Watch Us Grow
PEDIATRICS

Patient Consent Change

You may view patient medication history that has been provided by the patient's pharmacy benefit manager (PBM) and pharmacies as a partial reference service only; you must have patient consent to review this information.

The medication history must not be used at a substitute for a medication history to be taken by the patient's own physician.

Caution: The following history:

(i) May not be complete (patients may have purchased or obtained medications through sources which bypass the PBM or pharmacies supplying history)
(ii) May not include over-the-counter medications, nutritionals and other substances obtained by the patient.
(iii) The patient may have switched insurance plans recently.

CONSENT GIVEN_____ **CONSENT NOT GIVEN**_____

Please sign below to allow the physician to send prescriptions to the pharmacy electronically.

Signature	Date
Pharmacy Name	
Cross Roads (if available)	
Pharmacy Phone Number	

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment-'payment of health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____

Relationship to Patient_____

Signature and Date_____

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PEDIATRICS

Immunization Record Information

Parents/Guardians are responsible for keeping track of their child's vaccination history.

The only records that exist are the ones provided to parents/guardians when the vaccination is administered and the ones in the child's medical record of the doctor/clinic where the vaccines are given.

In addition, each individual state of residence keeps a record of an individual's vaccinations which are entered by the doctor/clinic at the time of administration. However, the information in their respective system is based upon the accuracy of the information that has been entered by the doctor/clinic.

In the event a patient moves from another state or transfers from another office, it is the responsibility of the parent/guardian to, provide the information to the doctor/clinic where the patient is currently being seen.

Sometimes, schools hold vaccination records for a period of time if the patient is a current student, however, it is the responsibility of the parent/guardian to maintain all current records and to continually update their respective child's record with the school.

Finding old immunization records can be very difficult to locate, especially in adulthood.

To avoid having to retrieve older records and possibly repeating vaccinations unnecessarily, it is imperative that a parent/guardian to keep a current and accurate record of their child's vaccinations.

**Center for Disease Control and Prevention (April 2015)

_____ _____

Parent/Guardian Date

_____ _____

Staff Member Date

Notice of Privacy Practices Acknowledgement

IMPORTANT NOTICE

Due to constant changes in health insurance, it is impossible for us to interpret each individual's policy.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE!

Please do not be angry with or blame this practice if your insurance does not cover a service that we have provided. All insurance companies have exclusions and most have co-payments and deductibles for which you as the policy holder are responsible.

Be aware that your insurance policy is a contract between you and your insurance company, and not between your insurance company and this practice.

_____

Signature of insured or responsible party

_____

Date

Authorization and Release

I authorize the doctor to release any information, including the diagnosis and the records of any treatment rendered to my child, to the insurance company. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

_____

Signature

Watch Us Grow
PEDIATRICS

Privacy Practice Acknowledgement

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

_____

Parent / Guardian (Please Print)

_____ _____

Patient Name Date of Birth