Redmont Pediatric Associates, P.C.

805 ST. VINCENT'S DRIVE, SUITE 430
BIRMINGHAM, ALABAMA 35205

DATE OF FIRST VISIT _____

ACCOUNT NUMBER _____

PLEASE PRINT

PATIENT'S FULL NAME _____ NICKNAME OF CALL NAME _____
LAST FIRST MIDDLE

HOME ADDRESS: _____ HOME: _____
STREET CITY STATE ZIP CODE TELEPHONE

DATE OF BIRTH _____ SEX: MALE ☐ FEMALE ☐ SOCIAL SECURITY NUMBER: _____
MO. DAY YR.

INSURANCE DATA

SUBSCRIBER/INSURED _____ INSURANCE CO. _____

CONTRACT OR I.D. NUMBER _____ GROUP NUMBER _____

EFFECTIVE DATE _____ DOCTOR _____

FAMILY DATA

	MOTHER	FATHER
NAME		
DATE OF BIRTH		
ADDRESS		
CITY, STATE & ZIP CODE		
EMPLOYER		
POSITION HELD		
WORK PHONE #		
HOME PHONE #		
CELL PHONE #		
SOCIAL SECURITY NUMBER		
FRIEND OR FAMILY MEMBER FOR EMERGENCIES		

REFERRED BY _____

LIST ALL CHILDREN IN FAMILY LESS THAN 18 YEARS OLD

#	NAME	SEX		BIRTHDAY			REMARKS
		M	F	MO.	DAY	YR.	
1							
2							
3							
4							
5							
6							

Redmont Pediatric Associates, P.C.

805 St. Vincent's Drive
Suite 430
Birmingham, Alabama 35205
205-939-1250

Stephen R. Blair, M.D.
Christina C. Cordell, M.D.

JoAnn M. Mays, M.D.
Ryan M. Walley, M.D.

Date _____

Patient's Name **Date of Birth** **Social Security Number**

_____ _____ _____

First MI Last

Patient Resides With *(Circle One)* **Both Parents Mother Father Other**

Insurance Company	Subscriber	Contract No.	Group No.

Parents' or Guardians' Names and Address(es)

Mother

_____
Name

_____
Street Address

_____
City State Zip

Home # _____

Cell # _____

Place of Employment

_____

Work # _____

Father

_____
Name

_____
Street Address

_____
City State Zip

Home # _____

Cell # _____

Place of Employment

_____

Work # _____

I have reviewed the information listed above and it is correct.

Date	Initial	Date	Initial	Date	Initial

Redmont Pediatric Associates, P. C.

HISTORY SHEET

CHILD'S NAME: _____ DATE OF BIRTH: _____

AGE: _____

BIRTH INFORMATION:

1. Birth Measurements: Weight _____ Height _____ Head circumference _____
2. List any problems with the pregnancy: _____
   _____
3. Was infant delivered by Caesarean-Section? If yes, for what reason? _____
   _____
4. Was infant premature? _____
5. Were there any problems in the nursery? _____ If yes, please list: _____
   _____

DEVELOPMENT:

1. At what age did your child: roll front to back _____: roll back to front _____: sit alone _____: crawl _____: walk _____
2. If your child is in school, what grade is he / she in? _____

PAST MEDICAL HISTORY:

1. Prior hospitalizations: (list age at that time and reason for hospitalization)
   _____
   _____
2. Prior surgeries: (list age at the time and reason for surgery) _____
   _____
3. List any allergies to medications: _____
4. List any chronic medical problems: _____
   _____
5. List current medications: _____

FAMILY HISTORY:

Do any of these diseases run in your family? patient's parents, siblings, grandparents? If yes, please circle:

allergies / asthma
birth defects
bleeding disorders
sickle cell disease / trait
bone or joint disease
mental retardation
cancer
cystic fibrosis
tuberculosis
blindness
deafness
seizures
thyroid disease
diabetes
heart disease
high blood pressure
kidney problems

Redmont Pediatric Associates, P.C. Consent Form

FINANCIAL RESPONSIBILITY

I hereby assign to Redmont Pediatric Associates, P.C. all payments for medical services rendered. I acknowledge full financial responsibility for all services provided, both those covered by my insurance contract and those non-covered services that may be deemed necessary for appropriate medical care. I accept full responsibility for knowing my insurance benefits and will advise the staff of Redmont Pediatrics accordingly. I understand that charges incurred are due at the time of service unless other financial arrangements have been made prior to treatment.

I also understand that charges may be incurred for other services provided, including a $20.00 cancellation fee when a well check-up is cancelled less than 24 hours before the appointment, a $20.00 fee for checks returned for insufficient funds and a $5.00 administrative processing fee for completion of forms. I understand that I am responsible for any and all charges incurred and that if the account remains unpaid and is referred to an attorney or collection agency, all costs of collections, including reasonable attorney's fees, will be my responsibility.

***Signature of Parent / Guardian** _____

Father (Agreement to Pay)

_____ _____

Patient's Name (Please Print) **Mother (Agreement to Pay)**

_____ _____

Date **Signature of Patient Age 14 – 19 (Agreement to Pay)**

The responsible party understands that no oral or written contract exists which designates by name or description the individual who will treat the patient.

I understand that any release of information or consent to treat other than the authorizations listed above will require my written or verbal approval.

_____ _____

***Signature of Parent** **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of Redmont Pediatric Associates, P.C. **Notice of Privacy Practices.** I am aware that this office is HIPAA compliant and is following federally regulated guidelines regarding my protected health information.

_____ _____

***Signature of Parent** **Date**

_____ _____

Signature of Patient (Age 14 – 19) **Date**

(OVER)

Consent for Use and Disclosure of Protected Health Information

You hereby consent for Redmont Pediatric Associates, P.C. to use or disclose information about you (or another person for whom you have the authority to sign) that is protected under federal law for the purposes of treatment, payment and healthcare operations. Due to recent changes involving federal laws regarding your Privacy, our authorizations are more extensive than ever before. Please understand that the goal of Redmont Pediatrics is to administer the best medical care available in the most efficient manner. We will strive at all times, to the best of our ability, to protect your privacy.

Please understand that in the normal course of running our medical office, discussions can sometimes be overheard. Ask at any time if you would like to assure a totally confidential discussion with one of the doctors, lab technicians, nurses or business office staff members.

Please read carefully the authorizations below and sign appropriately.

I hereby authorize Redmont Pediatric Associates, P.C. to communicate confidential information to any referring or consulting physician, to any medical facility or to my insurance carrier by facsimile, electronic transmission, telephone or U.S. mail. My personal information is protected under federal law and I have the right to revoke this consent at any time. By signing below, I recognize that the protected health information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

_____ _____

***Signature of Patient (If under age 14, must be signed by parent or guardian)** **Date**

ADOLESCENT PATIENTS (Ages 14 – 19)

I hereby authorize the physicians of Redmont Pediatrics to discuss my medical condition and treatment plan with my parent or guardian. I understand that if financial responsibility is assumed by my parent or guardian, they will have the right to review services rendered. I may ask for a private consultation with my physician at any given time.

_____ _____

Signature of Patient Age 14 – 19 **Date**

AUTHORIZATION TO PRESENT FOR MEDICAL TREATMENT

I hereby give my consent for medical treatment from the physicians of Redmont Pediatric Associates, P.C. I also authorize the following individuals to present with my child for medical treatment. In case of an emergency, I may be reached by telephone for verification if the person accompanying the patient is not named below.

Name	Phone	Relationship

_____ _____

***Signature of Patient if 14 or Over / Parent** **Date**

REDMONT PEDIATRIC ASSOCIATES, P.C.
805 St. Vincent's Drive, Suite #430
Birmingham, Alabama 35205
Phone (205) 939-1250 Fax (205) 939-1349

Stephen R. Blair, M.D. JoAnn M. Mays, M.D. Ryan M. Walley, M.D. Christina C. Cordell, M.D.

Medical Records Release

Today's Date: _____ Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Please release the following: *(Check only one)*

_____ All Records
_____ Immunization Records
_____ Records Dated from _____ to _____

Include sensitive records: *(Circle one)* Yes / No (ie. Psychological or Psychiatric Records, Sexually Transmitted Diseases, Pregnancy Tests, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Hepatitis, Drug or Alcohol Abuse)

Purpose of the Release:

___ Continuity of Treatment ___ Change of Physician ___ Other (Please Specify on Line Below)

_____

I wish to: *(Check only one)*

_____Pick Records Up Myself _____Have Records Mailed

The information may be released by:

_____
Name of Practice or Facility

The Information may be released to:

_____
Individual, Practice or Facility receiving the information

_____
Street Address

_____
City State Zip

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose the information and it may no longer be protected under HIPAA, a federal privacy law. This authorization is valid for ninety (90) days from the date signed unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand that I may revoke this authorization in writing at any time by completing a form available from Redmont Pediatric Associates, PC. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it and I may receive a copy of this form after I sign it. I may be charged reasonable copy fees as indicated under state law for my request. I represent that I have the authority and voluntarily grant permission for the information to be released as described above.

Full Name: _____

Address: _____

City State Zip _____

Phone Numbers: Home# _____ Work# _____ Cell#_____

*Signature of Parent _____
(if under age 14 must be signed by parent or guardian)

*Signature of Patient_____
(patient age 14 and up)