MITCHELLS PEDIATRICS
CARING FOR KIDS EVERYDAY
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
General Pediatrics & Pediatric Infectious Disease Specialist

PATIENT

Last Name: _____ **First Name:** _____
Date of Birth: _ _ / _ _ / _ _ _ _ | **SSN:** _ _ _ - _ _ - _ _ _ _ ☐ Awaiting SSN
Gender: ☐ Male ☐ Female | **Race:** _____ ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report
Mailing Address: _____ **City:** _____ **Zip code:** _ _ _ _ _
Physical address the same? ☐ Yes ☐ No

MOTHER / LEGAL GUARDIAN

Last Name: _____ **First Name:** _____
Date of Birth: _ _ / _ _ / _ _ _ _ | **SSN:** _ _ _ - _ _ - _ _ _ _ | **Occupation:** _____ ☐ N/A
Mailing Address: ☐ Same as patient _____ **City:** _____ **Zip Code:** _ _ _ _ _
Cellphone: _ _ _ - _ _ _ - _ _ _ _ | **Home Phone:** _ _ _ - _ _ _ - _ _ _ _ ☐ N/A | **Work Phone:** _ _ _ - _ _ _ - _ _ _ _ ☐ N/A
Email: _____ | **Marital Status:** ☐ Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Single

FATHER / LEGAL GUARDIAN

Last Name: _____ **First Name:** _____
Date of Birth: _ _ / _ _ / _ _ _ _ | **SSN:** _ _ _ - _ _ - _ _ _ _ | **Occupation:** _____ ☐ N/A
Mailing Address: ☐ Same as patient _____ **City:** _____ **Zip Code:** _ _ _ _ _
Cellphone: _ _ _ - _ _ _ - _ _ _ _ | **Home Phone:** _ _ _ - _ _ _ - _ _ _ _ ☐ N/A | **Work Phone:** _ _ _ - _ _ _ - _ _ _ _ ☐ N/A
Email: _____ | **Marital Status:** ☐ Married ☐ Engaged ☐ Separated ☐ Divorced ☐ Single

EMERGENCY CONTACTS

Please list emergency contacts other than the child's parent(s)/legal guardian(s). Do not list yourself.
Individuals listed here may be contacted in an emergency, are authorized to bring the child to visits, and may have access to the child's medical information per office policy.
If none, leave blank.

1. Last Name: _____ **First Name:** _____
Primary Phone Number: _ _ _ - _ _ _ - _ _ _ _ **Relationship to Child:** _____
2. Last Name: _____ **First Name:** _____
Primary Phone Number: _ _ _ - _ _ _ - _ _ _ _ **Relationship to Child:** _____
3. Last Name: _____ **First Name:** _____
Primary Phone Number: _ _ _ - _ _ _ - _ _ _ _ **Relationship to Child:** _____

PATIENT'S INSURANCE

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

☐ Medicaid Pending ☐ Commercial Pending ☐ Self-pay

Please be advised that if your child is over 30 days old and does not have active insurance, you are considered self-pay.

PRIMARY POLICY

Insurance Name: _____ **Subscriber #:** _____ **Group #:** _____

Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other _____

SECONDARY POLICY (if applicable)

Insurance Name: _____ **Subscriber #:** _____ **Group #:** _____

Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other _____

TERTIARY POLICY (if applicable)

Insurance Name: _____ **Subscriber #:** _____ **Group #:** _____

Subscriber: ☐ Child ☐ Mother ☐ Father ☐ Other _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize my insurance company to pay Mitchells Pediatrics directly for services provided to me or my dependent. **If my insurance does not cover these services, I understand that I am financially responsible for the charges.** I authorize Mitchells Pediatrics to release medical information necessary to process claims to my insurer or other responsible third-party payer. I certify that the information I provide is true and complete, and I agree to update any personal, insurance, or health information as needed.

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

HOUSEHOLD

Please list all individuals living in the same household as the child.

1. Last Name: _____ **First Name:** _____ **Relationship to Child:** _____
2. Last Name: _____ **First Name:** _____ **Relationship to Child:** _____
3. Last Name: _____ **First Name:** _____ **Relationship to Child:** _____
4. Last Name: _____ **First Name:** _____ **Relationship to Child:** _____

Any smokers in the home? ☐ Yes ☐ No

Any pets in the home? ☐ Yes ☐ No | **If yes, please list:** _____

PATIENT'S BIRTH HISTORY

Birth Hospital: _____ **Delivery:** ☐ Vaginal ☐ C-section

☐ Pre-term (<37 weeks) ☐ Full-term (37-41 weeks) ☐ Post-term (42+ weeks) ☐ Unknown | **NICU stay?** ☐ Yes ☐ No

Birth weight: _____ ☐ Unknown | **Length:** _____ ☐ Unknown | **Head Circumference:** _____ ☐ Unknown

Feeding type: ☐ Breastmilk ☐ Formula ☐ Both | **Current formula:** _____ ☐ N/A

Did mother have any illnesses or complications during pregnancy, labor, or delivery? ☐ Yes ☐ No

If yes, please explain: _____

Did mother use medications, tobacco, drugs, or alcohol during pregnancy? ☐ Yes ☐ No

If yes, please list: _____

PATIENT'S GENERAL HISTORY

Past hospitalizations? ☐ Yes ☐ No ☐ Unknown _____

Past surgery? ☐ Yes ☐ No ☐ Unknown _____

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

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 _____

PATIENT'S FAMILY HISTORY

Please indicate which family member(s) have these problems, illnesses, or diseases by using the key below.
If none, unsure, or unknown, leave blank.

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			

SPECIALTY CARE PROVIDERS

Specialty care providers are doctors other than your child's primary care provider who focus on a specific area of medicine, such as cardiology, dermatology, neurology, ENT, or allergy. Please list any your child has seen.
If none, unsure, or unknown, leave blank.

Provider Name: _____ **Specialty:** _____
Location: _____
Dates of care: _____

Provider Name: _____ **Specialty:** _____
Location: _____
Dates of care: _____

CONSENT TO OBTAIN PATIENT'S MEDICATION HISTORY

Your child's medication history includes prescription medicines prescribed by our providers or other healthcare providers. This information may come from pharmacies, insurance records, and electronic prescription databases and is stored in your child's

electronic medical record (EHR/EMR) as part of their health record. It helps us provide safe and effective care and avoid harmful drug interactions.

Please review your child's medication list with the provider to ensure it is complete and accurate. Some medications may not be included, such as those purchased without insurance, over-the-counter medicines, vitamins, supplements, or herbal products.

I authorize Mitchells Pediatrics to access my child's prescription history from pharmacies, insurance companies, and electronic prescription databases to support safe treatment and help avoid medication interactions. This authorization remains in effect until I withdraw it in writing.

Current Pharmacy: _____ **Location:** _____

We ask that you also bring in all current medications and over the counter supplements at each visit.

Current Medications/Supplements:	***Dosage/Frequency:***
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

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

MINOR PATIENT CONSENT TO TREATMENT (17 YEARS OR YOUNGER)

I, the parent/guardian of the above-named patient, 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 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 and consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

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

ADULT PATIENT CONSENT TO TREATMENT (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 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 and consent for treatment, and I understand that I may withdraw my consent for treatment at any time.

Patient Signature: _____ **Date:** _ _ / _ _ / _ _ _ _

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

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

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 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:** _ _ / _ _ / _ _ _ _

NOTICE OF PRIVACY PRACTICES

I, the parent/guardian of the above-named patient, have received a copy of the Notice of Privacy practices.

[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:** _ _ / _ _ / _ _ _ _

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, _____

Staff Signature: _____ **Date:** _ _ / _ _ / _ _ _ _

PATIENT RIGHTS AND RESPONSIBILITIES

Rights

To be informed of your rights and responsibilities before receiving care or discontinuing care.
To have your individuality, psychosocial, spiritual, personal dignity, values, beliefs, privacy, and preferences respected.
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.
To make informed decisions regarding care and participate in the development and implementation of care plans, treatment, and services.
To receive information about your own health status in a timely manner.
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, hospitalizations, 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 for any perceived risks and unexpected changes in your condition.
Follow instructions and guidelines given by those providing health care services.
Advise the physician for any dissatisfaction regarding your care at Mitchells Pediatrics.

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

PATIENT LAB POLICY AGREEMENT

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

When a provider at Mitchells Pediatrics orders medically necessary lab work at Rapides Outpatient Center, you will be given a specific timeframe in which the labs must be completed. This timeframe will be listed on your child's lab order and documented in their medical chart before you leave your appointment.

Please contact Rapides Outpatient Center (or whatever lab you prefer to use) to schedule your child's lab appointment within the required timeframe. If you are unable to get an appointment within that timeframe due to scheduling conflicts, please get the name of the person you spoke with and notify our office immediately at 318-487-1602.

Not completing lab work on time, or missing the follow-up appointment needed to review results, may delay or negatively affect your child's medical care.

Mitchells Pediatrics and its providers cannot be held responsible for negative outcomes that may occur if labs are not completed on time. Your cooperation is essential to ensure the best possible care for your child.
I acknowledge that I understand and agree to follow this policy.

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

COMMUNICATION CONSENT

I authorize Mitchells Pediatrics to contact me regarding my child's care and administrative matters using the following methods (check all that apply):

- ☐ Phone call
- ☐ Text message
- ☐ Email
- ☐ Mail correspondence

I understand that these communications may include appointment reminders, billing information, and other healthcare-related updates. This consent remains in effect until I revoke it in writing.

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

PHOTOGRAPH CONSENT FOR MEDICAL RECORD

I authorize Mitchells Pediatrics to take and include photographs of my child in their medical record for identification, documentation, and treatment purposes. I understand these images will be kept confidential and protected as part of the medical record and will not be used for any other purpose without additional written consent.

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

I do *not* give permission for Mitchells Pediatrics to take photographs of my child in their medical record for identification, documentation, or treatment purposes.

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

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

OFFICE AND FINANCIAL POLICIES

1. **Accompaniment Policy:** At every visit and while on company premises, your child must be accompanied by a parent/guardian or an authorized adult whose name is listed in your child's medical records.
2. **Age Limitation:** Medical care will be provided to your child from newborn to age 18 and within 30 to 90 days of their 19th birthday to provide urgent medical care.
3. **Demographic Changes:** You must notify our staff immediately when either your Address, Telephone Number, Pharmacy or Email address has changed.
4. **Telephone Calls:** Leave a detailed message with our receptionist for our nurse or provider to call you back before end of day or within 24 hours after calls have been triaged.
5. **School or Medical Paperwork:** If you have paperwork to be filled out by the provider, you must allow at least 48 hours to pick up.
6. **Medical & Vaccine Record:** 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 or medical record, they must show form of unexpired 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.
7. **Cell Phones:** No cell phone usage allowed in triage or exam rooms including photos and video recording.
8. **School & Work Excuses:** Excuses are given at the time of each visit; they will NOT be backdated unless cleared by provider.
9. **Food & beverages:** For the safety and cleanliness of our patients and staff, food and beverages may be limited in exam rooms during medical procedures or when there is a risk of exposure to blood or bodily fluids. Please follow staff instructions regarding food and drinks during your visit.
10. **ADHD/ADD:** Your child will have to be evaluated every 2-3 months to receive a refill. If you allow someone else to pick up your child's script, they must show ID and be listed as an authorized adult in your child's chart.
11. **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.
12. **Insurance information:** It is your responsibility to provide CORRECT insurance(s) information. Failure to do so will result in you being responsible for any balances for unpaid claims.
13. **Copayments/Deductibles/Outstanding Balances:** Payments are due at the front desk before the time of service. We accept all major credit cards and cash. We no longer accept checks.
14. **Self-Pay:** Our current rate is $90/visit. We no longer offer payment plans, so the visit must be paid in full before the time of medical provider service.
15. **Overdue Balances:** Failure to remain in good financial standing with Mitchells Pediatrics could result in dismissal from the practice. Any overdue balances must be paid before your visit regardless of how old the balance is.
16. **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, falsification of clinical records such as school and work excuses, general dishonesty, and non-paying patients.
17. **After Hours:** A medical provider is on call 24/7. Please call (318) 487-1602 and leave a message AND we 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 (unless authorized by provider). Non-urgent medication requests will be completed during the next workday.

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

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: Provider/Facility Name: _____

Address: _____ City: _____

Zip code: _ _ _ _ _ Phone: _ _ _ - _ _ _ - _ _ _ _ Fax: _ _ _ - _ _ _ - _ _ _ _

RE: Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

Parent/Legal Guardian Name: _____

Relationship to patient: _____ Phone: _ _ _ - _ _ _ - _ _ _ _

I hereby authorize the release and disclosure of the patient's protected health information, as described below, to Mitchells Pediatrics for the purpose of continuation of care.

- ☐ All records including growth charts and immunizations
- ☐ Newborn records
- ☐ ER/Hospital/Urgent Care records
- ☐ Laboratory results
- ☐ Imaging reports
- ☐ Operative reports
- ☐ Other, _____

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

- This medical information may be disclosed to and used by the individual or entity I have authorized for purposes including, but not limited to, medical treatment, consultation, billing, claims payment, or other purposes as specifically directed by me. This authorization shall remain valid for one (1) year from the date of signature unless revoked earlier in writing by the patient or the patient's legal representative.
- This authorization applies to information relating to all past, present, and future periods of care unless otherwise limited herein.
- I understand that I have the right to revoke this authorization at any time by providing written notice. I further understand that such revocation will not apply to actions already taken in reliance on this authorization, nor to circumstances in which this authorization was obtained as a condition of insurance coverage and the insurer has a legal right to contest a claim under the policy.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my signing of this authorization.
- I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by applicable federal or state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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

Staff Signature: _____ | Date: _ _ / _ _ / _ _ _ _ | Time: _ _:_ _ am/pm

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

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: **Mitchell** **Marcia** **E.**
   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.*

Patient Name: _____ Date of Birth: _ _ / _ _ / _ _ _ _

STAFF ONLY

- All pages completed and signed by parent/guardian: ☐ Yes ☐ Pending, BAU
- Faxed medical records request: ☐ Yes ☐ N/A
- Logged patient in medical records binder: ☐ Yes
- Scanned parent/guardian's current ID: ☐ Yes
- Scanned patient's insurance card(s) or uploaded from website: ☐ Yes ☐ Pending, BAU
- Scanned patient's social security card: ☐ Yes ☐ Pending, BAU
- Scanned patient's birth certificate: ☐ Yes ☐ Pending, BAU
- Entered in all demographics into patient's chart (including responsible party and emergency contacts): ☐ Yes
- Set cellphone as primary for text/voice alerts via messenger configuration: ☐ Yes ☐ No (parent requested otherwise)
- Web-enabled: ☐ Yes ☐ No (email not provided)

COMMENTS

Staff Signature: _____ **Date:** _ _ / _ _ / _ _ _ _

Supervisor Signature: _____ **Date:** _ _ / _ _ / _ _ _ _