Please complete the following forms and return to your child's first appointment.

Thank you!

Danville Pediatrics Medical Group, PLLC

303 South 4th Street, Suite 100
Danville, KY 40422

1180 Glensboro Road
Lawrenceburg, KY 40342

PATIENT INFORMATION FORM
(Asterisks * indicate required/mandatory fields)

Patient Name: Last:*______________________ First:*_____________________
Middle:*______________________

Name child goes by: _______________________ Date of Birth:*____/____/______
Sex:* ___________________

Phone (H): *(______) - _______- _______ Phone (C) :*(_____) - ______-______
SS #:*_______-_______-______

Address:*_______________________________ City:*_________________ State:*_________
Zip:*______________

Email: ____
Preferred Contact: * (Circle One) Home / Cell / Mail

Siblings:
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**
***Name__________________ Date of Birth:*_____________ Sex:* M or F SS#:*_____-_____-______**

Race: * ____ Asian
____ Black or African American
____ Hispanic
____ Middle Eastern
____ White
____ Native American
____ Other (please specify) ___________

Ethnic Group:*
___ Non-Hispanic or Latino
___ Hispanic or Latino

Preferred Language: *
___ English
___ Spanish
___ Sign
___ Other

Primary Care Provider:*
(Please choose one)
___ Dr. Jeremy Dickinson
___ Dr. Matthew Graves
___ Dr. Joshua Wiglesworth
___ Dr. Douglas Stein
___ Dr. Miranda Munday
___ Rachel Briese, APRN
___ Laryn Mertz, APRN
___ Caroline Glass APRN
___ Sara Monroe, APRN
___ Nicole Centers, APRN
___ Lee Ann Mangum, APRN

Pharmacy: * ____

PARENT and /or GUARDIAN INFORMATION

Mother Name / Other:*________________________

SS #: *____

Date of Birth:*_________________________________

Marital Status:* ______________________________

Address:*____________________________________

City / State / Zip:*_____________________________

Home Phone:*_________________________________

Cell Phone:*___________________________________

Employer:*____________________________________

Father Name / Other:*___________________________________

SS #:* ____

Date of Birth:*____

Marital Status:* ____

Address:*____

City / State / Zip:*_______________________________________

Home Phone:* ____

Cell Phone:*____

Employer:*____

EMERGENCY CONTACT
(Other than parent or legal guardian)

Name:*__________________________ Relationship:*_____________________ Phone:*__________________________

Who does the patient live with? ________________________ Who has custody of child? _________________________

Danville Pediatrics Medical Group, PLLC

PRIMARY INSURANCE INFORMATION
(The receptionist will need to get a copy of your insurance card, please bring to each visit.)

Child's Insurance Company:*________________________ Insured's Name:*________________________________

Policy ID #:*_______________________________________ Group #: ______________________________________

Ins Co. Address:* _________________________________ State:*____________________ Zip:*________________

Ins Co. Phone:*_________________________ Effective Date of Insurance:*___________________________________

Insured's Birthdate:*__________________ Relationship to Patient:*_______________________________________

SECONDARY INSURANCE INFORMATION

Child's Insurance Company:*________________________ Insured's Name:*________________________________

Policy ID #:*_______________________________________ Group #:* _____________________________________

Ins Co. Address:* _________________________________ State:*____________________ Zip:*________________

Ins Co. Phone:*_________________________Effective Date of Insurance:*__________________________________

Insured's Birthdate:*__________________ Relationship to Patient:*_______________________________________

At times circumstances may require that others such as babysitters, step-parents or grand- parents may need to bring my child or children in for treatment. Since immunizations require a signature, I give the following individuals consent to sign for immunizations. These individuals will not have the authority to sign for the release of medical records.

Name: ____ Relationship to patient: ___________________________

Name: ____ Relationship to patient: ___________________________

Name: ____ Relationship to patient: ___________________________

Name: ____ Relationship to patient: ___________________________

The undersigned hereby authorizes and directs Danville Pediatrics Medical Group, PLLC to prepare and submit all insurance claim forms as shall be necessary for the undersigned to obtain coverage for services rendered by Danville Pediatrics Medical Group, PLLC. The undersigned authorizes payment to be made directly to Danville Pediatrics Medical Group, PLLC for the surgical and or medical benefits. This authorization and signature may be kept on file by Danville Pediatrics Medical Group, PLLC for claims submitted from and after this date, unless this authorization is withdrawn in writing.

I understand that I am responsible for any amount not covered by my insurance.

Signature of Parent or Legal Guardian:* ____

Danville Pediatrics Medical Group, PLLC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

☒ We are committed to protecting the security and privacy of your child(ren's) personal information. I hereby give my consent for Danville Pediatrics Medical Group, PLLC to use and disclose my child's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO). These medical records are the property of Danville Pediatrics Medical Group, PLLC and are accessed for only purposes outlined by the *Notice of Privacy Practices* which provides a more complete description of such uses and disclosures. Medical records may be released or shared with other health care providers for treatment of your child. Patients are entitled to one free copy of their medical records. **A signed Medical Release form must be completed and on file to be able to receive a copy of your child's medical records.** Once we have a signed release form, according to law we have 30 days to have records copied. However, we strive to complete these requests in a timely manner.

☒ I understand that Danville Pediatrics Medical Group, PLLC may fax immunization certificates, school excuses, physical/sports forms, and/or medication instructions to my personal or work fax. *We cannot fax or send these documents to third parties (schools, daycares, etc.) without a separate, signed authorization form.*

☒ I understand that Danville Pediatrics Medical Group, PLLC may discuss patient information with adults or other minors present during the visit.

☒ With this consent, Danville Pediatrics Medical Group, PLLC may send mail and/or email about any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, billing statements, referrals, and any other info pertaining to my child's clinical care, including laboratory results among others as long as they are marked Personal and Confidential. Also, Danville Pediatrics Medical Group, PLLC may call my home, cell phone or other alternative location, and leave a message on voicemail or in person in reference to any info that may assist the practice in carrying out TPO.

☒ I consent to receiving appointment reminders and health notifications via SMS texts from Danville Pediatrics Medical Group, PLLC. Messaging and data rates may apply, message frequency may vary, and I may opt out at any time by replying 'STOP'. I may reply 'HELP' for assistance. I acknowledge I have read and agree to the Terms of Service and Privacy Policy given by the front desk or located at www.danvillepediatrics.com

☒ I have the right to request that Danville Pediatrics Medical Group, PLLC restrict how it uses or discloses my child's PHI to carry out TPO. However, DPMG is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

☒ I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Danville Pediatrics Medical Group, PLLC reserves the right to revise its Notice of Privacy Practices at any time they seem fit. A revised copy may be obtained by forwarding a written request to the Privacy Officer at Danville Pediatrics Medical Group, PLLC at 303 S. Fourth Street, suite 100, Danville, Kentucky 40422.

☒ I may revoke my consent in writing except to the extent that the practice of Danville Pediatrics Medical Group, PLLC has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Danville Pediatrics Medical Group, PLLC may decline to provide treatment to my child and or children.**

☒ I certify that I am the parent / legal guardian of the minor child. **By signing this form, I am consenting to Danville Pediatrics Medical Group, PLLC's use and disclosure of my child's PHI to carry out all TPO.**

Signature of Parent or Guardian: *________________________________ Date: * __________________

Printed Name: *________________________________ Relationship to Child: *________________

Danville Pediatrics Medical Group, PLLC

E-Prescribing Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care office. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that must be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Danville Pediatrics Medical Group, PLLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Danville Pediatrics Medical Group, PLLC to enroll my child in the ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name: ____

Patient DOB: _____________________

Date: __________________________

Signature of Parent or Guardian: ______________________________________

Danville Pediatric Medical Group, PLLC

Consent to Treat/ Mutual Satisfaction Statement

I, ___________________________, the parent /legal guardian of the below named child(ren),

Name: ___________________________________ Date of Birth: _______________________

Name: ___________________________________ Date of Birth: _______________________

Name: ___________________________________ Date of Birth: _______________________

Name: ___________________________________ Date of Birth: _______________________

I hereby authorize and consent to the examination and /or treatment of my child(ren) during office visits by the physicians and clinical staff of Danville Pediatrics Medical Group, PLLC. In the event of an emergency or other illness, I understand that the physicians and staff of Danville Pediatrics Medical Group, PLLC will deliver any medical care deemed necessary regardless of the accompanying adult. Unless we are notified in writing Danville Pediatrics Medical Group, PLLC will assume that a child's biological &/or legal parents are both legal guardians who have access to treatment options and medical information for that child.

Mutual Satisfaction Statement

In order to give the very best care to our patients it is important for parents as well as staff to have a satisfying experience in our clinic. We are very understanding and realize that sometimes parents with sick children can become stressed. We strive to be sympathetic and caring in each situation. However, there are occasions when parents do not seem to fit with our office policies. Though we do not like it, there are times when the staff of Danville Pediatrics Medical Group, PLLC feels that it is best for parents to locate other providers to care for their children. Some of these reasons may include one or more of the following;

- Irreconcilable personality conflict issues
- Chronic verbalization of displeasure with our practice policies
- Abusive language and behavior directed toward our provider and staff
- Use of profanity in the office
- Inappropriate items of clothing
- Blatant disregard for the provider's advised plan of care
- Misuse of, or suspicion of misuse of prescription drugs
- Habitual failure to show up or frequent last-minute cancelations for scheduled appointments
- Non-payment of account balances

I have read and understand the Mutual Satisfaction Statement

Signature of Parent or Legal Guardian ____

Date: ___________________________

Terms of Service

Danville Pediatrics Medical Group, PLLC

303 S 4th St, Danville, KY
1180 Glensboro Rd, Lawrenceburg, KY

Non-Discriminatory Policy:

Danville Pediatrics Medical Group, PLLC complies with all applicable State and Federal Civil Rights laws. No person shall be excluded from participation or be subjected to discrimination in any manner based on disability, race, color, religion, national origin, sex, age, sex orientation, or gender identity. DPMG provides language services to people whose primary language is not English and for people with disabilities in order to communicate effectively. Under the guidance of applicable laws that any person having reasonable cause to believe that any person is in the state of abuse, exploitation, or neglect shall report the information to the appropriate regulatory agency.

Practice Dismissal:

No Show Policy: If a patient and/or any child listed under the same guarantor does not come to scheduled appointments (in excess of three times within a 12-month period) without prior notification or cancellation, Danville Pediatrics Medical Group, PLLC may find it necessary to dismiss all family members from our practice.

Disruptive or Abusive behavior: Such behaviors will not be tolerated at our practice. It will be at the discretion of the medical director to dismiss patients/parents who show aggression or verbal abuse towards any staff member at Danville Pediatrics Medical Group, PLLC.

Late for Appointments:

If your child **is more than 15 minutes late** for their scheduled appointment, you may be asked to reschedule for another date and time.

Evening Clinic & Saturday Clinic:

If your child or children are seen during our Evening Clinic (after 5pm) and/or our Saturday Clinic **there will be an additional $25.00 charge.** Our billing department files these charges to your insurance plan. Most insurances will cover this charge; however, some do not, then it is your responsibility to pay. Please check with your insurance plan, before scheduling an appointment during these hours.

Immunizations:

By receiving care at our practice, you acknowledge that immunizations are administered according to CDC and state guidelines. You will be informed of risks and benefits. You may decline vaccines where legally permitted, with documentation.

Financial Policy:

The person (including parents, guardians, and/or any adult with written permission) bringing a patient in for medical care is responsible for payment of all co-pays, co-insurance, and/or deductibles at the time of service. **Noninsured patients will be seen and will be asked to pay day of service. If paid, a $40.00 discount will be applied to the payment amount.** We accept cash, check, and most major credit cards. **If you are unable to provide payment at the time of service, please make arrangements with our billing department prior to your child's appointment.** Your child's health is our priority, and we will work with you in the event of unusual circumstances to offer solutions to help you get your child covered. We will furnish a receipt for your records as proof of payment. **There will be a $25 charge for any check returned for non-sufficient funds.** Monthly statements will be sent for any unpaid balances. Prompt payment is expected and appreciated. Please contact our billing department at (859-236-7046) with any concerns regarding your bill. If your account becomes severely delinquent and is turned over to collections, you will receive a termination notice from our practice. Once services are terminated, the patient will no longer be allowed to return to our practice.

Insurance:

We must have current insurance and patient information on file to help ensure that we file claims correctly. Please review your coverage carefully and be familiar with any limitations in well child coverage and immunizations. Your policy is a contract with you, the parents and not with Danville Pediatrics Medical Group, PLLC. **Medicaid recipients are responsible for keeping their cards up to date and making sure that Danville Pediatrics Medical Group, PLLC is listed as the primary care physician.** Any charges incurred with a lapsed card will be the responsibility of the parent.

Newborns: **Most insurance companies will require that you add your newborn to your policy within 30 days of birth.** Failure to do so may mean that your child will not be covered, and you will have to wait until the next enrollment period.

Prescription, Medical Records, and Immunization Records:

Please give a 24-hour notice for immunization records. Please allow 48 hours for prescription refill requests. Medical records request could take up to 30 days to complete.

SMS & Text Message Communications:

By providing your mobile phone number to Danville Pediatrics Medical Group, PLLC, you consent to receive SMS/text messages from our office related to your child's care. Message frequency may vary depending on your child's care needs and appointment schedule. We do not send marketing messages without separate consent. By consenting, you accept the risks associated with SMS communication. By providing your number and opting in, you confirm you are the parent or legal guardian and authorized to receive messages regarding the child's care. You may opt out at any time by replying **STOP** to any text message or HELP for assistance. You can also call our office at 859.236.1080. Standard message and data rates may apply. Danville Pediatrics Medical Group, PLLC is not responsible for carrier charges. Delivery of SMS messages is subject to your mobile carrier's availability. We are not responsible for delayed or undelivered messages. We may update SMS messaging terms at any time. Continued participation indicates acceptance of updated terms.

Telehealth:

Telehealth visits are subject to clinical appropriateness and may have limitations compared to in-person exams. This will be at the individual providers discretion.

Privacy & HIPPA:

We protect your child's medical information in compliance with HIPAA. Please refer to our **Notice of Privacy Practices** for full details on how information is used and

Acceptance of Terms:

By scheduling an appointment, signing registration forms, and/or receiving services from **Danville Pediatrics Medical Group, PLLC**, you (the parent or legal guardian) agree to these Terms of Service on behalf of yourself and your child.