North Augusta Pediatrics

JOHN DAVID ALLEN, M.D. | JESSICA CORRAL DELACRUZ, M.D. | MINDY STANSFIELD, M.D.
LAUREN BOYNTON, FNP-C | ASHLEY DICKERT, CPNP | KATHY SAUMWEBER, PA-C

Welcome to our office, and thank you for selecting us to meet your child's medical needs. We look forward to working with you in the coming years as your child grows. Please take a moment to read this letter which outlines many of the details of our practice.

Our office hours are by appointment. Please always call before coming. We see patients beginning at 8:30 a.m. The office is closed from noon to 12:45 for lunch. We then open again from 12:45 until 5:00 p.m. Our office is open Monday through Friday.

Our Providers

Dr. John David Allen attended medical school and completed a residency in pediatrics at the Medical College of Georgia in Augusta. He is a Board Certified pediatrician and has a wife, Kathy, and three children, Michael, Katherine, and Amanda. He also has 3 grandchildren. He is off on Fridays.

Dr. Jessica Corral Delacruz graduated from medical school at UCC of Puerto Rico and went on to complete her residency in pediatrics at Georgia Regents University in Augusta. Dr. Corral Delacruz is fluent in Spanish, and she is married to Jonathan. She is off on Mondays.

Dr. Mindy Stansfield is a Board Certified pediatrician who received her medical degree and completed her residency in pediatrics at the Medical College of Georgia. She is married to Brian, and they have four children, Charlotte, Reese, Phillip, and Jack. She only works on Wednesdays.

Kathy Saumweber received her Bachelor of Science at Augusta State University and received her B.S. as a physician assistant at the Medical College of Georgia. She is certified by the NCCPA. Kathy is married to Marty, and they have a daughter, Laura. She is off on Thursdays.

Ashley Dickert received her Bachelors in Nursing at Clemson University. She then went to Vanderbilt to get her Masters in Nursing with a specialty as a Pediatric Nurse Practitioner. She is certified by the Pediatric Nursing Certification Board. Ashley is married to Fletcher, and they have three daughters, Zoe, Harper, and Sadie. She is off on Wednesdays.

Lauren Boynton graduated from Clemson University with a Bachelors in Nursing. While working as a RN in Obstetrics and Newborn at the hospital, Lauren went on to obtain her Doctorate in Nursing from Augusta University as a Family Nurse Practitioner. She is certified by the American Association of Nurse Practitioners Board. She is off on Tuesdays.

Our after-hours call group consists of four practices. Our offices rotate weekends, and one of the offices will be open on Saturday and Sunday afternoons from 12:00 p.m.—2:00 p.m. The four offices include our office, The Pediatric Office in Evans, Able Pediatrics in Martinez, and Tracy Middlebrooks, MD in Augusta. Our website, northaugustapediatrics.com, will have a schedule posted for each weekend. Be certain to call the on-call office before going to make sure they take your insurance. Medicaid and insurance companies now have a number you can call for after-hours medical questions. The number is on your insurance card. If your child needs to be seen at times when our offices are not open we recommend Kid's Prompt Care on Walton Way or the ER at the Children's Hospital of Georgia on Harper St.

Weekend Rotating Call Group

North Augusta Pediatrics
140 Allen Court
North Augusta, SC 29860
(803) 510-0007

The Pediatric Office
4321 University Pkwy
Suite 104
Evans, GA 30809
(706) 854-2600

Tracy Middlebrooks, MD
2315 Central Avenue
Augusta, GA 30904
(706) 667-0070

Able Pediatrics
3727 Executive Center Dr.
Augusta, GA 30907
(706) 842-5331

When you call our office with a problem, the staff will answer the phone. They will record the call, taking all pertinent information. They will then check with a provider, and the provider will either tell them what to do or call you back themselves. In a small number of calls, when the problems are very minor, our staff will advise you without first checking with a provider. However, all calls are recorded, and a provider will see the information sometime within the next hour or so. If the provider feels any corrections need to be made in the instructions given to you, we will call you back. Our goal is to provide excellent medical care for your child. If we feel the child needs to come in and be seen, then we will tell you so. Sometimes, our providers feel comfortable with the child being treated at home, but the parents may be more concerned. Whenever you are worried about your child and wish to be seen, simply let the staff know, and we will have you bring your child in.

If you have any questions concerning charges or bills, please speak with our billing service. Their number is (706) 868-3200 ext 6. When you check in, please give any insurance information to the receptionist. Thank you for taking the time to read this. Again, we look forward to helping you as your child grows. Whenever you are worried about your child, feel free to call us. That is why we are here.

NORTH AUGUSTA PEDIATRICS

JOHN DAVID ALLEN, M.D. | JESSICA CORRAL DELACRUZ, M.D. | MINDY STANSFIELD, M.D. | KATHY SAUMWEBER, PA | ASHLEY DICKERT, PNP | LAUREN BOYNTON, FNP

I request that your office release the following records of my child to North Augusta Pediatrics:

_____ Immunization Forms

_____ Vision / Hearing Screens

_____ Hospital Admission / Discharge Summaries

_____ Radiology and / or Laboratory Reports

_____ Complete Medical Records

Patient's Name _____ Date of Birth _____

_____

Parent / Guardian Signature Date

Name and Address of Previous Physician / Hospital:

_____

_____

_____

_____

140 ALLEN COURT | NORTH AUGUSTA, SC 29860 | 803-510-0007 (P) | 803-510-0144 (F)

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Today's Date:_____

Patient's Full Legal Name:_____ Nickname:_____

☐ Male ☐ Female Date of Birth:_____/_____/_____

Patient's Street Address:_____

City:_____ State:_____ Zip Code:_____

Cell/Home Number:_____ Patient's Social Security Number:_____

Patient Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

(If Other, Please Specify:_____)

If divorced, who has legal custody?_____

Please list responsible party below - If not the Mother/Father, please let us know.

Father's Name:_____ Social Security Number:_____

Father's Street Address:_____ DOB:_____

City:_____ State:_____ Zip:_____ Cell/Home Number:_____

Employed By:_____ Work Number:_____

Mother's Name:_____ Social Security Number:_____

Mother's Street Address:_____ DOB:_____

City:_____ State:_____ Zip:_____ Cell/Home Number:_____

Employed By:_____ Work Number:_____

Do you have medical insurance on this patient? ☐ Yes ☐ No

Name of Primary Insurance Company:_____

Policy Number:_____ Group Number:_____

Policyholder's Name:_____ Relation to Patient:_____

Name of Secondary Insurance Company:_____

Policy Number:_____ Group Number:_____

Policyholder's Name:_____ Relation to Patient:_____

Do you have Medicaid on this Patient? ☐ Yes ☐ No

Medicaid Number:_____

Please list all other children in your household that we see in this office:

Name: Date of Birth:

_____

_____

_____

_____

_____

Nearest Relatives (not living in the household above). These will be used as emergency contacts:

Name:_____ Relation:_____

Address:_____ City:_____State:_____Zip:_____

Cell/Home Number:_____ Alternate Number:_____

Name:_____ Relation:_____

Address:_____ City:_____State:_____Zip:_____

Cell/Home Number:_____ Alternate Number:_____

How did you hear of our practice?_____

PLEASE READ & SIGN THE FOLLOWING INFORMATION CONCERNING SOME OFFICE POLICIES AND ASSIGNMENT OF BENEFITS

Payment Policies:

Payment is expected at time of visit. **WE DO NOT CHARGE OFFICE VISITS**. If you have an insurance that we participate with, we will file the claim for you. However, **ALL COPAYS, COINSURANCES, DEDUCTIBLES, and SELF-PAY AMOUNTS** must be paid **BEFORE** your office visit.

Assignment of Insurance Benefits:

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim.

I,_____ hereby authorize_____to pay and hereby
(Name of Insured) (Name of Insurance Company)

assign directly to North Augusta Pediatrics all benefits, if any, otherwise payable to me for these services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefit when received by and paid to North Augusta Pediatrics will be credited to my account in accordance with the above assignment.

_____ _____

Insured's Signature Date

Initial History Form

****Check appropriate boxes and fill in blanks as they apply****

Past Medical History:

- Birth: Term_____ Pre-term_____ (_____weeks) Birth weight_____lbs_____oz
  Delivery: Vaginal_____ C-Section_____ Complications_____
  Feeding: Breast_____ Formula_____
- Developmental History: Normal_____ Abnormal_____
- Dietary History: Feeding problems: No_____ Yes (describe)_____
- Immunizations: Up-to-date_____ (Please provide copy of immunization record)
- Medication History:
  Chronic (on-going) medications:
  No_____ ; Yes_____ If so, list name of medication, dosage, and frequency below:
  _____
  Medication allergies:
  No_____ ; Yes_____ If so, list name of medication and type of reaction below:
  _____
- Prior Surgeries: (Check only if applies)
  Ear tubes_____ Tonsil/Adenoid Removal_____ Other_____
- Prior Hospitalizations: (List age and reason for hospitalization)_____
  _____
- Prior Medical Problems: (Check only if applies)
  Allergies____ Asthma____ Bleeding problems____ Blood transfusion____
  Chickenpox____ Diabetes____ Ear/hearing problems____ Eczema____
  Eye/vision problems____ Headaches____ Neurologic problems____ Serious injuries____
  Substance abuse____ Other_____

Social History:

- People living in my child's home: (List name, age, relationship)_____
  _____
- Smokers in the home: No_____ Yes_____
- Pets in the home: No_____ Yes_____ (list type_____)
- School grade_____ ; Day Care Attendance: Planned in the future?_____ Current_____

Family History: (Check only if applies)

- Alcohol abuse____ Allergies____ Anemia____ Asthma____ Bleeding problems____ Deafness____ Diabetes____
  Drug abuse____ Heart disease____ High blood pressure____ High cholesterol____ Immune problems____
  Kidney disease____ Liver disease____ Mental illness____ Mental retardation____ Seizures____
  Tuberculosis____ Other_____

Provider's
Comments:_____

Child's Name:_____

Parent/Guardian Signature:_____

Date:_____

North Augusta Pediatrics Financial Policy

Thank you for choosing us to be your child's primary care physician. Effective 08/22/2017 North Augusta Pediatrics (NAP) will implement a new Financial Policy. Please understand that payment of your bill ensures the practice remains financially healthy and stable so that we may continue to provide care for future generations. If you have any questions regarding this financial policy, please do not hesitate to speak with Management. We will be glad to assist you.

1. **INSURANCE COMPANY**: North Augusta Pediatrics is currently in-network with most commercial insurance plans as well SC and GA Medicaid and their CMO's. It is the responsibility of the parent to determine if the specific doctor you are seeing is in network with your insurance company. Certain "Mom-and-Pop" plan details are not always available to our staff so be sure to contact your insurance company to verify NAP is in network with your current policy. **We depend on you to provide us with correct insurance information so that we may file you claims appropriately. If you provide us with incorrect information and your insurance company denies payment, you may be responsible for all the resulting charges.**

2. **PAYMENTS**: You are financially responsible for the cost of your child's care. If you have a copayment, deductible, or coinsurance due, we will collect it at the time of service. This is due from the parent/guardian who brings the child(ren) to be seen.

3. **PROOF OF INSURANCE**: NAP must obtain a copy of your child's current valid insurance information. If you are unable or unwilling to provide current insurance information, your visit will be paid by you at the time services are rendered.

4. **NEWBORN INSURANCE**: When a child is born we understand that it may take time to have that new bundle of joy added to your insurance policy. Please contact the office as soon as your child's insurance is activated. After 30 days you will be responsible for any balances that are not paid by insurance.

5. **CLAIMS SUBMISSIONS**: We will submit your claims or assist you in any way we reasonably can to help get your claims paid. Please be advised that this is a courtesy provided by NAP rather than a responsibility. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

6. **COVERAGE CHANGES**: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. In the event that valid information is not provided to our office in a timely manner, NAP will not be held to timely filing requirements by your insurance company.

7. **ADD/ADHD VISITS**: Many insurance companies do not cover visits for ADD/ADHD because they categorize this care under mental health instead of medical care. It is your responsibility to find out from your plan if they do or do not cover these visits. This way you are not surprised if you receive a bill stating the office visit was not covered. In addition, these visits cannot be coded as a well-child exam. Copayments and deductibles may apply.

8. **WELL CHILD EXAMS**: It is the responsibility of the parent/guardian to find out what the approved schedule is for their child's well-baby/well-child exams. Coverage for these services varies by plan and our staff may not have access to specific information about your policy. Helpful information to find out – how many well-child exams are allowed per year, does your policy limit the age of coverage for well-child exams (ex: well-child coverage covered from ages 0-6 only), does your policy cover vaccines? If so, for what ages? These details could mean the difference of hundreds of dollars on your bill. Please be familiar with your specific plan's details and provide this information to our staff.

9. **DIVORCE AND SEPARATION ISSUES**: In the case of divorce or separation, it is imperative that we be notified as to who has primary responsibility, including financial responsibility, for the care of your child(ren). The person with PRIMARY RESPONSIBILITY for the child(ren) will be responsible for payment of all charges not paid by insurance unless we are notified otherwise. Proof of responsibility may be requested in the form copies of the divorce paperwork. **It is the parents' responsibility to work together to ensure that all charges not paid by insurance are paid in a timely manner. NAP will <u>not</u> get involved in how these charges are allocated between parents/guardians.**

10. **REBILLING FEES**: The policy of NAP is to provide your first billing statement as a courtesy. After the first billing cycle, if payment has not been made in full, a rebilling fee may be applied to the account in the amount of $10. This rebilling fee will be added to each statement thereafter if no payments are received.

11. **COLLECTIONS**: Delinquent accounts that are a minimum of $60 and 60 days past due will automatically be sent to the first phase of our profit recovery system. If the balance remains unpaid, the patient's account and any sibling accounts may be separated from the practice and their total balances turned over to a collections agency. When this occurs the outstanding balance must be paid in full and a reinstatement fee of 50% or up to $100 will be added to your account. This will not be covered by insurance, thus you will be responsible for this cost.

12. **AFTER HOURS CLINIC**: North Augusta Pediatrics utilizes The Augusta Pediatric Clinic (APC) on Wheeler Road for their after-hours and weekend urgent care. Every visit will also have an after-hour fee applied to it. While most insurance companies will cover this charge, some will not. If they do not, this charge is the responsibility of the parent. Patients of NAP who have unpaid balances will incur the same rebilling fees and profit recovery/collections practices as they do at NAP. Patients who are separated from APC for delinquent balances will also be separated from NAP.

North Augusta Pediatrics Financial Policy cont.

PATIENT NAME(S) & DOB

_____

_____

_____

_____

_____

FINANCIAL RESPONSIBILTY

With the exception of Copays, Coinsurances, Deductibles, and Self Pay which are due at the Time of Service, who is Financially Responsible for any bills that may be deemed the patient's responsibility after insurance has been filed?

Name: _____ **DOB:** _____

SSN: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____

_____

INSURANCE INFORMATION

Primary Ins Name: _____

Policy Holder: _____ **DOB:** _____

Sex (Circle): M F SSN: _____

Patient's Relationship to Insured: _____

Secondary Ins Name: _____

Policy Holder: _____ **DOB:** _____

Sex (Circle): M F SSN: _____

Patient's Relationship to Insured: _____

_____

I agree that the above information is true and correct to the best of my knowledge.

Print Name: _____ **Signature:** _____ **Date:** _____

Relationship to above patient: _____

NOTICE OF PRIVACY PRACTICES 01/01/14

North Augusta Pediatrics

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in our reception area. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with North Augusta Pediatrics contact our Privacy Officer at (803) 510-0007, 536 W. Martintown Rd. North Augusta, SC 29841. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient Name **Date**

_____

Parent/Guardian Signature

NORTH AUGUSTA PEDIATRICS

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Permission to Verbally Discuss Protected Health Information

Completion of this form is optional

Patient Name: _____Date of Birth:_____

I give permission to North Augusta Pediatrics to verbally discuss the following medical and billing information about my child (please put your initials next to all that apply):

_____ Scheduling/appointment information

_____ Medical information, including my child's symptoms, diagnosis, medications, and treatment plan

_____ Behavioral health information, including my child's symptoms, diagnosis, medications, and treatment plan

_____ Lab/test results

_____ Billing and payment information

_____ Other:_____

North Augusta Pediatrics has permission to discuss the above information with:

Name	Relationship to Patient	Phone Number

I understand that I may cancel this permission at any time by writing to North Augusta Pediatrics, but canceling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and I should only sign it if I want North Augusta Pediatrics to share my child's information with someone not listed as the parent/guardian on the demographics.

This authorization expires:

☐ When I cancel it in writing ☐ _____(specify date)

If no expiration date is specified, this authorization will remain in effect until North Augusta Pediatrics receives a written notice to cancel it.

Signature of parent/guardian Date Relationship to Patient

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Permission to Verbally Discuss Protected Health Information: Information Sheet

As a pediatric medical practice, we take great care in protecting your child's private health information. There are many different family situations throughout our practice, and in order to make certain we accommodate each different situation while maintaining your child's privacy, we have created this form to better serve our patients and their families.

How can I give others permission to get verbal information about my child?
Complete the Permission to Verbally Discuss Protected Health Information on the reverse side of this page to let us know to whom we may speak regarding your child's information. Place your initials next to the information you want shared.

How is the information on the form used?
Anytime your designated person calls or requests information, we will verify that person has permission to receive the information before we share the information.

What are some examples of when this might be useful?
- Stepparents
- Grandparents
- Babysitters/Nannies
- College student who wants information shared with a parent

Can the person I designate also get copies of my child's medical records?
No, they can only receive verbal information. Only the parent/guardian can obtain copies of their child's medical records.

What happens if I don't complete the form?
Then we will not give out any verbal information on your child to anyone except who you have listed on the demographics' sheet.

What do I do if I want to cancel this verbal permission?
Mail or drop off a written letter stating that you wish to cancel this verbal permission, and we will do so.

Send it to:
North Augusta Pediatrics
140 Allen Court
North Augusta, SC 29860