PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
6 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your child is able to do.

- ☐ Ride a standard bike.
- ☐ Hop on one foot 3 to 4 times.
- ☐ Catch a small ball with 2 hands.
- ☐ Draw a 12-part person.
- ☐ Write first and last names in uppercase or lowercase letters.
- ☐ Cut most foods with a knife.
- ☐ Tie shoes.
- ☐ Is dry day and night.
- ☐ Tell a story with a beginning, a middle, and an end.
- ☐ Choose preferred foods at breakfast and lunch.
- ☐ Start and continue conversations with peers.
- ☐ Master all consonant sounds and combinations, such as "d" or "ch."
- ☐ Play and interact with at least one "best friend."
- ☐ Print 3 or more simple words without copying.
- ☐ Count 10 objects.
- ☐ Do simple addition and subtraction with objects.

PATIENT NAME: _____ DATE: _____

Please print.

6 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	O No	O Yes	O Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your child infected with HIV?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence (Bullying and Fighting)		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child ever bullied or been aggressive with others?	O No	O Yes
Food Security		
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Connectedness With Family		
Does your family get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No

FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	O Yes	O No
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you let your child know when she is being good?	O Yes	O No
Does your child have problems dealing with angry feelings?	O No	O Yes
Do you help your child control his anger?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

6 YEAR VISIT

SCHOOL

Did your child attend a preschool program?		O Yes	O No
Has your child started elementary school?		O Yes	O No
Do you have any concerns about your child's school experience?	O NA	O No	O Yes
Are you able to attend activities or functions at your child's school?	O NA	O Yes	O No
Is your child involved in after-school activities?	O NA	O Yes	O No
Does your child receive any special education services?		O No	O Yes

STAYING HEALTHY

Healthy Teeth		
Does your child brush his teeth twice a day?	O Yes	O No
Does your child see the dentist twice a year?	O Yes	O No
Nutrition		
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Does your child drink soda, juice, or other sweetened drinks?	O No	O Yes
Does your child eat breakfast every day?	O Yes	O No
Physical Activity		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	O Yes	O No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	O No	O Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No
Does your child have a regular bedtime?	O Yes	O No
Does your child have trouble going to sleep or does he wake up during the night?	O No	O Yes

SAFETY

Car Safety		
Does your child always use a car safety seat or belt-positioning booster seat securely fastened in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone in the vehicle always wear a lap and shoulder seat belt or belt-positioning booster seat?	O Yes	O No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	O Yes	O No
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	O Yes	O No
Does your child know how to swim?	O Yes	O No
Does your child know to always have an adult watching him in the water and never to swim alone?	O Yes	O No
Does your child use sunscreen when playing outside?	O Yes	O No
Home Fire Safety		
Do you have working smoke alarms installed on every level of your home?	O Yes	O No
Do you have carbon monoxide detectors/alarms in your home?	O Yes	O No
Do you have an emergency escape plan in case of a fire?	O Yes	O No
Does your child know what to do if the fire alarm rings?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

6 YEAR VISIT

SAFETY (*CONTINUED*)

Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ Yes	○ No
Have you talked with your child about gun safety?	○ Yes	○ No

SAFETY

Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	○ Yes	○ No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	○ Yes	○ No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Southern Pediatric Clinic, LLC
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Kereese Gayle-Farias, M.D.
Pediatrics and Adolescent Medicine

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Patient Information Form

Today's Date _____

Child's Name _____ Birthdate _____ Sex M / F

Address _____ Zip Code _____ Social Security # _____

Name & birthdates of child's brothers and/or sisters (include last name if different)

Has your child ever been seen at our practice? ☐ NO ☐ YES When? _____

Have any of your child's brothers and/or sisters ever been seen at our practice? ☐ YES ☐ NO

If yes, which brothers or sisters? _____

If your child (or children) has not been seen before, who may we thank for referring you to our office? _____

Name of child's previous doctor _____

Name of parents' family doctor _____

Name of mother's obstetrician/gynecologist _____

How did you hear about SPC?
□Physician / Hospital □Marketing Ads □ Social Media (Facebook / Instagram)
□ Google □ SPC's Website □ Patient □ Signage (building)
□ Related Profession (Physical Therapy etc.):_____
□ Other: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Social Security # _____ Marital Status _____ Email _____

Address _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD

Primary Policy Holder Name	Primary Insurance	Secondary Ins./Medicaid

EMERGENCY CONTACT OTHER THAN PARENT Name _____

Relationship _____ Address _____ Home Phone _____

I authorize **Dr. Blache** to release any medical information necessary to process an insurance claim for my son/daughter _____ and request the insurance company to make payment to **Dr. Blache**. I also authorize **Southern Pediatric Clinic, LLC staff and/or Dr. Blache** to use the contact information listed above.

Parent/Guardian Printed Name	Signature	Date

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Financial Consent

1. ASSIGNMENT OF BENEFITS/BILLING AUTHORIZATION CONSENT:

____ Private Insurance: The cost of our services will be billed to your insurance company. If your private insurance denies coverage, or does not pay within 90 days of billing, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ Private Pay: You are financially responsible of all fees due at time of service. The amount of fees for services may vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ State Insurance: The cost of our services will be billed to your insurance company. If your state insurance denies coverage, or retro disenrolls the patient, you are financially responsible and will be billed directly for services rendered. The amount of fees for services will vary depending on changes in the patient's medical condition, progress, and physician order(s).

____ For those families where parents are separated or divorced, the parent who brings the child or children to the office visit and authorizes treatment is responsible for payment(s). Payments are due when services are rendered. If the divorced/custodial decree makes the non-custodial parent/guardian responsible for partial or all medical costs, it will be the responsibility of the authorizing parent to collect payment from the other parent.

2. NOTICE OF PATIENT RESPONSIBILITY FOR CO-PAYS, PERCENTAGES & DEDUCTIBLES:

Southern Pediatric Clinic will attempt to verify your insurance benefits and eligibility. The information we receive is based on the information you and your insurance company provide to us. As a courtesy, we will bill your insurance company for their portion of your bill. Ultimately it is your responsibility to see that we are paid appropriately by your insurance company. If the information given to us by you or your insurance company proves to be inaccurate and a balance remains, you will be billed for that balance and are responsible for payment within thirty (30) days unless you set up a payment plan with our billing specialists.

BY SIGNING BELOW, YOU INDICATE THAT:

1. You agree with the provisions of the payment source as described above. You understand that if you accept the services we have provided, you are ultimately responsible for payment. Should it be necessary to use collection services, any additional fees will also be your responsibility.
2. You authorize payment of any insurance benefits directly to Southern Pediatric Clinic.
3. You authorize the release of medical information to and from Southern Pediatric Clinic.
4. You agree to pay all co-pays, percentages, and deductibles at the time of service.

Patient Name _____ Date of Birth _____

Responsible Party Name and Signature _____ Today's Date _____

MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF INSURANCE CARD(S)

Primary Policy Holder Name	Primary Insurance	Primary Insurance Policy Number
M F		
Primary Policy Sex / Date of Birth	Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number

_____
Office Staff Initials

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Consent & Disclosure of PHI & Treatment of Patient & Statement of Persons Allowed to Accompany Patient to Office Visits

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name: _____ Date of Birth: _____

MOTHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

FATHER'S NAME WHO IS LEGAL GUARDIAN _____ Birthdate _____

Southern Pediatric Clinic, LLC and employees., may use and disclose PHI about the said patient above to carry out treatment, payment and healthcare operations (TPO). Please review the Notice of Privacy Practices for full information regarding this statement.

1. I have reviewed the Notice of Privacy Practices for Southern Pediatric Clinic and I acknowledge that Southern Pediatric Clinic has the right to revise its Notice of Privacy Practices at any time and that I will have access to revisions.
2. I have read and understand the Notices of Privacy Practices that are in place and that I may contact the Privacy Officer listed for further questions.
3. Southern Pediatric Clinic, and all those associated, may call my home or other designated location and leave a message on voice mail or in person in reference that assist the practice in carrying out TPO, such as appointment reminders and patient statements.
4. Southern Pediatric Clinic may treat my child and order diagnostic tests and labs for diagnosis and treatment.
5. Southern Pediatric Clinic may disclose Individually Identifiable Health Information (IIHI) that will be used to carry out TPO as referred to above, to anyone specified below who brings my child(ren) to the office for treatment.
6. Southern Pediatric Clinic will not act as mediator in separation, divorced, and/or custody battles. We must abide by the laws set forth in court-ordered documents for your child. Please make sure we have a copy on file.

DUE TO HIPAA REQUIREMENTS, PATIENTS CAN ONLY BE ACCOMPANIED TO OFFICE VISITS BY PARENTS, LEGAL GUARDIANS OR PERSONS WHOSE NAMES ARE DOCUMENTED IN THE PATIENT'S CHART. PLEASE INDICATE BELOW FOR BOTH IIHI AND HIPPA COMPLIANCE.

Name	Relationship to Patient	Disclose PHI	Accompany to Appointment
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no
		□ yes □ no	□ yes □ no

I have the right to request that Southern Pediatric Clinic restricts how it uses or discloses my PHI to carry out TPO. However, the practices are not required to agree to my requested restrictions, but if it doesn't, it is bound by this agreement. By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I my revoke my consent in writing, except to the extent that which the practice has already made disclosures upon my prior consent. If I do not sign this consent, providers for Southern Pediatric Clinic may decline to provide treatment for my child(ren).

_____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian

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Child's Name _____ DOB _____

CELL PHONE USE POLICY

The purpose of this policy is to outline the acceptable use of cellular phone ("cellphones") and other communication devices, including but not limited to, mobiles phones, iPhones, iPads, iPods, tablets, or any other wireless device (collectively referred to as "communication devices") at *Southern Pediatric Clinic, LLC.* These rules are in place to protect the workers and *Southern Pediatric Clinic, LLC,* along with the privacy of each of our patients. Inappropriate use of communication devices may harm others within the office by violating HIPAA laws and regulations.

1. **Who this Policy Applies To:**
   This Policy applies to patients that are being seen within the office and their family members.

2. **What devices this Policy Applies To: (Video recording or pictures during vaccinations is PROHIBITED)**
   a. All devices that can be used for recording.
   b. All devices that can be used for communicating with others.
   c. All devices that may hinder the quality of care the patient may receive.

3. **Permitted Use:**
   The devices mentioned can be used in the lobby if needed. However, it is recommended that the patient or family members be conscious of others that may be in the lobby.

4. **Violations of This Policy:**
   Patients or family members that violate this policy may be asked to leave and are subject to dismissal depending on circumstances.

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

_____

Signature of Parent/Guardian or Patient Date

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PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as 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(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date