Pelican Pediatrics, LLC (843)795-3344
452 Folly Rd. Charleston, SC 29412

DATE: _____

PATIENT NAME (FIRST, MI, LAST)	PERSONAL PHONE (Over 13):	DATE OF BIRTH	SEX □ M □ F
MAILING ADDRESS:	CITY/STATE/ZIP		
PARENT/GUARDIAN #1:	PHONE:	DATE OF BIRTH	
PARENT 1 EMAIL ADDRESS (MAIN)	CHILD'S EMAIL ADDRESS (If over 13)		

PARENT/GUARDIAN #2	PHONE:	DATE OF BIRTH
ADDRESS IF DIFFERENT FROM ABOVE	EMAIL ADDRESS	
EMERGENCY CONTACT:	PHONE:	PHARMACY
PARENTS ARE: MARRIED ____ SINGLE ____ SEPARATED ____ DIVORCED ____		

NAMES OF SIBLINGS	DOB	AGE

AUTHORIZED PEOPLE ALLOWED TO RELEASE INFORMATION TO AND BRING PATIENT FOR APPOINTMENTS:

NAME:_____ TELEPHONE _____

NAME:_____ TELEPHONE _____

NAME:_____ TELEPHONE _____

PLEASE NOTE, UNLESS THE PERSON IS LISTED ABOVE, WE CAN NOT RELEASE INFORMATION OR ALLOW YOUR CHILD TO BE SEEN WITHOUT YOUR WRITTEN CONSENT DUE TO PRIVACY LAWS.

I ACKNOWLEDGE THE ABOVE LIST OF PEOPLE,

_____

Signature of Parent or Guarantor Print name Date

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BIRTH HISTORY

HOSPITAL: _____ WAS YOUR CHILD PREMATURE? ____YES ____ NO

LENGTH OF PREGNANCY _____ WHAT WAS YOUR CHILD'S BIRTH WEIGHT? _____

TYPE OF DELIVERY: VAGINAL C-SECTION ANY PROBLEMS DURING PREGNANCY? __YES __NO

ANY PROBLEMS OR CONCERNS IN THE NURSERY? ___ YES ____ NO

FIRST FEEDING: ___BREAST ___FORMULA DID MOM SMOKE DURING PREGNANCY? ___YES__NO

CURRENT MEDICATIONS AND DOSAGES

_____

ALLERGIES

_____

PAST MEDICAL PROBLEMS

ASTHMA		FREQUENT PNEUMONIA/BRONCHITIS		ALLERGIES /SINUS PROBLEMS	
VISION PROBLEMS		HEARING PROBLEMS		FAINTING /DIZZINESS	
HEARING PROBLEMS		HEART PROBLEMS		DIABETES	
NOSE BLEEDS		CONSTIPATION		SEIZURES/EPILEPSY	
SPEECH DIFFICULTY		HEARTBURN		ECZEMA	
HEADACHES		SPITTING UP		HYPERACTIVITY	
BEHAVIOR PROBLEMS		KIDNEY PROBLEMS		RECURRENT EAR INFECTIONS	
SLEEP PROBLEMS		URINARY TRACT INFECTION		TANTRUMS	

FAMILY HISTORY

CONDITION	**MOM**	**DAD**	MATERNAL GRANDMA	MATERNAL GRANDPA	PATERNAL GRANDMA	PATERNAL GRANDPA	SISTER / BROTHER
CANCER							
DIABETES							
ASTHMA							
HEART ATTACK							
KIDNEY DISEASE							
THYROID DISEASE							
SEIZURES/EPILEPSY							
DEPRESSION							
MIGRAINES							
HIGH CHOLESTEROL							
HIGH BLOOD PRESSURE							
ANEMIA							
CROHN'S/COLITIS (UC)							

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SOCIAL HISTORY

WHO LIVES AT HOME? _____

ANY PETS?_____ DOES ANYONE SMOKE IN THE FAMILY?_____

DO YOU HAVE WORKING SMOKE DETECTORS?_____

IS YOUR CHILD IN DAYCARE? _____

ARE YOU CONCERNED ABOUT YOUR CHILD'S DEVELOPMENT?_____

WHAT SCHOOL DOES YOUR CHILD ATTEND?_____

WHAT IS THEIR CURRENT GRADE LEVEL?_____

HAS YOUR CHILD EVER REPEATED A GRADE?_____

ANY CONCERNS FROM THE SCHOOL?_____

DOES YOUR CHILD REQUIRE ANY SPECIAL OR RESOURCE CLASSES?_____

HOW DOES YOUR CHILD SLEEP?_____

DOES YOUR CHILD HAVE A DENTIST? _____

DO YOU HAVE A POOL?_____

IF SO, IS THERE A GATE AROUND IT?_____

DO YOU HAVE ANY GUNS AT HOME? _____

IF SO, DO YOU HAVE A GUN LOCK?_____

HOW DID YOU HEAR ABOUT PELICAN PEDIATRICS? _____

PLEASE LIKE US ON FACEBOOK AND TWITTER @PelicanPeds

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452 Folly Rd. Charleston, SC 29412

Consent for Disclosure of Protected Health Information for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my child's protected health information by *Pelican Pediatrics, LLC* for the purpose of diagnosing or providing treatment to my child, obtaining payment for my health care bills or to conduct health care operations of *Pelican Pediatrics, LLC*. I understand that diagnosis or treatment of my child by *Pelican Pediatrics* may be conditioned upon my consent as evidenced by my signature on this document. I also consent the use of my email address if provided to be used in correspondence *with Dr. Eliza Varadi* in the care of my child.

I understand I have the **right to request a restriction** as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. *Pelican Pediatrics, LLC* is not required to agree to the restrictions that I may request. However, *if Pelican Pediatrics, LLC* agrees to a restriction that I request, the restriction is binding on *Pelican Pediatrics, LLC* and *Dr. Eliza Varadi*

I have the **right to revoke this consent**, in writing, at any time, except to the extent that *Dr. Eliza Varadi* or *Pelican Pediatrics, LLC* has taken action in reliance on this consent for treatment.

My child's "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies my child or myself, or there is a reasonable basis to believe the information may identify my child.

I understand I have a **right to review** *Pelican Pediatrics, LLC*'s Notice of Privacy Practices prior to signing this document. Pelican Pediatrics, LLC's **Notice of Privacy Practices has been provided to me**. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Pelican Pediatrics, LLC the **Notice of Privacy Practices** for Pelican Pediatrics, LLC **is posted in the reception area** of the office. This Notice of Privacy Practices also describes my rights and the Pelican Pediatrics, LLC's duties with respect to my child's protected health information.

Pelican Pediatrics, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my child's current or future appointments.

Signature of Parent or Guarantor _____ Date _____

Print Name _____ Relationship to patient _____

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452 Folly Rd. Charleston, SC 29412

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize information to be released from: (Name of Previous Physician)

_____

I request and authorize the facility or provider named above to release health care information for the below listed child to Pelican Pediatrics, LLC at the below indicated address.

CHILD'S NAME _____DOB_____

The type of information to be used or disclosed is as follows:

- ☐ Discharge Summary
- ☐ Lab Results
- ☐ X-Ray, and/or Imaging reports
- ☐ Immunization Records
- ☐ Other, Please specify:_____
- ☐ Consultation Reports
- ☐ Entire Medical Record

This protected health information is being used for the following purpose:

- ☐ My Personal Records
- ☐ Health Care Provider
- ☐ Other, Please specify: _____

This authorization shall be in force and be **in effect for 1 year from date below**, unless otherwise specified at which time this authorization to use or disclose this protected health information expires.

I understand that the information in my child's health records may include information relating to sexually transmitted diseases, acquired immunodeficiency Syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and the treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Pelican Pediatrics, LLC at 354 Folly Rd. Suite #5, Charleston, SC 29412. I understand that a revocation is not effective to the extent that Pelican Pediatrics, LLC has relied on the use or disclosure of the protected health information.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or South Carolina law.

Pelican Pediatrics, LLC will not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I do not have to sign this authorization in order to obtain Healthcare treatment.

Signature of parent/guardian _____ Date _____

Print Name _____ Relationship to Child _____

Pelican Pediatrics, LLC
452 FOLLY RD.
CHARLESTON, SC 29412
O: 843-795-3344 F: 843-795-3143

Dear Pelican Pediatrics family member,

In order to make our billing process as simple and easy as possible and also touch-free, we decided to introduce a Credit Card on File policy or AutoPay. Please find enclosed the copy of the policy document. Here below we would like to highlights the benefits of this policy and answer some of your questions:

Paying Your Bill Just Got a Lot Faster & Easier.

Our new AutoPay service makes your office visits easier, your check-ins and check-outs faster, and your bill-paying a whole lot easier. No more juggling your kids and your credit cards, counting cash for your co-pay, managing paper billing statements, or preparing, stamping and mailing payments. Now, we take care of everything for you!

Your Payments are Quick and Easy

When you have a co-pay, you don't have to do a thing. We charge your account for it. If, after we bill your insurance and you have a balance due, we will still mail you the statement. After 14 days from the statement date we will run your credit card on file and email you receipt. It's as easy and convenient as iTunes or Amazon, but we do the clicking for you! AutoPay will be applied if your balance is under $200. For any amount larger than $200 we will first call you to confirm that is the method of payment you prefer.

Your Information is Safe and Secure

We swipe your credit card once, and that's it. Your payment information is encrypted and stored in your account, just as it is at iTunes or Amazon or any other reputable online retailer. Your information is protected by a payment gateway, kept off-site, and inaccessible to all Pelican Pediatrics employees, so it's even safer than it is at hotels or restaurants or anywhere else you hand over your card.

Your Statements will still be coming for you to review

You Can Sign Up in Less Than a Minute

The next time you come in to an office, tell one of our Front Office Associates that you want to sign up for AutoPay. We'll register your account, swipe your card, and collect your signature for enclosed policy document.

Pelican Pediatrics, LLC

Eliza Agrest Varadi, MD IBCLC FAAP
Namrita K. Malhi, MD FAAP
Desiree Rodriguez-Espada, MD
Simone Chinnis, DNP, NP-C, AE-C
452 Folly Rd
Charleston, SC 29412
Office: (843) 795-3344
Fax (843) 795-3143

Credit Card on File Policy: Pelican Pediatrics is committed to making our billing process as simple and easy as possible and as touch-free as possible. We encourage that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will be encrypted, protected by a payment gateway, kept off-site, and inaccessible to all Pelican Pediatrics employees. Credit cards on file can be used to pay copays at the time of the visit as well as other charges (such as toward the deductible or for non-covered services). Once processing the visit with your insurance, you may owe part of the patient responsibility fee. If we do not receive payment for the amount listed on your statement within 14 days, we will run the credit card on file for the full amount owed provided it is under $200. For any amount larger than $200 we will first call you to confirm that is the method of payment you prefer. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. Further delinquency will be subject to collections with additional finance fees.

For families who do not wish to leave a credit card on file, you will be obligated to maintain a $50 balance, per child, with the practice. That balance will be used for any unpaid patient responsibility, as outlined above, and will need to be replenished before a member of the family can be seen in the practice again.

By signing below, I give Pelican Pediatrics permission to charge my credit card for any copay or patient balance due on my account under $200.

If I have insurance coverage, with the exception of Copay that will be charged at the time of the appointment, my card will be charged the balance AFTER my insurance has paid their portion.

Name (please print): _____ Date: _____

Patient's Name and Birth Date: _____

Signature of Responsible Party (Guarantor): _____

Relationship to Patient(s) (please check): _____ Parent _____ Self _____ Other: _____

Witness Signature: _____Date:_____

Note: The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

Pelican Pediatrics, LLC (843)795-3344

452 Folly Rd. Charleston, SC 29412

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

UNDERSTANDING YOUR MEDICAL/HEALTH INFORMATION

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the doctor or the receptionist of your requests for any of these actions:

1. Request Restrictions: You have a right to request restrictions on the use of your information.
2. Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this notice.
3. Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your child's medical information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
4. Amend: You have the right to request that we amend your child's health information.
5. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
6. Request Communications of your Health Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
7. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

OUR RESPONSIBILITIES

Our practice is required to:

1. Maintain Confidentiality: Maintain the privacy of your health information.
2. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
5. Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION

- If you have a question or would like additional information, you may contact Dr. Varadi or the receptionist.
- If you have a concern about the privacy of your information, you may contact Dr. Varadi or the receptionist. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. Instructions on how to file a complaint to the Office of Civil rights are provided at the following web address: http://www.hhs.gov/ocr/privacyhowtofile.htm or asking for a copy of the complaint form from the receptionist.

EXAMPLES OF DISCLOSURES OF INFORMATION

1. **Treatment**:
   a. We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.
   b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.
2. **Payment**: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used.
3. **Healthcare Operations:** The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
4. **Business Associates:** There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.
5. **Notification**: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.
6. **Communication with family:** We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.
7. **Research**: We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.
8. **Funeral Directors:** We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
9. **Organ Donation**: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.
10. **Marketing:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
11. **Food and Drug Administration**: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.
12. **Public Health:** Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.
13. **Correctional institution:** If you are an inmate of a correctional institution, we may disclose to the institution or its agents health information that is needed for your health or the health and safety of other individuals.
14. **Law enforcement**: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
15. **Health investigation:** Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.
16. **Other disclosures**: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.