

KIDS FIRST PEDIATRIC SPECIALISTS

John F. Norton, M.D.
Deborah A. Hall, M.D.
Angella M. Talley, M.D.
Sarah Birge, APRN

1263 Hospital Dr. NW, Suite 180
Corydon, IN 47112
812-738-1200

5300 State Road 64, Suite 105
Georgetown, IN 47122
812-366-0012

Fax 812-738-1710

To Whom It May Concern:

We are pleased that you have chosen Kids First Pediatric Specialists as your pediatricians.

Our office hours are as follows:

Corydon:

Monday & Tuesday 7:30AM-6PM
Wednesday & Thursday 8:30AM-5PM
Friday 8:30AM-4:30PM

Georgetown:

Monday, Wednesday, Thursday 7:30AM-6PM
Tuesday 8:30AM-6PM
Friday 7:30AM-4:30PM

What we need from you:

Demographic forms (enclosed)
Medical records from your previous physician
Insurance card
Photo I.D.

It is our policy that we require you to arrive ten minutes prior to your appointment time, or we will ask you to reschedule.

If you have any questions, please feel free to contact my office at (812) 738-1200 ext. 4404

Sincerely,

Jennifer Lowe
Office Manager

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

KIDS FIRST PEDIATRIC SPECIALIST
5300 State Road 64, Suite 105
Georgetown, IN 47122
F: (812) 738-1710

Name of Patient:		Social Security Number:	Address of Patient:	
			Street _____	
Telephone Number:	Birthdate:	Age:	City _____	
()			State _____	Zip _____

AUTHORIZATION IS GIVEN BY THE UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

F R O M	Name of Organization or Person to RELEASE information:
	Street _____ City _____ State IN _____ Zip 47112
T O	Name of Organization or Person to RECEIVE information:
	Street _____ City _____ State _____ Zip _____

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:

- Continuing medical care
 - Claim for reimbursement
 - Litigation against third party other than [COVERED ENTITY], a [COVERED ENTITY] employee, or a physician
 - Litigation against [COVERED ENTITY], a [COVERED ENTITY] employee, or a physician (*Specify*) _____
- At the patient's request _____
- Other (*Specify*) _____

I understand that this authorization can be revoked by me at any time by submitting a written request to _____
 I understand that revocation will not apply if [COVERED ENTITY] has already released by information.
 I understand that [COVERED ENTITY] cannot require me to sign this authorization as a condition for providing treatment or obtaining payment for same.
 I understand that the material released as a result of this authorization may be subject to redisclosure and no longer protected by the laws applying to medical information release.
 This authorization will expire as follows: NONE

INFORMATION TO BE RELEASED

Dates of treatment:	Type of treatment:
	<input type="checkbox"/> Inpatient
	<input type="checkbox"/> Emergency Room
	<input type="checkbox"/> Outpatient

- Face Sheet
- History & Physical
- Discharge Summary
- Consultation Report
- Operative Report
- Pathology Report
- Emergency Room Report
- Entire Record
- X-ray Reports (*Specify type or all*) _____
- Laboratory Reports (*Specify type or all*) _____
- HIV Results
- Check here to request the information in electronic format (applies only to information we maintain in an electronic health record).

(Signature of Patient)

(Date Signed)

(Signature of Other Authorized Person)

(Relationship to Patient)

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative the spouse or adult child of a deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self.

HCH Physician Practices
Patient Registration and Consent to Treat

Primary Care Physician: _____
Pharmacy: _____

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
SSN: _____
Email Address: _____

Student: Yes No Name of School: _____
Do you consider yourself Hispanic or Latino: YES NO Primary Language: _____

Guarantor: _____ DOB: _____
Relationship: _____ SSN: _____
Employer: _____

Emergency Contact: _____ Relationship: _____
Phone:(MUST BE DIFFERENT THAN PATIENTS) _____

PROVIDE CARD AT CHECK IN

Primary Insurance: _____
Subscriber's Name: _____ DOB: _____
Relationship to Patient: _____ SSN: _____
Address (if different): _____
Cardholder's Employer: _____

PROVIDE CARD AT CHECK IN

Secondary Insurance: _____
Subscriber's Name: _____ DOB: _____
Relationship to Patient: _____ SSN: _____
Address (if different): _____
Cardholder's Employer: _____

Patient/Guardian Signature _____ Date: _____

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AUTHORIZATION FOR CONSENT TO TREAT A MINOR

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

I, _____, as the Parent/Legal Guardian of the above-named minor, do hereby authorize the Designated Individual(s) listed below (must be 18 years of age or older) to give consent for the above-named minor:

(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

(Printed Full Name of Individual Authorized to Consent) (Relationship) Contact Phone Number

for the following Medical Treatments: **(CHECK ONE)**

All surgical and medical treatment, including vaccinations, deemed necessary by the provider.

– OR –

Only the surgical and/or medical treatment deemed necessary by the provider for the condition or symptoms listed below: **(SPECIFY CONDITION OR SYMPTOM)**

This authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature: _____ Date: _____
(must be signed by Parent or Legal Guardian)

VERBAL CONSENT WITNESSED BY: (Two KFPS associate/provider witnesses are required)

Signature: _____ Date: _____
(Witness #1 – KFPS associate/provider)

Signature: _____ Date: _____
(Witness #2 – KFPS associate/provider)

KIDS FIRST PEDIATRICS SPECIALISTS VACCINE POLICY STATEMENT

Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated. We will vaccinate according to the below schedule which follows AAP recommendations. Combination vaccines are incorporated into the schedule to minimize the number of individual shots given at one visit.

Birth: Hep B vaccine. Optional seasonal RSV monoclonal antibody
2 mos: Hep B, DTap, Polio, Hib, Rotavirus, and Pneumococcal vaccines
4 mos: DTap, Polio, Hib, Rotavirus, and Pneumococcal vaccines
6 mos: Hep B, DTap, Polio, Hib, Rotavirus, and Pneumococcal vaccines. Optional seasonal Flu and Covid vaccines and yearly thereafter pending CDC recommendations
12 mos: Hep A, Measles, Mumps, Rubella, and Varicella Vaccines
15 mos: DTap, Polio, Hib, and Pneumococcal vaccines
18 mos: Hep A vaccine
4 year: Measles, Mumps, Rubella, Varicella, DTap, and Polio vaccines
11 year: Tdap and Meningococcal ACYW vaccines. Optional HPV series.
16 year: Meningococcal ACYW and Meningococcal B vaccines
16 year and 6 months: Meningococcal B vaccine.

Initial _____

We will **NOT** allow alternate catch up schedules, delayed vaccine schedules, nor spacing of vaccines. Spacing of vaccines/alternative/delayed schedules have not been scientifically evaluated for safety and efficacy. Please be advised, that delaying or spacing of vaccines 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 Kids First Pediatrics.

Initial _____

We will answer your questions about vaccines **PRIOR** to your appointments and present you with facts. However, if you choose to not vaccinate at the appointments despite our efforts, we will ask you to find another healthcare provider who shares your views within 30 days. We do not keep a list of such providers, nor would we recommend any such physicians.

Initial _____

<https://www.chop.edu/vaccine-education-center>

[Vaccine Information Statements](#) | [Pediatric Patient Education](#) | [American Academy of Pediatrics](#)

Sincerely,

All of your healthcare providers at Kids First Pediatrics:

John F. Norton, MD

Deborah A. Hall, MD

Angella M. Talley, MD

Sarah Birge, APRN

My signature below acknowledges that I have reviewed the above policy and I have agreed to vaccinate according to the above schedule or I will be asked to find another health care provider within 30 days.

Signature of parent/guardian _____ Date _____

HCH Physician Practices
Authorization Signature Form for HIPAA

Please Print

Patient Name: _____

Date of Birth: _____

Your signatures on this form acknowledges receipt of this notice, and that you have been given the opportunity to review it and ask questions regarding its concerns.

Please designate below the individuals (i.e. family members, caregivers, power of attorney, etc) with whom we may discuss your care. Other than the entities listed in the Notice of Privacy Practice any individual not listed below will not be given information about your care without your permission.

Patient Signature/Responsible party: _____ **Date** _____

Witness: _____ **Date** _____

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PATIENT PREFERENCES FOR WRITTEN AND ORAL COMMUNICATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of personal health information. The individual is also provided the right to request confidential communications regarding their personal health information be made by alternative means, such as sending correspondence to the individual's office rather than their home. Please complete the following information so that we may provide your child's information to you in a confidential manner that is to your liking.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (check all that apply)

Home phone: _____ Cell phone: _____

OK to leave a message with detailed information []

OK to leave a message with another adult in the household (ex. Spouse, grandparent, babysitter, etc.) []

Leave message with call-back number only []

Work Phone _____

OK to leave message with detailed information []

Leave message with call-back number only []

Written Communication

OK to mail to my home address []

OK to mail to my office address []

OK to fax to this number _____ []

Other Information: _____

Signature: _____

Date: _____

Kids First Pediatric Specialists
Historical Intake Form

Name _____

Date of Birth _____

*Medical Problems—Current and past medical problems affecting your child—such as allergies, eczema, etc

*Allergies—Please list any known allergies and the child's reaction to the allergen

Medication(s) _____ Reaction _____

Food(s) _____ Reaction _____

Insects/Bee(s) _____ Reaction _____

*Medication—List medication name(s), strength, and dosing. Check the appropriate box to the right. Include prescription and non-prescription medications and vitamins. Remember inhalers. Tell the nurse if there are other medications or write them in at the end of the form.

As needed

As needed

1. _____ [] 3. _____ []

2. _____ [] 4. _____ []

*Social History

Child lives with _____

Pets/Animals Cat [] Dog [] Fish [] Chicken/Birds [] Farm Animals [] Other _____

Smoke Exposure None [] In-home [] Outside of Home []

Water Source Public/City [] Well [] Cistern []

Heat Source Electric [] Gas [] Indoor Wood Stove [] Outdoor Wood Stove []

*Surgeries—Please include date or year of surgery if known.

Ear Tubes [] Date(s) _____ How many sets? _____

Tonsillectomy [] Date _____

T & A [] Date _____

Fracture Repair [] Date _____ Site _____ Outside pins [] Internal pins/plates []

Oral Surgery [] Date _____

Other Surgeries _____ Date _____

*Hospitalizations (Overnight stay other than newborn) [] None

Reason _____ Date _____

*Therapy Services—List the service(s) that your child is currently receiving and who is providing the service(s). i.e. PT, OT, ST, DT

*Family History—Please mark the problems on this list that have affected someone in the child’s biological family. Indicate the relationship of that person to the child. List maternal or paternal. May go as far back as great-grandparents.

- | | | | |
|---------------------|-----------|----------------------|-----------|
| Acid Reflux (GERD) | [] _____ | Kidney Disease | [] _____ |
| Allergies | [] _____ | Lupus | [] _____ |
| Anemia | [] _____ | Mental Illness | [] _____ |
| Arrhythmia | [] _____ | Migraines | [] _____ |
| Asthma | [] _____ | MRSA (in same house) | [] _____ |
| Cardiomyopathy | [] _____ | Rheumatoid Arthritis | [] _____ |
| Crohn’s Disease | [] _____ | Seizures | [] _____ |
| Diabetes | [] _____ | Stroke | [] _____ |
| Eczema | [] _____ | Sudden Death at age | |
| Gallbladder issue | [] _____ | less than 50 yrs | [] _____ |
| Heart Defect | [] _____ | High Thyroid | [] _____ |
| Heart Disease | [] _____ | Low Thyroid | [] _____ |
| High Blood Pressure | [] _____ | Ulcerative Colitis | [] _____ |
| High Cholesterol | [] _____ | Urinary Reflux | [] _____ |
| Cancer | [] _____ | | |

Type _____ Relationship _____

Type _____ Relationship _____

Genetic Diseases/Mutations [] _____

Type _____ Relationship _____

Other Problems [] _____ Relationship _____

*Birth History

Weeks gestation _____ Vaginal [] or C-section delivery []

Any complications with pregnancy or delivery? _____

Treated with IV antibiotics as a newborn? Yes [] No []

If you are a new patient/family, how did you learn about our office? _____

Please return this form to the nurse or receptionist. Thank you for taking your time to help us.

New Patient Information

CHILD'S FULL NAME _____

DOB _____ BIRTH WEIGHT _____ LENGTH _____

Has he/she ever spent the night in the hospital?

When: _____ Where: _____

Why: _____

Has your child had any of the following illnesses?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures or Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No Chickenpox |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies/Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Ear Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Strep Throat |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint or Muscle Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Problem Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Problem Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Medicine Allergy |

If any were checked YES please explain (ex: when, how often, family history of?)

Does your child see any specialists? Yes No

If so, please list the name(s) of the specialist(s) and the reason.

How would you describe your child's appeettie? Good Fair

Date last seen by a doctor? _____ Date last seen by a denist? _____

QUESTIONS FOR PARENTS OF NEWBORNS ONLY

Did you have any problems during pregnancy? Yes No

Was the baby within 2 weeks of being on time? Yes No

Were there problems at delivery? Yes No

Did the baby go home with your form the hospital? Yes No

Have you had any miscarriages? Yes No

How do you feed your child? Breast? How often? _____
Formula? Brand? _____ Amount per day? _____

TO WHOM MAY WE THANK FOR REFRRING YOUR FAMILY TO OUR OFFICE?

Name: _____ Address: _____

KIDS FIRST PEDIATRIC SPECIALISTS POLICIES AND PROCEDURES

Thank you for choosing Kids First Pediatric Specialists as your pediatrician. We are committed to providing your child with the best possible care. We want to make sure you have a clear understanding of our policies, as this is very important to our professional relationship.

INSURANCE

We do file insurance as a “courtesy” to our patients. While we are participating with most insurance companies, it is your responsibility to know prior to your appointment if our providers are participating with your insurance plan.

It is also your responsibility to know what your insurance plan benefits are (what is covered/not covered). Some insurance plans have copayments, deductibles, and/or coinsurance. Copayments are due at the time of service. This is per your insurance guidelines. If you do not have your copayment at time of service, you will be asked to reschedule.

Once insurance is filed and we receive a remittance advice back from them, any balances due by you will be sent out via a statement. We ask that you send in payment promptly to avoid us having to refer the account to an outside collection agency, in which additional agency fees may apply. If you are having financial problems, we ask that you contact our billing department to set up payment arrangements to keep your account current.

If you do not provide us with accurate insurance information for each visit, and within the timely filing limits set by your insurance company, you will be held responsible for any balances due. The same applies in situations where the insurance company has requested additional information from you. If the information requested is not received by you and the claim is denied, you will be responsible for all charges incurred.

Since insurance changes occur frequently, you will be required to present your insurance card at **each and every visit** to ensure that we have the most up to date policy.

If your insurance company requires your child to be assigned to a specific primary care provider and one of our providers is not listed as the primary care provider, you will be asked to reschedule the appointment until it is updated and confirmed.

Most insurance companies pay 100% for well child visits, but please note that if you bring your child in for a well visit and they are having an acute illness or problem, a sick visit may be charged in addition to the well visit, resulting in you being responsible for your copayment, deductible, and/or coinsurance.

If your child does not have health insurance, payment is due at time of service. We do offer a cash discount to patients without health insurance coverage. To receive the discount, the visit must be paid at the time of service.

We accept the following payment types: Cash, check, money order, Visa, Mastercard, and Discover.

RETURNED CHECKS

If a check is returned, there will be a \$25.00 fee added to the account. The returned check fee and balance must be paid before any further services are rendered, and checks will no longer be allowed as a payment type for any future balances on the account.

MINOR AGE PATIENTS

We encourage that all patients be accompanied by an adult and that billing arrangements be made with our office ahead of time. If treatment is rendered we resume, in good faith, that the parents or guardians are responsible for any and all charges that are incurred. We do ask that whomever may be bringing your child to an appointment be listed on the Medical Authorization form.

PREGNANCY

It is our policy that if we have a patient that becomes pregnant or marries, we ask that they seek care of an adult PCP. As a pediatrician, we treat only the child and not the parent and the child.

FORMS

Please bring with you any form that needs completed for school, sports, daycare, etc. to your child's scheduled appointment. This will be completed at no charge, as part of the office visit. FMLA forms, or any other forms that need to be completed outside of a scheduled appointment, do require a \$20.00 fee to be paid in advance of the paperwork being filled out. This will not be billed to your insurance.

MEDICAL RECORDS

We will provide one copy of the patient's medical records upon request, at no charge, to be released to the parent or other physician's office. In accordance with the Indiana State Statute IC 16-39-9-4, Kids First Pediatric Specialists will provide additional copies of the records for the following fees.

- \$15.00 for the first 10 pages of records.
- \$0.25 for each additional page thereafter.
- An additional \$10.00 rush fee may be applied to provide the records within 2 working days of the request.
- Notary fee \$10.00

SICK APPOINTMENTS

These appointments are typically scheduled as same day appointments. Same day appointments may be scheduled with a provider other than your usual provider.

WELL CHECK APPOINTMENTS

These appointments are typically scheduled in advance. On some occasions, we may be able to accommodate scheduling a well visit same day, depending on availability. It is recommended that you schedule your child's next well visit appointment prior to leaving the office. Well checks will only be scheduled with your usual provider.

MEDICATION CHECKS

We ask that you schedule these appointments in advance to avoid potential problems with getting your child's medication(s) refilled.

MISSED APPOINTMENTS (NO SHOWS)

These are tracked and may result in dismissal from the practice. 3 no shows in a calender year equals grounds for dismissal. If you know you are not going to be able to make it to your child’s appointment, please call to cancel and/or reschedule. We do understand that there may be times when you cannot make it to an appointment due to emergencies or obligations for work or family. However, when you do not call and cancel your child’s appointment, this may prevent another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule your child for a visit, due to a seemingly “full” appointment schedule.

CANCELLATIONS

We ask that you try to give our office as much advance notice as possible when cancelling an appointment. We do understand that there may be times when you must cancel an appointment due to emergencies or obligations for work or family. However, when you do not give an advance notice, this also may prevent another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel with advance notice and we are unable to schedule your child for a visit, due to a seemingly “full” appointment schedule.

LATE POLICY

If you are more than 10 minutes late for your child’s appointment, you will be asked to reschedule the appointment. New Patients are asked to be at their appointment 10 minutes prior to their appointment time. 10 minute late policy applies according to the time you are asked to be at our office.

TELEPHONE MESSAGES

Please note that it may take up to 24 hours to receive a call back on a message that was left for the provider. In most situations, messages are returned at the end of the day, after all patients have been seen.

COURTESY

We strive to provide the best medical care for our patients. While we make every effort to provide on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We appreciate your understanding and patience. Angry or foul language directed to our staff regardless of the issues involved will absolutely not be tolerated and will be grounds for immediate dismissal from our practice.

I have read and understand the above policies and procedures of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient Name & DOB (Please list all children)

Patient or Responsible Party

Date