

# Rhodes Pediatric Clinic

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ (\_\_\_\_\_) DR: Rhodes /Marzullo/Adams  
 Last First Middle Preferred  
 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

Full Name: \_\_\_\_\_ (Maiden): \_\_\_\_\_  
 Birthday: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Email: \_\_\_\_\_

### Father/Guardian's Information

Full Name: \_\_\_\_\_  
 Birthday: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Email: \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL: \_\_\_\_\_ Permission to TEXT appt. reminders: \_\_\_yes\_\_\_ no (initial)

### Are there other siblings under our care? Y N

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 Soc. Sec. #: \_\_\_\_\_

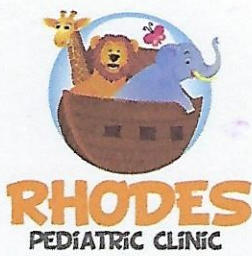
2<sup>ND</sup> INS.: \_\_\_\_\_ Subscriber/ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Insured Name: \_\_\_\_\_ Relationship to pt.: \_\_\_\_\_ Policy holder Soc. Sec. #: \_\_\_\_\_

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: \_\_\_\_\_



**JOHN N. RHODES, M.D., F.A.A.P.**  
**MICHAEL J. MARZULLO, M.D., F.A.A.P.**  
**BRIAN L. ADAMS, 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

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

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	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Anesthesia Risk	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Genetic	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Gastroenteritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Genitourinary	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Heart	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Lipids	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Neurologic Diagnosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Psychiatry	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Ophthalmology	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Respiratory	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Skin	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Thyroid	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____
Negative Family History	<input type="checkbox"/> Y <input type="checkbox"/> N	Who _____	Comments _____

Additional Family History/Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Initial Review (initials/date): \_\_\_\_\_

RHODES PEDIATRIC CLINIC

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

Patient Name:

\_\_\_\_\_

Last                                  First                                  Middle

Home Address:

\_\_\_\_\_

\_\_\_\_\_

Home Telephone:

\_\_\_\_\_

Date of Birth:

\_\_\_\_\_

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:  
(please list only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 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 required 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 is 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 may be asked to find another provider.

### LATE ARRIVALS, CANCELLATIONS 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 cancellation fee will be charged, whether you are seen then or not.
- Failure to give proper notice for cancellation or reschedule will result in:
  - A \$25.00 charge for missed vaccine appointments or late cancellations, 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: \_\_\_\_\_