Rhodes Pediatric Clinic

Date: _____

Patient's Name: _____ (_____) **DR: Rhodes / Marzullo**
Last First Middle Preferred **NP: Jane Ann**

Date of Birth: _____ **Sex: M or F** **SS#** _____-_____-_____ **Race:** _____ **Lang:** _____

Person patient lives with: _____ **Relationship:** _____

Parents Marital Status: ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Unmarried** ☐ **Widowed** **Custody: Joint or Sole**

Mother/Guardian's Information	**Father/Guardian's Information**
Full Name: _____ **(Maiden):** _____	**Full Name:** _____
Birthday: _____	**Birthday:** _____
Address: _____	**Address:** _____
City, State, Zip: _____	**City, State, Zip:** _____
Cell Phone #: _____	**Cell Phone #:** _____
Employer: _____	**Employer:** _____
Occupation: _____	**Occupation:** _____
Email: _____	**Email:** _____

PERSON RESPONSIBLE FOR BILL: _____ **Permission to TEXT appt. reminders:** ☐ **YES** ☐ **NO** (initial)

Are there other siblings under our care?

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

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

Emergency Contact: Contact other than parent: _____ **Phone:** _____
Relationship to Patient: _____

Preferred Pharmacy: _____ **Phone:** _____

CONSENT: ***I consent to medical treatment necessary for the above patient.***

_____ _____ _____
Signature of Parent/Legal Guardian **Relationship** **Date**

Insurance Information:

PRIMARY INS: _____ Subscriber/ID#: _____ Group #: _____ Employer: _____

Insured name: _____ Relationship to pt: _____ Policy holder SSN: _____-_____-_____

2nd INS: _____ Subscriber/ID#: _____ Group #: _____ Employer: _____

Insured name: _____ Relationship to pt: _____ Policy holder SSN: _____-_____-_____

I understand that payment in full is expected at the time of service. However, in the event Rhodes Pediatric Clinic files claims on my behalf, I authorize all benefits to be paid directly to Rhodes Pediatric Clinic. I authorize Rhodes Pediatric Clinic and or the rendering physician(s) to release all information required by my insurance company to file for medical benefits.

Parent/Guardian _____ **Date:** _____

Acknowledgement of Receipt of Notice of Health Information Privacy Practices

I, (parent name) _____, *acknowledge receipt of Notice of Health Information Privacy Practices.* **By:** _____ **Date:** _____

Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F
Previous Physician/Office	Request for Records Transfer Complete Y N		Date of Last Physical	
Mother's Name Occupation Age		Father's Name Occupation Age		

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late?_____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication?	☐ Y ☐ N	Explain _____
Does your child have any serious or chronic illnesses?	☐ Y ☐ N	Explain _____
Has your child had serious injuries or accidents?	☐ Y ☐ N	Explain _____
Has your child had any surgery?	☐ Y ☐ N	Explain _____
Has your child ever been hospitalized?	☐ Y ☐ N	Explain _____
Is your child allergic to any medicine or drugs?	☐ Y ☐ N	Explain _____
Has your child had any reactions to immunizations?	☐ Y ☐ N	Explain _____
Does Your Child Have, or Ever Had:		
Asthma, recurrent cough, bronchitis, or pneumonia	☐ Y ☐ N	Explain _____
Nasal allergies or eczema	☐ Y ☐ N	Explain _____
Frequent ear infections or sore throats	☐ Y ☐ N	Explain _____
Problems with ears or hearing	☐ Y ☐ N	Explain _____
Problems with eyes, vision, or teeth	☐ Y ☐ N	Explain _____
Frequent headaches or other neurologic problems	☐ Y ☐ N	Explain _____
Frequent abdominal pain	☐ Y ☐ N	Explain _____
Constipation requiring doctor visits	☐ Y ☐ N	Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old)	☐ Y ☐ N	Explain _____
Any heart problem or heart murmur	☐ Y ☐ N	Explain _____
Anemia or bleeding problem	☐ Y ☐ N	Explain _____
Thyroid or other endocrine problem	☐ Y ☐ N	Explain _____
Diabetes	☐ Y ☐ N	Explain _____
ADHD	☐ Y ☐ N	Explain _____
Mental health issues (anxiety, depression)	☐ Y ☐ N	Explain _____
Use of alcohol or drugs	☐ Y ☐ N	Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, Speech Therapy? ☐ Y ☐ N Explain _____

Is your child in special or resource classes in school? ☐ Y ☐ N Explain _____

Do you have any other issues or concerns not listed above? _____

Do you have a problem immunizing your child? _____Yes _____No

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

Initial Review (initials/date):

RHODES PEDIATRIC CLINIC

JOHN N. RHODES, M.D., F.A.A.P.
MICHAEL J. MARZULLO, M.D., F.A.A.P.
37 Calvert Drive
Alexandria, LA 71303
Phone: (318) 443-9634 - Fax: (318) 443-9809

IMMUNIZATION POLICY AND ACKNOWLEDGEMENT

Patient's Name: _____ DOB: _____

It is the policy of Rhodes Pediatric Clinic to adhere to the recommendations and schedule set forth by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Advisory Committee for Immunization Practices for fully immunizing children. Flu and COVID vaccines are optional.

- Rhodes Pediatric Clinic believes in the effectiveness of vaccines as a means to protect children and young adults from contracting a potentially dangerous or even deadly disease.
- As physicians, we believe a community that is fully immunized protects those who can't be immunized, such as very young children, immunocompromised people and elderly people.
- Vaccines are safe. They must go through years of extensive safety testing and evaluation before they are approved in the United States (with the exception of the COVID vaccine).
- Louisiana requires students to be immunized in order to attend school or have a valid exemption. Most daycares follow the Louisiana law.
- Your doctor welcomes the opportunity to talk with you about vaccinations if you are unsure.
- As a clinic, we do not support any alternative vaccine schedule.

____ I **agree** with fully immunizing my child and will follow the recommended immunization schedule as stated in the initial statement above.

_____ _____ _____
Printed name Signature Date

____ I **do not** agree with fully immunizing my child and will not follow the recommendation and therefore, I will seek another pediatrician.

_____ _____ _____
Printed name Signature Date

Parents of minors to fill out

Rhodes Pediatric Clinic

CONSENT OF PARENTS/GUARDIANS OF MINOR PATIENTS
TO DISCLOSE HEALTH INFORMATION FOR PAYMENT,
TREATMENT, AND HEALTH CARE OPERATIONS

Patient's Name: _____
Last First Middle

Home Address: _____

_____
City State Zip

Date of Birth: ____/____/____ **Home Telephone:** ____-____-____

ACKNOWLEDGEMENT OF RECEIPT OF RHODES PEDIATRIC CLINIC (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY CHILD'S GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child; seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment:
Example: Tom Jones, Grandfather, 888-888-8888

Name	Relation	Phone

Person/People listed must be over 18 years of age

ASSIGNMENT OF INSURANCE BENEFITS:
By my signature below, I authorize medical benefits to be paid to Rhodes Pediatrics on my child's behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges not covered by insurance for this service date as well as all future service dates.

ASSIGNMENT OF RECEIPT OF PRACTICE'S NOTICE OF THE BILLING POLICY:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of the Billing Policy.

Signature of Parent/Guardian/Personal Representative of minor child	Description of Authority	Date

RHODES PEDIATRIC CLINIC

Divorce, Custody or Legal issues

As a pediatric facility our goal is foremost the treatment of the identified patient. It is essential that both parents of a minor child are in full agreement as to medical care, treatment goals and appointment times. The following informed consent states that both parental parties will agree to these terms and communicate effectively with each other as well as with the provider to create the most successful outcome possible for the patient.

Our responsibility to your child may require our involvement in conflicts between parents and guardians. You agree that:

- Our involvement will be strictly limited to that which will benefit your child.
- Neither parent/guardian will attempt to gain advantage in any legal proceeding between the two parents/guardians from our involvement with the child.
    - In particular, in any such proceeding, neither of you will ask us to testify in court, whether in person, or in writing.
- Our role is limited to providing treatment..
    - You will not involve us in any legal dispute, especially a dispute concerning custody or custody arrangements (visitations, etc.).

If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, we will provide general information about the minor. However, this will not include recommendations concerning custody or custody arrangements, nor any confidential or privileged information unless otherwise ordered by a court.

I_____ give my permission to _____,
(relationship to patient: _____) to make decisions regarding medical care and treatment, scheduling appointments and cancelling appointments, if I am not physically present during any appointments.

I_____ accept the responsibility of communicating with _____after every appointment to be updated regarding any change in the medical care or treatment plan related to _____.

I _____ understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Rhodes Pediatric Clinic, will look to me as the sole party responsible for the financial obligations of the account.

Parent/Guardian _____ Date_____

Rhodes Pediatric Clinic Financial Agreement and Consent

We are committed to providing your family with the best possible pediatric care. Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

BILLING YOUR INSURANCE:

- Please present your current health insurance card at each office visit.
- Our office will bill validated **Primary Insurance** as a courtesy. You must pay for any patient responsibility.
- If you have **No Insurance**, then payment in full is require at the time of service.
- Know your insurance and **REMEMBER: Non-covered services such as vaccines can be VERY EXPENSIVE.**

PAYMENT FOR SERVICES:

- Co-pays, co-insurances, and deductibles must be paid at the time of service. _____ **Please Initial**
- We accept cash, checks, money orders, Visa®, MasterCard®, Discover, American Express and debit cards.

RETURNED CHECKS:

- **The charge for a non-sufficient funds (NSF) check is $45.** You must pay in full for the NSF check and NSF fee within 10 days of notice. If payment in not received by the due date, we reserve the right to proceed with legal representation. It is a felony to knowingly write a bad check. For the next 12 months, cash or equivalent payment at the time of service is required.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days we reserve the option to refer the account to an outside collection agency. **If your account is sent to an outside collection agency, there will be a 40% surcharge added to your balance.** Rhodes Pediatric Clinic reserves the right to reschedule or deny future appointments for delinquent accounts. If your account is sent to a collection agency you must be asked to find another provider.

LATE ARRIVALS, CANCELATIONS AND NO SHOWS:

Please arrive 10 minutes prior to your scheduled appointment to allow for check-in and any paperwork.

- We require a **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, a 2-hour notice is required. **If you arrive 15 minutes late to your appointment, you have missed your appointment; therefore, a late cancelation fee will be charged, whether you are seen then or not.**
- Failure to give proper notice for cancelation or reschedule will result in:
  - A $25.00 charge for missed vaccine appointments or late cancelations, per child.
  - A $25.00 charge for the first missed appointment, per child.
  - A $50.00 charge for the second missed appointment, per child.
  - A $75.00 charge for the third missed appointment, per child.
  - Your family could be subject to dismissal for a third or subsequent missed appointment.
- **Please initial that you understand the fees above.** _____

***I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay Rhodes Pediatric Clinic directly. A copy of this authorization can be considered an original for insurance purposes.**
***I do hereby consent to and authorize the performance of all examinations, treatments, and medical services by Rhodes Pediatric Clinic and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.**

_____ _____
Signature Date

_____ _____
Print Name Relationship to Child(ren)

Child/Children's Names and Date(s) of Birth: _____ _____

_____ _____

Form Completion Fees

Effective 8/18/2021

Rhodes Pediatric Clinic works hard to provide outstanding medical care. We understand that various forms, shot records and letters may be required of parents for school, day care, camps, sports participation, life insurance purposes and other non-medical needs. Rhodes Pediatric has always offered completion of these forms, which are not required by your health insurance, as an added service to our patients.

We receive many requests, which involve increased administrative time and financial resources in excess of what is normally needed to complete the medical record. As a result, it is now our office policy to charge for the review and completion of any form or letter as follows:

- Form Fee: $20.00
- If form is brought in and completed at the time of an office visit, there is no charge as it is included with your visit.
- No form will be completed for any patient who has not had a well-child checkup in our office in more than 12 months.
- There is **no charge** for authorizations for schools to administer medication that Rhodes Pediatric Clinic has prescribed. This **does not include** over the counter medication that schools require a medication label for (i.e. Tylenol, Pepcid, Claritin, etc.).
- **Payment is due prior to the completion of the form.**
- Turnaround time for form completion is usually fewer than 3 business days, but we request up to one week for completion. We will not interrupt our patient's care to fill out forms.
- ASAP/Same Day requests will have a fee of $15.00 in addition to the standard form fee.

We appreciate your understanding of these changes in policy.

By signing below I attest that I have read and understand the above policy.

_____

Print Name

_____ _____

Signature of Parent (legal representative) Date