Pelican Pediatrics, LLC
(843)795-3344

DATE: _____

PATIENT NAME (FIRST, MI, LAST)	SOCIAL SECURITY NUMBER:	DATE OF BIRTH	SEX □ M □ F
MAILING ADDRESS:	CITY/STATE/ZIP		
HOME PHONE NUMBER	CELL PHONE NUMBER		
EMERGENCY CONTACT NAME AND PHONE NUMBER	EMAIL ADDRESS		

ALLERGIES TO MEDICATIONS: _____ **INSURANCE**: _____

(PLEASE GIVE INSURANCE CARD TO RECEPTIONIST TO MAKE A COPY FOR OUR RECORDS)

MOTHER/GUARDIAN #1	SOCIAL SECURITY NUMBER	DOB
EMPLOYER/WORK PHONE	INSURANCE FOR CHILD □ YES □ NO	
FATHER/GUARDIAN #2	SOCIAL SECURITY NUMBER	DOB
EMPLOYER/WORK PHONE	INSURANCE FOR CHILD □ YES □ NO	
PARENTS ARE: MARRIED ____ SINGLE ____ SEPARATED ____ DIVORCED ____		

NAMES OF SIBLINGS	DOB	AGE

HOW DID YOU HEAR ABOUT US? _____

PREFERRED PHARMACY: _____

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

NAME: _____ TELEPHONE _____

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 Date

_____

Print Name

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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 *Dr. Eliza Varadi* 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

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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

PAST MEDICAL HISTORY

ANY MEDICAL PROBLEMS(FOR EXAMPLE: ASTHMA, SEIZURES, ADHD, ETC)?

ANY ER VISITS?

ANY HOSPITALIZATIONS?

ANY ACCIDENTS?

CURRENT MEDICATIONS

WHAT MEDICATIONS OR VITAMINS DOES YOUR CHILD TAKE REGULARLY OR AS NEEDED?

IMMUNIZATION STATUS

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE?

ALLERGIES

HAS YOUR CHILD EVER REACTED TO MEDICATIONS?

ANY PROBLEMS WITH POLLEN, GRASSES, ETC?

REVIEW OF SYSTEMS (CURRENT OR PAST CONCERNS)
(PLEASE MARK WITH X ANY CONCERNS)

FATIGUE		BURPING		BIRTH MARKS	
VISION PROBLEMS		GAS		FAINTING	
HEARING PROBLEMS		BELLY PAIN		DIZZY	
NOSE BLEEDS		CONSTIPATION		RECURRENT FEVERS	
SPEECH DIFFICULTY		VOMITING		RECURRENT INFECTIONS	
MOUTH ULCERS		SPITTING UP		HYPERACTIVITY	
MOUTH PAIN		BLOODY STOOL		HARMS ANIMALS	
NECK PAIN		URINARY TRACT INFECTION		TANTRUMS	
SWOLLEN GLANDS		PAINFUL URINATION		DIFFICULT TO CONTROL	
COUGH		FREQUENT URINATION		TOO SKINNY	
CONGESTION		PAINFUL JOINTS		TOO MUCH WEIGHT	
EXCESSIVE THIRST		JOINT SWELLING		BLEEDS/BRUISES EASILY	
ASTHMA		PROBLEMS WALKING		PROBLEMA SLEEPING	
HEART PROBLEMS		RECURRENT RASHES		RECURRENT EAR INFECTIONS	
CHEST PAIN		ECZEMA		HEADACHES	

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FAMILY HISTORY

CONDITION	YES	NO	WHO HAS IT?	CONDITION	YES	NO	WHO HAS IT?
CANCER				THYROID PROBLEMS			
DIABETES				SEIZURES/ EPILEPSY			
ASTHMA				MIGRAINES			
HEART ATTACK <50 YO				HIGH CHOLESTEROL			
KIDNEY PROBLEMS				STOMACH PROBLEMS			
GENETIC PROBLEM				GAMBLING			
ALCOHOLISM				MANIC DEPRESSION			
DEPRESSION				NERVOUSNESS			

SOCIAL HISTORY

WHO LIVES AT HOME? _____

ANY PETS?_____

DOES ANYONE SMOKE IN THE FAMILY?_____

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?_____

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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
- ☐ Other, Please specify: _____
- ☐ Immunization Records
- ☐ Consultation Reports
- ☐ Entire Medical Record

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

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

This authorization shall be in force and be **in effect for 1 year from date below**, unless otherwise specified (Optional) _____ 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
354 FOLLY RD. SUITE #5
CHARLESTON, SC 29412
O: 843-795-3344 F: 843-795-3143

Pelican Pediatrics, LLC
(843)795-3344

D H E C
PROMOTE PROTECT PROSPER

Patient Eligibility Screening Record
South Carolina's Vaccine Assurance For All Children

Date: _____

Child: _____
Last Name First Name MI

Date of Birth: _____

Parent/Guardian/
Individual of Record: _____
Last Name First Name MI

Provider: _____

A record must be kept in the healthcare provider's office that reflects the status of each child 18 years of age or younger, or otherwise eligible, who receives immunizations through South Carolina's Vaccine Assurance For All Children (VAFAC) Immunization Partnership (which includes the federal Vaccines for Children [VFC] Program). The record may be completed by the parent, guardian or individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as 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.

This child qualifies for VAFAC vaccine because he/she (check only one box):

(a) Is enrolled in Medicaid ☐ or

(b) Does not have health insurance ☐ or

(c) Is American Indian or Alaskan Native ☐ or

(d) Has health insurance that **does not** pay for vaccine ☐ or

This child does not qualify for VAFAC vaccine because he/she:

(e) Has health insurance that **does** pay for vaccine (eligible through private insurance). ☐

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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.

Pelican Pediatrics, LLC
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354 Folly Rd Ste 5, James Island, SC 29412

SERVICES

Pelican Pediatrics offers a full spectrum of pediatric care. Some of these services include:

1. Well Child Examinations
    a. Newborn
    b. Infant
    c. Child
    d. Adolescent
2. Vaccinations (For children without insurance, we offer free vaccinations)
3. Same Day Sick Visits
4. Sport & Camp Physicals
5. Preschool/Head Start Physicals
6. Behavioral Evaluations
7. Developmental Evaluations
8. ADHD Care
9. Parent Conferences

INSURANCES ACCEPTED

Medicaid, First Choice by Select Health, Blue Cross Blue Shield, Blue Choice, Molina, Cigna, Consummer's Choice, United Health and many more.

CLINIC HOURS

Monday, Tuesday, Wednesday, Friday
8:30 am – 5pm

Thursdays closed for appointments
9 am – Noon
to pick up prescriptions, records

(THESE HOURS MAY CHANGE. PLEASE CALL FOR CURRENT HOURS)

ASSOCIATED HOSPITALS

Roper/St. Francis Healthcare System