221 Pecan Park Avenue
Alexandria, LA 71303
Phone: 318-487-1602 | **Fax:** 1-877-526-9271

NEW PATIENT REGISTRATION

Today's Date: _ _ / _ _ / _ _ _ _
M T W T F S S

Your relationship to patient:
☐ Mother ☐ Father ☐ Legal Guardian
☐ DCFS ☐ Other, ___________________________

Marcia Mitchell, MD
Pediatrics & Pediatric Infectious Disease Specialist

PATIENT

Last Name: ________________________________ **First Name:** ______________________________
DOB: _ _ / _ _ / _ _ _ _ **SSN:** _ _ _ - _ _ - _ _ _ _ **Gender:** ☐ Male ☐ Female ☐ Transgender
Race: ________________________ ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report
Billing Address: ___________________________________ **City:** _______________ **State:** _________
Zip code: _ _ _ _ _ **Physical address the same?** ☐ Yes ☐ No

MOTHER

Last Name: ________________________________ **First Name:** ______________________________
DOB: _ _ / _ _ / _ _ _ _ **SSN:** _ _ _ - _ _ - _ _ _ _ **Occupation:** ______________________________
Billing Address: (if same as patient, no need to complete) _____________________________________
City: _______________ **State:** ________ **Zip code:** _ _ _ _ _ **Cell Phone:** (_ _ _) _ _ _ - _ _ _ _
Home Phone: (_ _ _) _ _ _ - _ _ _ _ **Work Phone:** (_ _ _) _ _ _ - _ _ _ _ **Ext:** _ _ _ _ _
Email Address: ____

FATHER

Last Name: ________________________________ **First Name:** ______________________________
DOB: _ _ / _ _ / _ _ _ _ **SSN:** _ _ _ - _ _ - _ _ _ _ **Occupation:** ______________________________
Billing Address: (if same as patient, no need to complete) _____________________________________
City: _______________ **State:** ________ **Zip code:** _ _ _ _ _ **Cell Phone:** (_ _ _) _ _ _ - _ _ _ _
Home Phone: (_ _ _) _ _ _ - _ _ _ _ **Work Phone:** (_ _ _) _ _ _ - _ _ _ _ **Ext:** _ _ _ _ _
Email Address: ____

Mother & Father are: ☐ Married ☐ Separated ☐ Divorced ☐ Single

EMERGENCY CONTACTS

Please note that persons listed below (other than legal guardian) will have access to your child's medical records and authorization to bring child to office visits.

1. **Last Name:** ____________________________ **First Name:** ____________________________
   Phone #: (_ _ _) _ _ _ - _ _ _ _ **Relationship to child:** _______________________________
2. **Last Name:** ____________________________ **First Name:** ____________________________
   Phone #: (_ _ _) _ _ _ - _ _ _ _ **Relationship to child:** _______________________________
3. **Last Name:** ____________________________ **First Name:** ____________________________
   Phone #: (_ _ _) _ _ _ - _ _ _ _ **Relationship to child:** _______________________________

Patient Name: ___________________________________ **DOB:** _ _ / _ _ / _ _ _ _

INSURANCE INFORMATION

- If your child is 30 days old or ***under*** and you are waiting for insurance to become active, please check one (or both) of the following: ☐ Private insurance pending ☐ Medicaid insurance pending
- If your child is ***over*** 30 days old and you do not have active insurance currently, please check the following: ☐ Self-pay/uninsured

Primary Policy

Insurance Name: ______________________ **Policy #:** ___________________ **Group #:** _________
Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other, ____

Secondary Policy (if applicable)

Insurance Name: ______________________ **Policy #:** ___________________ **Group #:** _________
Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other, ____

Tertiary Policy (if applicable)

Insurance Name: ______________________ **Policy #:** ___________________ **Group #:** _________
Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other, ____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize my insurance company, including Medicare if I am a Medicare Beneficiary, to make payments to Mitchells Pediatrics for medical services rendered to me or my dependent by Mitchells Pediatrics. Should my insurance carrier deny Mitchells Pediatrics payment, I understand that I am financially responsible for the charged. I authorize Mitchells Pediatrics to release all my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses.

I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update all personal, insurance and health information.

Parent/Guardian Signature: ____ **Date:** _ _ / _ _ / _ _ _ _

HOUSEHOLD

Please list names of all persons living with child:

Last Name: ___________________________ **First Name:** _________________________________
Last Name: ___________________________ **First Name:** _________________________________
Last Name: ___________________________ **First Name:** _________________________________
Last Name: ___________________________ **First Name:** _________________________________

- **Smokers in home?** ☐ Yes ☐ No | If yes, who? _____________________________________
- **Pets in home?** ☐ Yes ☐ No | If yes, what kind? _____________________________________

BIRTH HISTORY OF CHILD

Birth Hospital: ____ **Delivery:** ☐ Vaginal ☐ C-section
Baby was born: ☐ Preterm (36wks or before) ☐ Term (37-42wks) | **NICU stay?** ☐ Yes ☐ No
Birth weight: __________ **Length:** __________ **HC:** __________ **Initial feeding:** ☐ Formula ☐ Breast
Current formula: ______________________________________

- Did mother have any illnesses or complications during pregnancy, labor or delivery?
  ☐ Yes ☐ No | Please explain. ____
- Did mother use tobacco, medications, drugs or alcohol during pregnancy?
  ☐ Yes ☐ No | Please list dates and what was used. ______________________________________

Patient Name: ____ **DOB:** _ _ / _ _ / _ _ _ _

GENERAL HISTORY OF CHILD

Past hospitalizations? ☐ Yes ☐ No ☐ Unknown ____

Past surgeries? ☐ Yes ☐ No ☐ Unknown ____

Medical conditions? ☐ Yes ☐ No ☐ Unknown ____

Drug allergies? ☐ Yes ☐ No ☐ Unknown ____

Environmental or food allergies? ☐ Yes ☐ No ☐ Unknown ______________________________

Developmental delays or concerns? ☐ Yes ☐ No ☐ Unknown ____________________________

Recent travel outside of Louisiana? ☐ Yes ☐ No ☐ Unknown ___________________________

Immunizations up to date? ☐ Yes ☐ No ☐ Unknown

FAMILY HISTORY

Please indicate which family member(s) have these problems, illnesses or diseases by using the following key:

Mother **(M)**	Father **(F)**	Sibling **(S)**	Mom's Parents **(MP)**	Dad's Parents **(DP)**	Aunt **(A)**	Uncle **(U)**	Other **(O)**

ADD/ADHD	Diabetes (before age 50)
Alcohol Abuse	Drug Abuse
Anemia	Epilepsy/Convulsions
Anxiety	Heart Disease (before age 50)
Asthma/Allergies	High blood pressure (before age 50)
Bedwetting (after age 10)	High cholesterol
Birth Defects	HIV/AIDS
Cancer	Hypertension
Crohn's Disease	Kidney Disease
Cystic Fibrosis	Liver Disease
Deafness	Mental Illness
Depression	Sickle Cell

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice provider(s), or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

Current pharmacy: ____ **Location:** ______________________

If patient is 17 years or younger:

I give consent to allow Mitchells Pediatrics provider(s) to obtain my child's medication history from their pharmacy, health plans, and their other healthcare provider(s).

Parent/Guardian Signature: ______________________________ **Date:** _ _ / _ _ / _ _ _ _

If patient is 18 years or older:

I give consent to allow Mitchells Pediatrics provider(s) to obtain my medication history from my pharmacy, my health plans, and my other healthcare provider(s).

Patient Signature: ______________________________ **Date:** _ _ / _ _ / _ _ _ _

Patient Name: ___________________________________ **DOB:** _ _ / _ _ / _ _ _ _

NOTICE OF PRIVACY PRACTICES

[If Mitchells Pediatrics' Notice of Privacy Practices is not attached to this packet, please notify front desk before signing this section.]

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information and how you can get access to this information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please ask to speak with our designated Privacy Officer.

Parent/Guardian Signature: ________________________ **Date:** _ _ / _ _ / _ _ _ _

ADMINISTRATION ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.
☐ Due to an emergency, it was not possible to obtain an acknowledgement.
☐ We could not communicate with the patient.
☐ Other, ____

Employee Signature: ________________________ **Date:** _ _ / _ _ / _ _ _ _

PATIENT RIGHTS AND RESPONSIBILITIES

1. To be informed of your rights and responsibilities before receiving care or discontinuing care.
2. To have your individuality, psychosocial, spiritual, personal dignity, values, beliefs, privacy and preferences respected.
3. Equal care and treatment based on the American Academy of Pediatrics standards and guidelines – regardless of race, age, religion, national origin, sex, sexual preferences, physical impairment, diagnosis, ability to pay or source of payment.
4. To make informed decisions regarding care and participate in the development and implementation of care plan, treatment and services.
5. To receive information about your own health status in a timely manner.
6. To sign an informed consent documenting a mutual understanding between the patient and physician about the care, treatment and services the patient receives.

Responsibilities:

- Tell the physician and nurse about present complaints, past illnesses, hospitalization and your medications- including over-the-counter medicines such as aspirin, ibuprofen and dietary supplements like vitamins, diet pills and herbals.
- Report to the physician and nurse any perceived risks and unexpected changes in your condition.
- Follow instructions and guidelines given by those providing health care services.
- Advise the physician of any dissatisfaction regarding your care at Mitchells Pediatrics.

Patient Name: ___________________________________ **DOB:** _ _ / _ _ / _ _ _ _

CONSENT TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN AND/OR MENTAL HEALTH PROVIDERS

I authorize Mitchells Pediatrics to communicate information to other health care providers, including mental health providers, as well as my insurance company if necessary. [These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to what is necessary for the determination of coverage and coordination of care. Many insurance companies require us to document whether you will allow this permission or not.]

Parent/Guardian Signature: ______________________ **Date:** _ _ / _ _ / _ _ _ _

CONSENT TO TREATMENT (MINOR – 17 YEARS OR YOUNGER)

I authorize the rendering of such medical care, including diagnostic and therapeutic treatment by the provider(s) (physician or nurse practitioner) and staff of Mitchells Pediatrics, as may be deemed necessary or beneficial.

Treatment may include, but is not limited to laboratory procedures, capillary puncture, and medication administration

I acknowledge that no guarantees have been made as to the effect of the examination or treatment of my child's condition.

I understand that I have the right to make decisions concerning my child's healthcare, including the right to refuse medical treatment.

My signature below indicates my acknowledgement that I have read and agree to all the above.

I give my authorization & consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

Parent/Guardian Signature: ______________________ **Date:** _ _ / _ _ / _ _ _ _

CONSENT TO TREATMENT (ADULT – 18 YEARS OR OLDER)

I authorize the rendering of such medical care, including diagnostic and therapeutic treatment by the provider(s) (physician or nurse practitioner) and staff of Mitchells Pediatrics, as may be deemed necessary or beneficial.

Treatment may include, but is not limited to laboratory procedures, capillary puncture, and medication administration

I acknowledge that no guarantees have been made as to the effect of the examination or treatment of my condition.

I understand that I have the right to make decisions concerning my healthcare, including the right to refuse medical treatment.

My signature below indicates my acknowledgement that I have read and agree to all the above.

I give my authorization & consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

Patient Signature: ______________________ **Date:** _ _ / _ _ / _ _ _ _

Patient Name: ___________________________________ **DOB:** _ _ / _ _ / _ _ _ _

OFFICE AND FINANCIAL POLICIES

At every visit and while on company premises, your child MUST be accompanied by a parent/guardian or authorized adult whose name is listed in your child's medical records

- **Age Limitation:** Medical care will be provided to your child from newborn to age 18 and within 30 days of their 19th birthday.
- **Demographic Changes:** You must notify our staff immediately if your address, telephone number, pharmacy or email address has changed.
- **Telephone Calls:** Leave a detailed message with our receptionist in order for our nurse or provider to call you back before end of day.
- **School or Medical Paperwork:** If you have paperwork needing to be filled out by the provider, you must allow at least 48 hours for pick up.
- **Vaccine Records:** An updated vaccine record along with the appropriate VIS forms will be given to you when your child receives vaccines. If you allow someone else to pick up your child's vaccine record, they must show form of ID and be listed as an authorized adult in your child's chart. Vaccine records will NOT be faxed or mailed unless a signed authorization to do so is received.
- **Food and Beverages:** In keeping with OSHA, no food or drinks are allowed in the office please.
- **Cell Phones:** No cell phone usage allowed in triage or exam rooms.
- **School and Work Excuses:** Excuses are given at time of each visit, they can NOT be backdated unless cleared by provider.
- **ADHD/ADD:** Your child will have to be evaluated every other month in order to receive a refill. If you allow someone else to pick up your child's script, they must show form of ID and be listed as an authorized adult in your child's chart.
- **Divorced Parents:** The parent who brings the child to the visit is responsible for the copayment before the time of service. We will not be involved in any legal matters.
- **Insurance Information:** It is your responsibility to provide any and all correct insurance information. Failure to do so can result in you being responsible for any balances or unpaid claims.
- **Copayments/Deductibles/Outstanding Balances:** Payments are due at the front desk *before* the time of service. We accept all major credit cards, checks and cash. A payment plan is available upon request, however, a minimum of $5.00 must be collected at that time with an exact date as to when the remaining balance will be paid in full. Returned checks will attract a $25.00 fee along with any bank incurred expenses. If this happens, checks will no longer be accepted as a form of payment from you.
- **Overdue Balances:** Failure to remain in good financial standing with Mitchells Pediatrics after 180 days (6 months) have passed, outstanding balances will be forwarded to collections and/or you may be dismissed from the practice. Payment plans are in place to avoid this. Please visit or call our office at (318) 487-1602 for more information.
- **Terms of Dismissal:** Our facility has the right to terminate the provider/patient relationship for non-compliance, threatening or abusive behavior, tampering, altering or improper use of prescriptions or medications and non-paying patients.
- **After Hours:** A medical provider is on call 24/7 to speak with you if needed. Please call (318) 487-1602 and leave a message with the answering service and the provider will return your call within 30-45 minutes. *Please do not text or call the provider's personal phone for any medical issues related to your child.*

Parent/Guardian Signature: ___________________________________ **Date:** _ _ / _ _ / _ _ _ _

MITCHELLS PEDIATRICS, LLC

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ **Date of birth:** _ _ / _ _ / _ _ _ _
Parent/Legal Guardian Name: ____

I hereby grant the receiver of this document to release, to Mitchells Pediatrics, disclosure of said patient's protected health information as described below, for continuation of medical care.

Facility Name: _______________________________________ **Facility Phone:** (_ _ _) _ _ _ - _ _ _ _
Facility Address: _______________________________________ **Facility Fax:** (_ _ _) _ _ _ - _ _ _ _
City, State, Zip code: ____

I am requesting the following:

☐ All records including growth chart and vaccine records
☐ ER/Urgent Care visit with labs
☐ Hospital discharge summary
☐ Immunizations only
☐ Laboratory reports
☐ Operative reports
☐ Other, ____

Requested medical records should be mailed or faxed to: Mitchells Pediatrics 221 Pecan Park Avenue Alexandria, LA 71303
Phone: 318-487-1602 | **Fax:** 1-877-526-9271

- This medical information may be used by the person I authorize to receive it for medical treatment or consultation, billing or claims payment, or other purposes that I may direct. This authorization shall be in force and effect for one year of the date signed, at which time this authorization expires.
- This authorization for release of information covers all past, present and future periods.
- I understand that I have the right to revoke this authorization in writing at any time.
- I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of acquiring insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be released by the recipient and may no longer be protected by federal or state law.

Parent/Guardian Signature: ______________________________ **Date:** _ _ / _ _ / _ _ _ _

Faxed: _ _ / _ _ / _ _ _ _ at _ _ : _ _ am/pm
Employee Initials: ____

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 3 years or longer depending on state law. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name : ______________________________
   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record: ______________________________
   Last Name First Name MI

4. Primary Provider's Name: ______________________________
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in CHIP

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*