCER (BEFORE AGE 55 YRS)			
CHILDHOOD HEARING LOSS			

IMMEDIATE FAMILY HISTORY OF CHILD CONTINUED

CONDITION	Y	N	WHO
DENTAL DECAY OR MULTIPLE CAVITIES			
DEPRESSION OR ANXIETY			
DEVELOPMENTAL DISABILITY			
DIABETES			
HEART ATTACK (MYOCARDIAL INFARCTION)			
HEART DISEASE (BEFORE AGE 55YRS)			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HIV OR AIDS			
KIDNEY DISEASE			
LIVER DISEASE			
MENTAL HEALTH CONDITIONS			
OBESITY			
SEIZURES OR EPILEPSY			

IMMEDIATE FAMILY HISTORY OF CHILD CONTINUED

CONDITION	Y	N	WHO
STROKE			
SUBSTANCE USE PROBLEMS			
SUDDEN DEATH (BEFORE AGE 50YR)			
THYROID OR OTHER ENDOCRINE DISEASE			
TOBACCO USE PROBLEMS			
TUBERCULOSIS			
VISION OR EYE PROBLEMS			
OTHER MEDICAL CONDITIONS:			

SURGICAL HISTORY OF CHILD

SURGERY/PROCEDURE	DATE

Oconee Pediatrics Privacy Form 2026

PATIENT NAME _____ **DOB** _____

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 test/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 then patient's parent/legal guardians:

_____

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

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 the 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 29678.1 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 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 Responsible Party/ Payment/Consent to Treat Form 2026

PATIENT NAME _____ **DOB** _____

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 tot he 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.****

_____ _____ _____

Signature of Responsible Party Date Relationship to 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 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

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 Relationship to Patient

CONSENT TO TREAT

I, _____, authorize Oconee Pediatrics to provide medical care, including exams, diagnostics, and treatment, for my child_____ DOB _____. This consent will be valid from one (1) years of signing

_____ _____ _____

Signature of Parent /Legal Guardian Date Relationship to Patient

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 AND HOW CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ CAREFULLY.

EFFECTIVE: REVISED April 1, 2026

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 offce 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, phone, or text 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, phone or text, 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 amendments 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 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.

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 participate 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 may result in discharge from the practice. A missed appointment is any appointment not canceled within 24 hours of the scheduled appointment or that you do not show for. 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 js 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.