KIDS COVE
PEDIATRICS

Vaccine Policy

We require all patients adhere to the vaccination schedule endorsed by the American Academy of Pediatrics.

Kids Cove Pediatrics requires meningitis and HPV vaccines. ____ Initial Here

We stand firm in our knowledge that vaccines are safe and effective and absolutely the right thing to do for all children and young adults.

We do not offer an alternate schedule or spacing of vaccines. _____ Initial Here

Consent for Vaccination

By signing this document, you acknowledge and <u>consent</u> to all required vaccines recommended by Kids Cove Pediatrics listed below on our Consent for Vaccination Form.

2 Months – **Pediarix** (DTap, Polio, Hep B), **Hiberix** (haemophiles influenza type B), **Vaxneuvance** (pneumococcal 15), **Rotarix** (Rotavirus types G3, G4, G9)
4 Months – **Pediarix** (DTap, Polio, Hep B), **Hiberix** (haemophiles influenza type B), **Vaxneuvance** (pneumococcal 15), **Rotarix** (Rotavirus types G3, G4, G9)
6 Months – **Pediarix** (DTap, Polio, Hep B), **Hiberix** (haemophiles influenza type B), **Vaxneuvance** (pneumococcal 15)
12 Months – **Priorix** (MMR), **Varivax** (Varicella), **Havrix** (Hep A), **Vaxneuvance** (pneumococcal 15)
15 Months – **Infanrix** (DTap), **Hiberix** (haemophiles influenza type B)
18 Months – **Havrix** (Hep A)
4 years – **Proquad** (MMR and Varicella combo), **Kinrix** (DTap and Polio combo)
11 years – **Gardasil 9**(protects against HPV 6, 11, 16, 18, 31, 33, 45, 52 & 58) (6 mo follow up for **Gardasil 9**#2), **Boostrix** (Tdap), **Menveo** (MeningitisACYW135)
16 years – **Menveo** (MeningitisACYW135), **Bexsero** (6 mo follow up for MenB#2)

Patient's name: _____ DOB:_____
Patient's name:_____ DOB:_____
Patient's name: _____ DOB:_____
Patient's name: _____ DOB:_____
Patient's name: _____ DOB:_____

By signing this document, you acknowledge and <u>agree (consent)</u> to our vaccine policy.

Parent/Guardian's Name: _____

Parent/Guardian's Signature_____ Date_____

Please fill out the forms entirely and accurately.

Patient Information

Child 1: Legal Name: _____ DOB:_____ Birth Gender: M/F
Nickname: _____ Race:_____ Ethnicity:_____
Resides with the following parent/guardian: _____
Email and phone (if age 16+): _____

Child 2: Legal Name: _____ DOB:_____ Birth Gender: M/F
Nickname: _____ Race:_____ Ethnicity:_____
Resides with the following parent/guardian: _____
Email and phone (if age 16+): _____

Child 3: Legal Name:_____ DOB:_____ Birth Gender: M/F
Nickname: _____ Race:_____ Ethnicity:_____
Resides with the following parent/guardian: _____
Email and phone (if age 16+): _____

Child 4: Legal Name:_____ DOB:_____ Birth Gender: M/F
Nickname: _____ Race:_____ Ethnicity:_____
Resides with the following parent/guardian: _____
Email and phone (if age 16+): _____

Child 5: Legal Name:_____ DOB:_____ Birth Gender: M/F
Nickname: _____ Race:_____ Ethnicity:_____
Resides with the following parent/guardian: _____
Email and phone (if age 16+): _____

Primary Contact (Parent/ Legal Guardian)

__ Mom __Dad __ Guardian
Primary Contact Legal Name:_____ Date of Birth: _____
Cell phone:_____ Email:_____
Employer:_____ Occupation:_____
Address:_____
Practice contact preference: __Cell __Email

Secondary Contact (Parent/ Legal Guardian)

__ Mom __Dad __ Guardian
Secondary Contact Legal Name:_____ Date of Birth: _____
Cell phone:_____
Email:_____
Employer:_____ Occupation:_____
Address: _____
Practice contact preference: __Cell __Email

Electronic Communication Consent

I authorize Kids Cove Pediatrics to contact me by phone, voicemail, text message (SMS), and through the patient portal regarding my child's appointments, healthcare, prescriptions, laboratory results, referrals, billing, and other healthcare-related matters.

I understand that:

- Standard message and data rates may apply.
- It is my responsibility to provide current contact information to the practice.
- To ensure your message is HIPAA protected, documented in your child's medical record, and directed to the appropriate care team, please use the **patient portal** for all non-urgent medical questions, prescription refill requests, and follow-up concerns. Providers and staff should not be contacted through other methods to include, but not limited to: Facebook, Instagram, TikTok, personal cell phone, and other social media platforms. _____ Initial Here
- **Portal messages must NOT be used for an emergency or urgent medical concerns**:
    - **If your child is experiencing a medical emergency, call 911 or go to the nearest emergency department immediately. Do not send a portal message. _____ Initial Here**
    - **If your child ingests any object or substance, do not send a portal message or call and leave a message. Call Poison Control 1-800-222-1222 immediately. _____ Initial Here**
        - We strongly recommend programming Poinson Control into your phone
- Portal messages are NOT for urgent medical requests and are only responded to during clinic hours of 8am through 4pm Monday through Friday. The portal is not monitored on the weekends or after 4pm on the weekdays. **_____ Initial Here**
- **I acknowledge the practice will not diagnose or discuss new medical concerns through the patient portal and requires an appointment for evaluation. _____ Initial Here**
- You understand and agree that all electronic communications sent through the portal will be documented in your child's medical record in accordance with HIPAA regulations.
- I may revoke this consent at any time by notifying Kids Cove Pediatrics in writing.
- The practice reserves the right to terminate or restrict portal access if these terms are not followed.
- **Access to records is available for all children under 18 years of age.**
    - When a patient turns 18 years old in Alabama, by law, their record automatically becomes private.
    - I understand the practice requires a portal account and email address be maintained to communicate care and billing concerns regarding the child(ren) managed at the practice.

By signing below, I acknowledge that I have read and understand the Electronic Communication Consent.

Parent/Legal Guardian Signature: _____

Printed Name: _____ **Date: _____**

Preferred Pharmacy (Name and Street): _____

Custody and Legal Restrictions
Are there any legal restrictions that would restrict a parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Both parents will automatically have authorization unless court documents are presented specifically stating one is not authorized.

□ Yes □ No
If yes, please explain and provide a copy of any legal paperwork that supports the restriction:
_____

Authorization Other Than Parent or Guardian
I hereby authorize Kids Cove Pediatrics providers, and staff, to share any and all medical and financial information with the following individual(s).

- ☐ At this time I do not want to authorize anyone other than parent(s).
- ☐ The individuals listed below have authorization to talk to our staff on the phone and/or bring my child into the office:

Caregiver 1
First & Last Name: _____ Relationship to the Patient:_____

Caregiver 2
First & Last Name: _____ Relationship to the Patient:_____

I understand that I may revoke this consent at any time, and that I must notify Kids Cove Pediatrics in writing.

Signature Parent/Guardian :_____ Date:_____

Printed Name of Parent/Guardian:_____

Consent to Treat Minor

I, the undersigned parent/legal guardian, authorize Kids Cove Pediatrics, and its medical staff to provide medical evaluation, treatment, and necessary procedures, including emergency care, to my child, listed in the new patient paperwork, as deemed necessary by the provider(s). I authorize emergency medical treatment for the above named child(ren) if they are brought into this practice by any person other than myself.

Signature Parent/Guardian :_____ Date:_____

Printed Name of Parent/Guardian:_____

HIPPA & Privacy Policy

I acknowledge that I have received and reviewed Kids Cove Pediatrics' Notice of Privacy Practices, which explains how my child's medical information may be used and disclosed under the Health Insurance Portability and Accountability Act (HIPAA).
I understand that:

- My child's health information may be used for treatment, payment, and healthcare operations.
- I have the right to request restrictions on how my child's information is used or disclosed in writing to the practice.
- I may request a copy of the Notice of Privacy Practices and understand it is always available online: https://kidscovepediatrics.com/Office-Info/Policies

By signing below, I consent to the use and disclosure of my child's health information as described in the Notice of Privacy Practices for all child(ren) listed in the new patient practice registration form.

Signature Parent/Guardian :_____ Date:_____

Printed Name of Parent/Guardian:_____

Insurance and Billing

The responsible party for all medical bills is:
□ Primary Contact
□ Secondary Contact
□ Other: _____

Insurance Information
Primary Insurance Company: _____
Policy/ID: _____ Group: _____
Policy holder full name:_____ DOB: _____
Policy holder relationship to patient: _____ Effective date:_____

Secondary Insurance Company: _____
Policy/ID: _____ Group: _____
Policy holder full name:_____ DOB: _____
Policy holder relationship to patient: _____ Effective date:_____

Tertiary Insurance Company: _____
Policy/ID: _____ Group: _____
Policy holder full name:_____ DOB: _____
Policy holder relationship to patient: _____ Effective date:_____

Assignment of Benefits:
I authorize payment of medical benefits directly to Kids Cove Pediatrics for services provided and authorize the release of medical information necessary for processing claims.
By signing below, I am also <u>verifying that I do NOT have any other insurance policies</u> than what has been provided to the clinic. _____ Initial Here

Signature Parent/Guardian :_____ Date:_____

Printed Name of Parent/Guardian:_____

Kids Cove Pediatrics
Practice Policies and Procedures

Well Visits
Thank you for selecting Kids Cove Pediatrics as your child's(ren's) health care provider. We recommend routine well check-ups per the American Academy of Pediatrics Bright Futures Schedule.

Aging Out of Practice.
We encourage patients to transition to an adult Primary Care Provider (PCP) when they turn 18. We will continue to care for your teen until their 19th birthday. At 19, they will need to see an adult primary care provider (PCP). ____Initial Here

No-Show for Scheduled Appointments*
We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of **$50 per appointment**. No show for immunization only visits will result in a $20 no show fee. **Repeated no-shows will result in the family being dismissed from the practice.** _____ Initial Here

Telephone Advice Billing Disclosure*
Our practice may provide medical advice via telephone when initiated by the parent or guardian. These services are billable, and as a courtesy, we will submit claims to your insurance. If your insurance does not reimburse or applies the service to your deductible, you are responsible for the balance as dictated by your insurance company. **By initiating a telephone consultation for medical advice, you acknowledge and accept financial responsibility.** _____ Initial Here

After-Hours Clinical Services Disclosure*
The Kids Cove Pediatrics website's Medical Library and Symptom Checker, available online 24/7, outlines home care and advises on when to seek medical care. Routine questions, medication refills, appointment scheduling, school forms, billing concerns, and non-urgent concerns should be addressed during normal business hours or through the patient portal. **When a parent or guardian contacts our on-call provider after hours, the After-Hours Fee of $35 is charged to the account, which is not covered by insurance. By contacting the on-call provider, you acknowledge and accept financial responsibility.** _____ Initial Here

Prescription Refills*
The providers at Kids Cove Pediatrics write for medication and refills to last until the patient needs to be seen again in the office. If refills are requested outside of an office visit, a fee of $25 may be assessed. ____Initial Here

Family Dismissal
Kids Cove Pediatrics reserves the right to terminate the patient/practice relationship for the entire family, at any time, due to violation of the practice policies or failure to maintain rapport. _____ Initial Here

Paperwork Requests*
Kids Cove Pediatrics strives to complete all requested forms brought to the appointment while you are present. We understand that families may not always be aware of forms needed during a well visit or office visits. Paperwork requested outside of an appointment may be subject to the following forms fees and require 48-72 hours for the staff and provider to complete the request:
Express Fee (Same Day Need): $30
Additional Letters by Physician/Provider: $30
FMLA Paperwork: $40
Daycare/School Forms: $15
Sports Physical Paperwork Not Brought to Well Visit: $15

Additional Fees*
No Show Fee $50
After Hours Fee $35
Prescriptions Outside of An Office Visit: $25
Ear Piercing $75
Repeat Requests to Send Referral to A New Agency: $25
Returned Check Fee $30
Declined Credit Card Fee (if practice is not alerted/CC updated): $25
_____ Initial Here

*Medicaid eligible/enrolled patients are exempt from additional fees per Alabama Administrative Code 560-X-38-.09

Financial and Billing Policies

I understand I am required to present ANY and ALL insurance information before the scheduled appointment. Failure to present accurate insurance policy information can result in a claims denial making me financially responsible for the entire visit. I understand and will complete a coordination of benefits if requested by Kids Cove Pediatrics staff if I hold more than one insurance policy. _____ Initial Here

Kids Cove Pediatrics will send claims to your insurance. I acknowledge that my insurance may not cover all services and am responsible for any balances sent to personal responsibility as determined by my insurance company. I acknowledge and understand that payment for outstanding balances is required before the visit and co-pays are due at the time of service and cannot be waived or collected later. _____ Initial Here

I have confirmed that Kids Cove Pediatrics is in-network with my insurance plan. I understand that if my insurance requires a Primary Care Physician/Provider (PCP) designation, I am required to designate Dr. Rhonda Graham as my child's(ren's) PCP **BEFORE** the first appointment at the clinic. I understand failure to designate a PCP may cause my insurance company to not pay for the visit making me responsible for the cost of the entire visit. _____ Initial Here

I understand that unpaid medical bills of more than 120 days past due may be deferred to a collections agency. We encourage you to contact the clinic to set up a payment plan to avoid collections actions. _____ Initial Here

Credit Card on File Policy

Due to the number of high deductible health plans and higher patient co-insurance benefits, we require a credit card on file. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card on file when they inform us of your responsibility. Circumstances when your card would be charged include but are not limited to uncollected copays, coinsurance, deductible, any non-covered services, and/or denial of services.

- Once your insurance processes your claims, an Explanation of Benefits (EOB) is sent to you and our office showing your responsibility. If you disagree with the patient responsibility, please contact your insurance carrier immediately.

If the credit card on file becomes invalid, please notify Kids Cove Pediatrics immediately. If the credit card on file is declined, we will attempt to reach you to update the information. If we are unable to reach you, a fee of

$25.00 may be applied to your account for a declined payment. Credit card information will need to be updated prior to scheduling any future appointments. ____ Initial Here

By signing below, I acknowledge receipt of the Kids Cove Pediatrics *Policies and Procedures*, *Financial Policy*, and *Credit Card on File Policy*. I acknowledge that I have read, understand, and agree to comply with these policies, as they may be amended from time to time in accordance with applicable law. I understand that these policies constitute a part of the agreement governing the professional relationship between Kids Cove Pediatrics and the patient, parent, or legal guardian.

Signature Parent/Guardian :_____ Date:_____

Printed Name of Parent/Guardian:_____

CREDIT CARD AUTHORIZATION

I authorize Kids Cove Pediatrics to charge my deductibles, co-payment, fees, and/or 60-days past due balances under $200 to the credit card listed below. Any balance over $200 not paid in full will require a payment plan on file. Kids Cove Pediatrics will contact you to discuss payment options and establish a written payment plan.

***Newborns** will have a **30 day grace period** to obtain active insurance. After 30 days, the visit will be converted to cash pay pricing and the credit card on file will be charged $140 for the visit.

This authorization will remain in force on each of my children's accounts until they are no longer patients of Kids Cove Pediatrics or until a written request by the cardholder instructing the practice to remove the authorization.

The credit card of file agreement applies to the following children enrolled at Kids Cove Pediatrics

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

Patient's Name:_____ DOB: _____

Your card will be securely encrypted and stored into our payment system.

VISA MC DIS AMEX
Please circle

_____
Last-4 Digits of Card Number

_____
Name On Card

_____
Cardholder Signature

_____
Date of Authorization

_____
Cardholder Email Address for all payment receipts

KIDS COVE
PEDIATRICS

5729 Cove Commons Dr. SE Suite C, Brownsboro, AL 35741 Phone: 256-367-2686 Fax: 256-292-0114

Authorization for Release of Medical Information

Patient Name:_____ **DOB**: _____

I, _____ , hereby authorize the release of medication information

TO: KIDS COVE PEDIATRICS
Address: 5729 Cove Commons Drive SE Ste C, Brownsboro, AL 35741
Telephone: 256-367-2686 FAX: 256-292-0114

FROM: Doctor/Clinic/Hospital: _____
Address:_____
Telephone:_____ Fax:_____

Please release the following:
___ All health information (including growth charts and vaccination records)
___ Developmental Reports
___ History/Physical Exam
___ Discharge Summary
___ Diagnostic Test Reports
___ Progress Notes
___ Consultation Reports
___ Radiology Reports
___ Laboratory Results
___ Pathology Reports
___ Birth Records/Newborn Report
___ Other (specify):_____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records
____ Yes, I consent to the release of this information.
____ No, I do not consent to the release of this information.

Purpose of disclosure:
____ Transfer of Care
____ Treatment/Continuing Medical Care
____ Specialist Referral
____ Other (specify):_____

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date:_____

Print Name: _____

Relationship to Patient: _____