BAMA PEDIATRICS & ALLERGY

2701 20th Ave
Northport AL 35476

Date: ________________

Patient's Full Name: ____

Date of Birth: ____________________ Age: ____________________ Sex: ____________

Social Security #: ____________________ Preferred Pharmacy: ____________________

Home Address: ____

City: ____________________ State: ________________ Zip: ________________

E-mail address: ____

Patient lives with: ________________ Primary Contact #: ________________ Alternate #: ____________

Emergency Contact: ________________ Relationship: ________________ Phone: ____________

Whom may we thank for referring you to our office? ______________________________

Please circle appropriate answer below:

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown

Race: African American Asian Caucasian Hispanic Native American Pacific Islander Other: ______

Language: English Spanish German Other: ____________

Mother Step-Mother Guardian
(Circle One)

Name: ______________________________

DOB: ______________________________

Home Phone: ______________________________

Cell Number: ______________________________

Email Address: ______________________________

Employer: ______________________________

Social Security: ______________________________

Father Step-Father Guardian
(Circle One)

Name ______________________________

DOB: ______________________________

Home Phone: ______________________________

Cell Number: ______________________________

Email Address: ______________________________

Employer: ______________________________

Social Security: ______________________________

<u>Patient's Primary Insurance</u>

Insurance Company: ______________________________

Contract #: ______________________________

Group #: ______________________________

Policy Holder: ______________________________

Policy Holder DOB: ______________________________

Relationship to Child: ______________________________

<u>Patient's Secondary Insurance</u>

Insurance Company: ______________________________

Contract #: ______________________________

Group #: ______________________________

Policy Holder: ______________________________

Policy Holder DOB: ______________________________

Relationship to Child: ______________________________

Bama Pediatrics Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines

We firmly believe that all children and young adults should receive all recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe, based on all available literature,evidence,and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccine schedule are results of years and years of scientific study and data gathering in millions of children by thousands of our brightest scientists and physicians.

We recognize that this choice may be a very emotional one for some parents. **Please be advised, however, that delaying or "breaking up the vaccines "to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at (Bama Pediatrics).** Such additional visits will require additional co-pays on your part. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Because we are committed to protecting the health of your children through vaccination, we require all our patients to be vaccinated. Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any of us.

Thank you,
The Physicians at Bama Pediatrics

I, ____

have read the above Bama Pediatrics Vaccine Policy and I plan to Vaccinate my child according to the recommended vaccination schedule from the American Academy of Pediatrics and The Center for Disease Control

__________________________ ____________________ __________

Signature Relation to Patient Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Safeguarding the Protected Healthcare Information (PHI) of our patients has always been and will always remain a primary concern of the staff at BAMA PEDIATRICS & ALLERGY LLC, Sudha Sagar Bennuri, MD and Bindu Bennuri, MD. Disclosure documentation and written consent to PHI as well as "chains of trust" with our vendors, appropriately executed contracts with business associates and "minimum necessary" release of information standards will provide a front line determent to any breach of practice procedures.
Moreover, through staff and provider training with periodic updates and monitoring Bama Pediatrics & Allergy engineered office policy and procedure standards will protect orally (spoken) thereby ensuring
compliance with Federally mandated act known as the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

My signature affixed to this document acknowledges my awareness of the established practice and policy of Bama Pediatrics & Allergy to protect the PHI of all patients under its care.

I,______________________________, acknowledge that I have received a copy of privacy practices at Bama Pediatrics & Allergy LLC, Sudha Bennuri, MD and Bindu Bennuri, MD.

Name of Patient: ______________________________

____

Signature of patient/patient's guardian/representative

____ __________________

Printed name of the person signed Date

DIVORCE/CUSTODY POLICY

The providers and staff at Bama Pediatrics & Allergy are dedicated to giving the best care to our patients. Our focus is on their health whether it be medical, psychological or emotional. We are NOT here to discuss legal issues regarding divorce, separation, or custody agreements. We cannot be put in the middle of domestic issues or disagreements over the phone or in the office.

- When a child visits our office accompanied by either parent, we will assume that parent has full legal custody and authority to make medical decisions for the child, unless we are instructed otherwise, **in writing, by a court order.**
- It is the parents' responsibility to communicate with each other regarding the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits. They can have access to the visits in writing with a signed medical release form. We reserve the right to charge an administrative fee for copying records should the requests become excessive.
- We will not call the other parent for consent prior to treatment or restrict either parent's involvement in the patient's care unless authorized by law. We will not tolerate appointment scheduling/canceling patterns of behavior between parents.
- We cannot mediate financial disputes between parents. When children visit our office, we hold the accompanying parent/guardian responsible for any balances and co-payments required.
- Should the issues that come between parents become disruptive to our practice or interfere with the care of child(ren), we reserve the right to discharge your family from further treatment.

Signature of Parent: ______________________________ Date: ____________

BAMA PEDIATRICS & ALLERGY

2701 20th Ave
Northport AL 35476

Bama Pediatrics Payment Policy

Thank you for choosing us as your primary care provider and/or allergy specialist. We are committed to providing you with quality and affordable health care. Please read it carefully, ask us any questions you have and sign in the space provided.

1. **Insurance**: We participate in most insurance plans, including BCBS, Medicare, Medicaid, UHC, Aetna, Cigna, etc. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are uninsured by a plan we participate in but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. It is your responsibility to know your insurance benefits. Please contact your insurance company if you are not sure of your coverage. We file your insurance as a courtesy and we cannot make them pay.
2. **Co-payment and Deductibles**: All co-payments and deductibles must be paid at the time of service. The arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services**: Please be aware that some and perhaps all of the services you received may be non-covered or not considered reasonable or necessary by some insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance**: All patients must complete our patient information form before seeing a doctor. We must obtain a copy of your current valid insurance card to obtain proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If your insurance changes, it is your responsibility to notify our office. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
5. **Claims Submission**: We will submit your claims and assist you in any way we can to get your claims paid within reason. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
6. **Nonpayment**: Our billing company will send out two (2) statements and a priority letter before turning your account over to collection. You will be required to pay your balance at your next appointment. Nonpayment may result in you or your child not being seen at our office and possible dismissal from our practice. If dismissal occurs, we will notify you through mail and you have 30 day to find a new doctor. During that 30 day period, our physician will treat you or your child.
7. **Missed appointments**: Our policy is to charge a fee of $25 for missed appointments. We reserve this time for you and your child. Excessive no shows and you may be asked to find another doctor. <u>All fees will have to be paid at your next visit</u>.
8. **Medical Records Fee**: If you or your child changes doctors please be aware there is a $20 fee per child. If there is a balance on your account that will have to be paid in full. It does not matter if you or another doctor's office requests them. The fee is the same. Please beware there is a 72 hour notice for all medical records. Please note Alabama Law allows us to charge a $5 fee for a medical records search and $ 1.00 for the first 25 pages and $ .50 for any additional pages.
9. **Immunization Records**: We require a 48 hour notice for an Immunization form request. If you owe a balance, it has to be paid in full before the form will be release to you.
10. **After-hours calls**: Due to the high volume of non-urgent call we are now charging $20 for all calls made to our after-hours call center.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. **Please let us know before you sign this agreement if you have any questions or concerns.**

I have read and understand the payment policy and agree to abide by its guidelines.

______________________________ ____________________
Signature of patient or responsible party Date

____
Print name of responsible party

BAMA PEDIATRICS & ALLERGY
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Patient's Name: ______________________________

DOB: ______________________________

Please list all names below that are allowed to accompany your child(ren) to Bama Pediatrics.

- By writing these names, you are allowing them to sign the consent for Authorizations for Payment and Treatment.
- Please be advised that patient's health information may be shared with whomever is accompanying the child(ren).

NAME:	RELATIONSHIP:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

I, ____________________________, give the above listed person(s) permission to make informed decision in the care of your child (such as immunizations, allergy shots, allergy testing and any medical necessity decision and/or procedures).

____
Print Legal Name

____
Signature

____
Date