MANNING PEDIATRICS, LLC

4139 Hospital Drive
Covington, Georgia 30054
770-786-0012 Fax – 770-786-9988

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Medical Records

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. -

Patient Signature: _____ Date Signed: _____

Once HIPAA information is disclosed to another entity the information may be subjected to future use and disclosure without protection offered by HIPAA.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Manning Pediatrics, LLC *Cheryl A. Manning, MD*
4139 Hospital Dr. NE, Covington, GA 30014

Patient Information
Patient Name _____ Nickname _____ Birthdate ____/____/____ ☐M ☐F

Emergency Contact *(Relative or friend not living in the same household)*
Name: _____ Relation: _____ Phone#: _____

Responsible Party
Father's Name_____ Home phone# _____ Cell Phone#_____

Date of Birth_____ Social Security Number_____

Address: _____ City_____ State _____ Zip_____

Work Name and Phone Number_____

Mother's Name_____ Home phone# _____ Cell Phone#_____

Date of Birth_____ Social Security Number_____

Address: _____ City_____ State _____ Zip_____

Work Name and Phone Number_____

Email_____ **Preferred Pharmacy**_____

PLEASE PROVIDE FRONT OFFICE STAFF WITH YOUR CURRENT INSURANCE CARD

Insured's Name_____ Relationship_____ Date of Birth_____

Home phone # _____ Cell Phone #_____ Social Security # _____

Address: _____ City_____ State _____ Zip_____

Company Name_____ Phone Number_____

Medical Information
Please list allergies, sensitivities or reactions to any drug or food that the patient may have:

_____

Please list all current medications the patient is presently taking:

_____

Is there any cultural or religious beliefs that our office staff needs to be aware of prior to seeing that may affect patient care?

☐yes ☐no If yes, please explain_____

By signing I affirm that I have read and agree to the Appointment Policy Set forth by Manning Pediatrics LLC.

Signature X_____ Date_____

CHILD'S HEALTH HISTORY CONT'D

PATIENT NAME_____

HAVE ANY OF YOUR CHILD'S BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING:

- ☐ YES ☐ NO ANEMIA
- ☐ YES ☐ NO ARTHRITIS
- ☐ YES ☐ NO ASTHMA
- ☐ YES ☐ NO BIRTH DEFECTS
- ☐ YES ☐ NO CANCER
- ☐ YES ☐ NO DEAFNESS
- ☐ YES ☐ NO DIABETES MELLITUS
- ☐ YES ☐ NO DRINKING OR DRUG PROBLEMS
- ☐ YES ☐ NO ECZEMA
- ☐ YES ☐ NO EPILEPSY/SEIZURE DISORDER
- ☐ YES ☐ NO GLAUCOMA
- ☐ YES ☐ NO HEART DISEASE
- ☐ YES ☐ NO HIV/AIDS
- ☐ YES ☐ NO HIGH BLOOD PRESSURE
- ☐ YES ☐ NO MENTAL OR EMOTIONAL PROBLEMS
- ☐ YES ☐ NO NERVE OR MUSCLE DISEASE
- ☐ YES ☐ NO OBESITY
- ☐ YES ☐ NO STROKE
- ☐ YES ☐ NO SUICIDE OR ATTEMPTED SUICIDE
- ☐ YES ☐ NO TUBERCULOSIS
- ☐ YES ☐ NO OTHER

PLEASE LIST BELOW:

_____

_____

DO YOU OR YOUR FAMILY HAVE ANY CONCERNS WITH THE FOLLOWING:

- ☐ YES ☐ NO OTHER FAMILY MEMBERS
- ☐ YES ☐ NO FRIENDS
- ☐ YES ☐ NO HOUSING OR LIVING ARRANGEMENTS
- ☐ YES ☐ NO FINANCES
- ☐ YES ☐ NO EDUCATION
- ☐ YES ☐ NO JOB OR EMPLOYMENT
- ☐ YES ☐ NO LEGAL
- ☐ YES ☐ NO TRANSPORTATION
- ☐ YES ☐ NO RECENT LOSS OF JOB OR RETIREMENT
- ☐ YES ☐ NO MENTAL OR EMOTIONAL DIFFICULTIES
- ☐ YES ☐ NO SERIOUS ILLNESS OR DIFFICULTY
- ☐ YES ☐ NO ALCOHOL OR DRUG USE
- ☐ YES ☐ NO RECENT, SEPARATION OR DIVORCE
- ☐ YES ☐ NO RECENT DEATH OF A SPOUSE OR FRIEND OR FAMILY MEMBER
- ☐ YES ☐ NO NEIGHBORHOOD VIOLENCE
- ☐ YES ☐ NO FAMILY VIOLENCE OR ABUSE
- ☐ YES ☐ NO OTHER

PLEASE LIST BELOW:

_____

_____

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE):

Name(s)	Male/Female	Date of Birth or Age	Marital Status	Living at home?
Parents:				
Children:				
Others living in household:				

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS OR INFORMATION ABOUT YOUR CHILD, YOURSELF, OR YOR FAMILY THAT YOU WOULD LIKE TO SHARE WITH YOUR HEALTH CARE PROVIDER:

_____

_____

_____

SIGNATURE X_____RELATIONSHIP_____DATE_____

Manning Pediatrics, LLC *Cheryl A. Manning, MD*
4139 Hospital Dr. NE, Covington, GA 30014

PLEASE FILL OUT THIS MEDICAL HISTORY COMPLETELY

PATIENT NAME_____ DOB_____ TODAY DATE _____

MOTHER'S MAIDEN NAME_____HOSPITAL CHILD WAS BORN_____ C-SECTION VAGINAL

CHILD'S BIRTH WEIGHT_____ CHILD'S GRADE IN SCHOOL _____(IF APPLICABLE)

PARENTS: Never married Living with significant other Married Separated Divorced Widowed

ETHNICITY: Hispanic non Hispanic RACE: White Black Asian other

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING CHILD'S MEDICAL HISTORY:

YES NO Were there any complications during the pregnancy?
YES NO Were there any complications during the birth and delivery?
YES NO Was the pregnancy full-term (9 months or 40 weeks)?
YES NO Was there any problems with child immediately following the birth?
If yes, please explain_____
YES NO Was the child released at the same time as the mother?
YES NO Did your child have jaundice?
YES NO Does your child have any birth defects?
YES NO Does your child have any problems with feeding or nutrition?
YES NO Has the child's growth and development been normal?
YES NO Is your child's immunizations up to date?
YES NO Does anyone in the child's home smoke?
YES NO Has your child been exposed to any sources of lead?

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

YES NO ANEMIA (LOW BLOOD COUNT)
YES NO ARTHRITIS
YES NO ASTHMA
YES NO BRONCHITIS OR PNEUMONIA
YES NO CANCER
YES NO CHICKEN POX
YES NO DENTAL PROBLEMS
YES NO DIABETES MELLITUS
YES NO EAR INFECTIONS
YES NO ECZEMA
YES NO EPILEPSY/SEIZURE DISORDER
YES NO GERMAN MEASLES
YES NO ALLERGIES OR HAYFEVER
YES NO HEARINGPROBLEMS
YES NO HEART DISEASE
YES NO HIV/AIDS
YES NO LEARNING OR ATTENTION DIFFICULTIES
YES NO MEASLES
YES NO MENTAL OR EMOTIONAL PROBLEMS
YES NO MONONUCLEOSIS
YES NO MUMPS
YES NO RHEUMATIC FEVER
YES NO TONSILLITIS OR STREP THROAT
YES NO VISION PROBLEMS (NOT GLASSES)
YES NO WEIGHT PROBLEMS
YES NO OTHER

PLEASE LIST BELOW:

_____
_____

LIST NON-PRESCRIPTION DRUGS YOUR CHILD IS ON:

_____
_____
_____

PRESCRIPTION DRUGS YOUR CHILD IS CURRENTLY TAKING:

_____
_____
_____

LIST ANY DRUGS YOUR CHILD IS ALLERGIC TO:

_____
_____
_____

LIST ANY INJURIES OR FRACTURES (ALSO LIST AGE):

_____
_____

LIST ANY OPERATIONS (ALSO LIST AGE):

_____
_____

LIST ANY HOSPITALIZATIONS (ALSO LIST AGE):

_____
_____

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PATIENT ACKNOWLEDGEMENT FORM

Patient acknowledgment of understanding of Manning Pediatrics, LLC. Office's Privacy Practices

Patient name: _____ **Date of Birth:** _____ **SSN:** _____

I understand that the patient's health information is private and confidential. I understand that Manning Pediatrics, LLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Manning Pediatrics, LLC may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be a patient threatened to hurt someone.)

Manning Pediatrics, LLC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Manning Pediatrics, LLC. may update this Acknowledgment and "Notice of Privacy Practices". If I asked, I will be provided with the most current "Notice of Privacy Practices". Within this Notice of Privacy Practices is contained a complete description of my privacy & confidentiality rights. These rights include, but aren't limited to, access to my medical records, restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Manning Pediatrics, LLC. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgment, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Manning Pediatrics, LLC. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

I authorize direct payment of medical benefits to Manning Pediatrics, LLC for services received.

☐Private Pay-I understand and agree that I need to make arrangements with office staff prior to seeing the physician to handle pre-payment for services. _____**Please initial that you understand the above statement.**

☐Health Insurance-I understand and agree that I will need to provide a current copy of my insurance card to the office staff at the time of service. _____**Please initial that you understand the above statement.**

☐I understand that I am financially responsible any and all monies not covered by my insurance provider including but not limited to co-insurance, co-pay and deductibles. Any balance over 90 days all will be reviewed for further legal collection efforts. _____**Please initial that you understand the above statement.**

☐I understand that appointments may be rescheduled or cancelled until my account is paid in full. _____**Please initial that you understand the above statement.**

☐I understand that if my account is turned over for further collection efforts I am responsible not only for the balance due but also for any interest or collections fees that are added to my account. _____**Please initial that you understand the above statement.**

_____OK to leave message on answering machine

My signature below indicates that I have been given the chance to review a current copy of Manning Pediatrics, LLC's "Notice of Privacy Practices".

X_____ _____ _____

Signature of patient or legally authorized individual Date Time

_____ Relationship to patient if signed by anyone other than the patient

MANNING PEDIATRICS
Appointment Policy

It is our intention to provide your children the best possible care at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

In the Office

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each visit. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.

- **Schedule an appointment by calling 770-786-0012.** We do not take walk-in appointments.

- **Schedule same day appointments for ill visits.** Appointments are used on a first-available appointment basis.

- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your child's visit.

- **Call ahead if you are late or unable to make your appointment.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment.

- **Late arrivals (over 15 minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge for the lost appointment may apply. While we will do all that is possible to accommodate requests, the first available appointment may or ***may not*** be on the day the appointment was missed.

- **The no-show charge will be waived if you contact the office before your appointment.** Remember that appointments cancelled more than 3 hours prior to when they were scheduled do ***not*** incur a no-show fee.

- **Appointments for additional children should be made by phone *prior* to coming to the office.** If you would like another child to be seen, please schedule appointments for ***both*** children ***by phone*** prior to coming to the office.

- **Please turn off cell phones while in examination rooms.**