For Office Use:

□ New Patient
□ Update to Current Patient
Account #_____
Date _____

Dr. Erica Menina
Dr. Kimberly Thorguson
Abby Burke, NP
Alana Andras, NP
Alyssa Viet Vu, NP

The Pediatric Clinic Of St Mary Parish

Patient Information:
Full Name (First, Middle, Last): _____

Nickname: _____ Gender: □ Male □ Female Date of Birth:_____ Age: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email Address: _____

Which racial category does the patient identify with?
□ African American □ Caucasian □ Native Hawaiian/Pacific Islander □ American Indian/Alaska Native
□ Asian □ More Than One Race □ Other _____

Ethnicity: What is the patient's ethnicity? □ Hispanic or Latino □Not Hispanic or Latino

What is the Patient/Family's primary language? □ English □ Spanish (Must have ADULT Translator Present)
□ Other _____

Family Information:

Primary Parent/Legal Guardian
Full Name (First, Middle, Last): _____

Gender □ Male □ Female Relationship to Patient: _____ Phone Number: _____

Date of Birth: _____ SSN: _____-_____-_____ Employer: _____

Email: _____ Address: _____

Other Parent
Full Name (First, Middle, Last): _____

Gender □ Male □ Female Relationship to Patient: _____ Phone Number: _____

Date of Birth: _____ SSN: _____-_____-_____ Employer: _____

Email: _____ Address: _____

Preferred Pharmacy and Location:_____

Parental Marital Status: □ Married □ Divorced □ Other _____ With whom does the patient reside?_____

Please list all siblings under 21 years of age currently treated at The Pediatric Clinic (full name and DOB):

_____

_____

_____

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Insurance Information:

Primary Insurance: □ Private □Medicaid

Name of Insured: _____

Employer: _____ Insurance Company: _____

SSN of policy holder: _____-_____-_____ DOB: _____

Patient Relationship to Insured: □Self □Dependent □Spouse

Group #:_____ Policy #: _____

Secondary Insurance: □ Private □Medicaid

Name of Insured: _____

Employer: _____ Insurance Company: _____

SSN of policy holder: _____-_____-_____ DOB: _____

Patient Relationship to Insured: □Self □Dependent □Spouse

Group #:_____ Policy #: _____

Permission to Treat Patient:

By signing this form, I hereby acknowledge The Pediatric Clinic of St. Mary Parish (PRACTICE) has the right to use and disclose Protected Health Information (PHI) for treatment, payment aid, health operations, and that I have received the Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed, and that the Practice is not required to agree to any restriction, but if any agreement is reached, the Practice is bound by the agreement.

_____ I hereby authorize The Pediatric Clinic of St. Mary Parish to evaluate and recommend any testing and/or treatment.

_____ I understand I have the right to refuse any such recommendations and/or treatment.

Print Name: _____ Signature: _____

Date:_____ Responsible Party Signature:_____

Dr. Erica Menina
Dr. Kimberly Thorguson
Abby Burke, NP
Alana Andras, NP
Alyssa Viet Vu, NP

HIPAA Disclosure Form

Doctor: The Pediatric Clinic of St Mary Parish

Patient Name:_____ **Date:** _____

Mailing Address: _____

Street Address: _____

Primary Phone #: _____

Primary Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? □Yes □No

May we identify ourselves over the phone? □Yes □No

May we leave messages? □ Yes □No

I, the Patient or Patient Representative, hereby authorize the doctor listed above to release my medical information (appointments, test results, diagnosis, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ **DOB:** _____ **Relationship:**_____

Name: _____ **DOB:** _____ **Relationship:**_____

Name: _____ **DOB:** _____ **Relationship:**_____

Name: _____ **DOB:** _____ **Relationship:**_____

Name: _____ **DOB:** _____ **Relationship:**_____

I further release my medical information to the following physicians, specialists, clinics, and/or hospitals:

Doctor:_____ **Clinic:**_____**Phone number:** _____

Doctor:_____ **Clinic:**_____**Phone number:** _____

Doctor:_____ **Clinic:**_____**Phone number:** _____

Doctor:_____ **Clinic:**_____**Phone number:** _____

Doctor:_____ **Clinic:**_____**Phone number:** _____

HIPAA Notice of Privacy Practices

THE PEDIATRIC CLINIC OF ST. MARY PARISH (A PMC)
1055 DAVID DRIVE · MORGAN CITY, LOUISIANA 70380 · 985-384-2430

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

The Pediatric Clinic of St. Mary Parish (TPC) provides many types of services. TPC staff must collect information about you to provide these services. TPC knows that the information we collect about you and your health is private. TPC is required to protect this information by Federal and State law. We call this information "protected health information" (PHI).

This Notice of Privacy Practices tells you how TPC may use or disclose information about you. Not all situations will be described. We are required to give you a notice of privacy practices for the information we collect and keep about you. TPC is required to follow the terms of the notice currently in effect. However, TPC may change its privacy practices and make that change effective for all PHI maintained by the Clinic. The effective date of this notice of Privacy Practices is April 14, 2003 according to the Louisiana Department of Health.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, TPC may provide PHI to bill your health plan for services provided to you.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures:
Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Right to See and Get Copies of Your Records. In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You will be charged a fee for the cost of copying your records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceedings, and protected heath information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

All authorizations with our facility expire when the minor reaches the age of majority.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Copies of this Notice are available at the front desk. Your signature below is acknowledgement that you have read this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

KIMBERLY THORGUSON, M.D.
ERICA MENINA, M.D.
ALANA ANDRAS, F.N.P.
ABBY BURKE, F.N.P.
ALYSSA VIET VU, F.N.P.

ATTENTION

Automated email/text/call appointment confirmation is coming to The Pediatric Clinic! To ensure you receive all messages from our automated system, please put your preferred contact information below so we can update your child's account. You will receive a confirmation email/text to enroll in the alerts.

Patient name: _____ DOB: _____

Email address: _____

Cell #: _____

Landline #: _____

Parent/guardian Signature: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

1055 DAVID DR • MORGAN CITY, LA 70380
WWW.THEPEDIATRICCLINIC.ORG
985.384.2430 • 985.384.2473