TLC Pediatrics, PA

Parents/Guardian Information:

Mother's Name:_____ Date of Birth: ___/____/_____
*Social Security Number: _____ *Driver's License: _____
Insurance Policyholder Yes No Employer: _____
Home Address: _____
Cell Phone: (____) _____- _____ Alternate Phone: (____) _____- _____
E-mail Address: _____

Father's Name:_____ Date of Birth: ___/____/_____
*Social Security Number: _____ *Driver's License: _____
Insurance Policyholder Yes No Employer: _____
Home Address: _____
Cell Phone: (____) _____- _____ Alternate Phone: (____) _____- _____
E-mail Address: _____

Patient Information:

Name: _____ Date of Birth: ___/____/_____ Sex: Male Female
Please select a primary physician. Daniel Moulton, MD, FAAP Jenna Cash, DO, FAAP

Name: _____ Date of Birth: ___/____/_____ Sex: Male Female
Please select a primary physician. Daniel Moulton, MD, FAAP Jenna Cash, DO, FAAP

Name: _____ Date of Birth: ___/____/_____ Sex: Male Female
Please select a primary physician. Daniel Moulton, MD, FAAP Jenna Cash, DO, FAAP

Name: _____ Date of Birth: ___/____/_____ Sex: Male Female
Please select a primary physician. Daniel Moulton, MD, FAAP Jenna Cash, DO, FAAP

How did you hear about our practice? _____

***Must be completed for policy holder.**

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Appointment Scheduling

Well visits and medication checks should be scheduled a minimum two weeks in advance. Problem / illness visits are always scheduled the same day. Calls received before 11:30am will be scheduled in the morning. Calls received after 11:30am will be scheduled in the afternoon. Please state your preferred provider when requesting an appointment. We require 24 hour notice of cancellation for wellness visits and medication checks. Please be advised there may be a charge associated with appointments cancelled the same day and "no show" appointments.

Saturday Clinic

We are open most Saturday mornings to treat illness and injuries. We will not have Saturday clinic on holiday weekends and will occasionally be closed for training. Please check our facebook page for notice of these closures.

Financial Policy

Copayments, coinsurance and deductible payments are due at time of service. An additional balance may be due after your insurance payments are applied to your account. Please remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All outstanding balances greater than 90 days old will be turned over to a collection agency unless prior arrangements have been made with this office. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25 % of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

After Hours Nurse Triage

Our nurses are available by phone during clinic hours. After hours we utilize a triage service. These calls are answered by registered nurses and the advice given is based on the Barton Schmitt protocol for pediatrics. There is a charge of $20 per call for patients age 6 months and older. This triage information can also be found on our website. We encourage you to read the "Is Your Child Sick" information available at www.tlcpedi.com before placing a call to the after hours service.

Parent Signature: _____ Date: _____

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HIPAA Release of Information Agreement

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Records may be delivered to any physician that is directly or indirectly responsible for you medical care the payment thereof. We are legally obligated due to the compliance with HIPPA, to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. You may speak with the Office Manager to obtain additional information regarding questions you may have concerning this Notice or to receive a printed copy of the Notice.

Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

I wish to be contacted in the following manner:
Primary Phone: _____ Leave a detailed message: Yes No *Text message: Yes No
Alternate Phone: _____ Leave a detailed message: Yes No *Text message: Yes No
Email: _____
*Text messages will not contain health information. Detailed messages may contain health information.

Statements, requested medical records and appointment reminder cards may be mailed to the following address:

_____
_____
Street Address City State Zip

The individuals listed below may schedule appointments and request medical information related to my child / children.
Name:_____ Relationship to Child: _____
Name:_____ Relationship to Child: _____

In the event that I am unable to attend an appointment I authorize the individuals listed below to consent to medical treatment for my child/children.
Name:_____ Relationship to Child: _____
Name:_____ Relationship to Child: _____

Parent Signature: _____ Date: _____

Immunization Policy / Vaccination Schedule

Routine childhood immunizations have contributed to a significant reduction in many life threatening childhood diseases. Our providers believe it is important to adhere to the recommended immunization schedule. We understand that parents may have questions about vaccines and we are committed to taking the time during well visits to answer all your questions. In our practice we utilize combination vaccines. Combination vaccines combine protection against two or more diseases into one injection. Our combination vaccines are Pentacel (dtap, HIB and polio), ProQuad (varicella and MMR) and Quadracel (dtap and polio).

We do not accept new families who have made a decision to refuse or delay vaccinations for non-medical reasons. We encourage these parents to schedule a meeting with one of our providers to discuss their decision. If, despite our recommendations, parents refuse immunizations after they have already established care with us, we will ask you to seek a different pediatric practice for your child's care.

	Hep B	Pentacel	Prevnar	Rototeq	ProQuad	Hep A	Quadracel	Adacel	Menactra	Trumenba**	Gardasil**
3-5 Days *	**x**										
1 mo	**x**										
2 mo		**x**	**x**	**x**							
4 mo		**x**	**x**	**x**							
6 mo		**x**	**x**	**x**							
9 mo	**x**										
12 mo					**x**						
15 mo		**x**	**x**								
18 mo						**x**					
2 year						**x**					
4 year					**x**		**x**				
11 year								**x**	**x**		**x**
16 year									**x**	**x**	

*If not given in the hospital at birth **Recommended but not required

Treatment Consent

I agree to allow my child to receive medical care at TLC Pediatrics. This consent applies to routine medical care including, but not limited to, physical exams, routine testing, office treatments and standard vaccinations. I understand that no interventions or treatment will be performed without first discussing with a parent / guardian.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Parent Signature: ____ Date: _________________________