



Jeb S. Teichman, M.D., F.A.A.P.  
Klaus M. Boel, M.D., F.A.A.P.  
Carrie A. Crigger, D.O.  
Merideth Missi, PNP-BC

Specializing in Infants,  
Children & Adolescents

Please read front and back carefully and complete to the best of your knowledge.

Child's Name: \_\_\_\_\_ M F Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_ School: \_\_\_\_\_

Street Address: \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred Contact #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Child lives with: \_\_\_\_\_

Full Names and Ages of Siblings: \_\_\_\_\_

Are they patients of our office? \_\_\_\_\_

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Work Ph ( ) \_\_\_\_\_ Employer: \_\_\_\_\_

May we call you at work? \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_

May we call you at work? \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name, address, phone number, relation to patient

Who Referred you to us? (please check one) \_\_\_\_\_ Insurance Book/Company  
\_\_\_\_\_ Phone Book \_\_\_\_\_ Dr. \_\_\_\_\_ Friend/Our Patient \_\_\_\_\_  
(if so, which one?) (if so, who?) (if so, who?)

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Please present insurance cards to Receptionist.

Since the terms of coverage are an agreement between you and your insurance company, questions and problems concerning your policy will need to be directed to your insurance company.

Each insurance company has a different policy covering your medical costs. Even within the same company the coverage and benefits vary. **You are responsible for knowing the details of your coverage.** This includes what are covered and non covered services. In addition, **you are responsible for any co-payment or deductible not covered by your insurance.** In cases where there is no insurance coverage, the balance is due at the time of service. Co-payments are due at the time of service. If you are not prepared to pay the co-pay, you will be asked to reschedule.

**Patient Fees:**

Record Transfer Fees, Monthly Billing Fees for past due balances, Missed Appointment Fees, and Form Completion Fees are examples of fees that are payable by you.

**Consent for Treatment:**

I am authorized to consent for treatment for the above named patient by Jeffersonville Pediatrics. **I understand that all patients under the age of 18 must be accompanied by a patient or guardian for all appointments.**

**Assignment of Benefits:**

I give my permission for Clark Physician Group, LLC, to release medical information to my insurance company for claims payment for services rendered. I authorize payment directly to Clark Physician Group, LLC. I understand that I am financially responsible for any balance not covered by my insurance company.

A photocopy of this assignment shall be valid as the original.

Parent/Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



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**PROOF**

We realize that Parents or Legal Guardians may not always be able to personally bring their child to the office themselves. However, Indiana Law dictates that a patient under the age of 18 CANNOT be treated without a Parent or Legal Guardian present. If a Parent or Legal Guardian can not be present, then anyone authorized below can accompany the child and give consent for treatment. This form MUST be completed by a Parent or Legal Guardian.

I, \_\_\_\_\_, the Parent or Legal Guardian of  
\_\_\_\_\_, give consent for the following people to have my child.  
(child's name)

treated by Dr. Jeb S. Teichman, Dr. Klaus M. Boel, Dr. Carrie A. Crigger, Merideth Missi PNP-BC and staff:

**Authorized People**

**Relationship to Patient**

\_\_\_\_\_  
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Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Jeffersonville Pediatrics

## Medical Questionnaire

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Marital status of parents: M S D W Are there smokers in the house? Y N

*For Newborns, Complete Sections A & B. All Other New Patients, Complete A, B, C, D.*

### **(A) PREGNANCY & BIRTH**

Mother's age during pregnancy: \_\_\_\_\_ Any illnesses during pregnancy? Y N

Were medications taken during pregnancy (besides vitamins and iron)? Y N

Activity during pregnancy:  Smoking  Alcohol  Illegal drugs

The baby was born:  Early  On-time  Late. The baby was delivered:  Vaginal  C/Section

At birth, did the baby experience:  Breathing Problems  Jaundice  Other

Did baby have problems during the hospital stay? Y N After discharge, at home? Y N

If you answered "Yes" to any of the above, explain here: \_\_\_\_\_

### **(B) FAMILY MEDICAL HISTORY** (*List all blood relatives of your child who have had the following.*)

*Abbreviate relation with: (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Maternal Grandmother, (MF) Maternal Grandfather, (FM) Fraternal Grandmother, (FF) Fraternal Grandfather, (A) Aunt, (U) Uncle, (C) Cousin.*

AIDS	Cystic Fibrosis	High Cholesterol
Alcoholism	Diabetes	Mental Retardation
Anemia/Blood Disorder	Drug Dependence	Migraines
Arthritis	Early Deafness	Muscular Dystrophy
Asthma	Epilepsy/Seizures	Sudden Infant Death
Birth Defects	Heart Disease	Tuberculosis
Cancer	High Blood Pressure	

\*\*\*\*\*If the patient is a newborn, STOP here. The remainder is not applicable.\*\*\*\*\*

### **(C) DEVELOPMENT & BEHAVIOR**

Indicate age at which child:

Sat alone: \_\_\_\_\_ Walked: \_\_\_\_\_ Used sentences: \_\_\_\_\_ Toilet trained: \_\_\_\_\_ Rode a bike: \_\_\_\_\_

If in school, what grade? \_\_\_\_\_ Any learning difficulties? Y N Any problems in school? Y N

Does child get along well with other children? Y N

How does child's development compare to other children of same age? \_\_\_\_\_

Does child have behavioral problems? Y N Any habits that concern you? Y N

(Check any applicable):  Bedwetting  Nail biting  Problems sleeping  Thumbsucking

Social history:  Smoking  Alcohol use  Drug use

Social activities (list child's hobbies, interests, sports): \_\_\_\_\_

Explain "Yes" answers here: \_\_\_\_\_

### **(D) MEDICAL HISTORY**

Has child had an allergic reaction to:  Medicine  Food  Animals  Insect bites

Does child take any medication on a regular basis (except vitamins)? Y N

Has patient ever been hospitalized? Y N Sustained any serious injuries? Y N

Are immunizations up-to-date? Y N Do you have an immunization record? Y N

Does patient have a history of:  Red measles  Mumps  German measles  Chicken pox

Whooping cough  Rheumatic fever  Scarlet fever  Asthma  Eczema  Seizures  Hepatitis

Bleeding tendency  Anemia

Does child have a history of recurrent infections (ear, throat, other)? Y N

Explain "Yes" answers here: \_\_\_\_\_

When and where was patient's last eye exam? \_\_\_\_\_

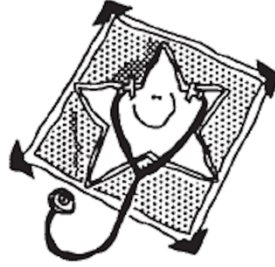
When and where was patient's last dental exam? \_\_\_\_\_

Previous medical care provided by: \_\_\_\_\_

# Jeffersonville Pediatrics

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207 Sparks Avenue, Suite 403  
Jeffersonville, IN 47130  
Telephone: 812-288-9141  
Fax: 812-288-1023

## OFFICE POLICIES

### ALLERGY SHOTS/IMMUNIZATIONS

Our office recommends all patients remain SEATED in the office for 15 minutes after an injection is administered. This is a precaution to assure that your child does not have a reaction to the injection.

Your signature below indicates that you have been informed of this risk, and if you choose to leave prior to time period, it is against medical advice.

### APPOINTMENT CANCELLATION

We are a busy office and do our best to accommodate our patients scheduling needs. Therefore, our office requires 24 hours notice to cancel a scheduled appointment. In most cases, appointments for sick visits are made same day, so if cancellation is necessary, informing us promptly is appreciated. **If you fail to cancel an appointment** with proper notice, eliminating our ability to offer the time to another patient, **a charge of \$25.00 will be added to the patient account.** This is not reimbursable by insurance. This will also be documented in the patient chart. If three appointments are missed in a six-month time period, the patient will be released from our practice. Thank you for respecting our policy.

### CO-PAYMENT POLICY

A service fee of \$10.00 will be assessed immediately to any account unable to pay their co-payment at the time of service. We reserve the right to reschedule anyone who does not pay their co-payment at the time of visit.

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Parent/Guardian signature

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Patient Name

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Date

- **We are required to notify you if we are unable to agree to a requested restriction.**
- **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. For example, you may ask that we contact you at work or by U.S. Mail. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address. This address must be where the individual will receive bills for service rendered by the facility, and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A PAPER COPY OF THIS NOTICE:** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
  - **You may obtain a copy of this notice at our web site:**
    - [www.clarkmemorial.org](http://www.clarkmemorial.org)

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the hospital and include the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the hospital Privacy Officer and with the Secretary of the U.S. Department of Health and Human Services by sending correspondence to:

Clark Memorial Hospital  
 Director of HIM/Privacy Officer  
 1220 Missouri Avenue  
 Jeffersonville, IN 47130

**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 Indiana law will be made only with your written permission. 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 revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Clark Memorial Hospital Privacy Officer  
 (812) 283.2626

Effective Date: April 14, 2003



#### **NOTICE OF PRIVACY PRACTICES EFFECTIVE DATE: April 14, 2003**

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**

If you have any questions about this notice, please contact the Clark Memorial Privacy Officer by dialing (812) 283.2626

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all the records of your care generated by the hospital, whether made by hospital personnel, agents of the hospital, or your personal doctor. Your personal doctor may have different policies or notices regarding his or her uses and disclosures of our medical information created in the doctor's office or clinic.

#### **OUR RESPONSIBILITY**

We are required by law and by our own standards to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

#### **USES AND DISCLOSURES**

How we may use and disclose medical information about you.

**FOR TREATMENT:** We may use your medical information to provide you treatment or services. We may disclose your medical information to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital.  
**For example:** A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the hospital also may share your medical information in order to coordinate the different things you may need, such as prescriptions, lab work, meals and x-rays.

We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from Clark Memorial.

**FOR PAYMENT:** We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer.  
**For example:** We may need to give your insurance company information about your surgery so it will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.  
**FOR HEALTH CARE OPERATIONS:** Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.  
**For example:** We may combine medical information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses and students for education purposes. And we may combine medical information we have with that of other hospitals to see where we can make improvements. We may remove information that identifies you from this set of medical information to protect your privacy.

**We may also use and disclose medical information:**

- To business associates we have contracted with to perform agreed upon service and billing;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professionals.

**BUSINESS ASSOCIATES:** There are some services provided in our organization through contracts with business associates.

**Examples include** physician services in the emergency department and radiology, certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**DIRECTORY:** We may include certain limited information about you in the hospital directory while you are a patient at Clark Memorial. The information may include your name, location in the hospital, your general condition (i.e. good, fair, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. You will have the option to Opt Out (decline) of being in the Clark Memorial Hospital directory while you are an inpatient.

**INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE:** We may disclose to your family, a relative, a close friend or any other person you identify as your emergency contact(s), your health information that relates to that person's involvement in your care or payment related to your care. In addition, we may disclose your medical information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**RESEARCH:** We may disclose information to researchers after an institutional review board has reviewed the research proposal and the established protocols to ensure the privacy of your health information has approved their research.

**FUTURE COMMUNICATION:** We may communicate to you via newsletters, direct mail or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities our facility is participating in.

**ORGANIZED HEALTH CARE ARRANGEMENT:** This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access in their offices to protected health information to assist in reviewing past treatment as it may affect treatment at the time.

**AS REQUIRED BY LAW, we also may use and disclose health information to the following types of entities, including but not limited to:**

- Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National security and intelligence agencies
- Protective services for the President of the United States and others

**LAW ENFORCEMENT/LEGAL PROCEEDINGS:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

**STATE SPECIFIC REQUIREMENTS:** Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the State privacy laws are more stringent than Federal privacy laws, the State law preempts the Federal law.

**YOUR HEALTH INFORMATION RIGHTS**

Although your health record is the physical property of the health care practitioner or facility that compiled it, you have the **RIGHT to:**

- **INSPECT & RECEIVE COPY:** You have the right to inspect and have copied protected health information that is in a designated record set and may be used to make decisions about your care after completion of appropriate forms. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceedings. We may deny your request to inspect and have copied certain protected health information. If you are denied access to medical information, you may request that denial be reviewed. Another licensed health care professional chosen by Clark Memorial Hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **AMEND:** If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment in writing for as long as the information is kept by or for Clark Memorial. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial. To request an amendment, your request must be made in writing and submitted to our Privacy Officer.
- **AN ACCOUNTING OF DISCLOSURES:** You have a right to request an accounting of disclosures of your health information. This is a list of certain disclosures we make of your medical information for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices.
- **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 in the payment for your care, like a family member or friend. **For example,** you could ask that we not use or disclose information about a surgery you had.



CONSENT TO TREATMENT & FINANCIAL ASSIGNMENT/RESPONSIBILITY
CLARK PHYSICIAN GROUP

I. PERMISSION FOR ADMISSION AND TREATMENT

Permission is hereby granted to Clark Physician Group to render such medical examinations, treatments, and procedures as are considered advisable by my physician for my health and well-being.

I understand that each patient has the right to consent or refuse consent to any proposed procedure or treatment and that no patient will be involved in any research or experimental procedure without his or her knowledge and written consent.

II. AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I authorize Clark Physician Group to release and/or obtain information from my medical record, or permit inspection of such medical information, including but not limited to psychological/psychiatric, drug/alcohol related conditions, communicable disease diagnosis, and/or testing including the results for Human Immunodeficiency Virus Infection (HIV), Hepatitis, or other blood-borne infectious disease for the purpose of treatment, payment, or health care operations as more fully described in The Notice of Privacy Practices.

I understand that certain information may be released to the Health Department officials responsible for control of infectious diseases in accordance with the requirements of federal, state, and local laws and regulations.

III. FINANCIAL RESPONSIBILITY

Assignment of Insurance Benefits

As a courtesy, a claim will be submitted to the insurance provided for the services rendered. I hereby authorize payment of my insurance benefits (otherwise payable to me) directly to physicians, but not to exceed the balance due of the regular charges for this date of service. I understand that I am financially responsible to Clark Physician Group for charges not covered by this authorization including deductibles and/or co-insurance amounts.

IV. GUARANTEE OF ACCOUNT

The undersigned hereby agrees to pay the provider(s) for services rendered during my physician visits. I understand patient monies received by the Clark Physician Group will be applied to any of my accounts with an outstanding balance.

I understand and agree that if I fail to make any of the payments that I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney, I will be responsible for all monies including court costs, collection agency, and/or attorney fees.

I hereby authorize the following person(s) to obtain medical information about me, i.e., tests results, outcomes, diagnosis, etc.

- 1.
2.
3.
4.
5.

Patient's Initials

I acknowledge that I have received a copy of the The Notice of Privacy Practices (effective 4/14/03).

Patient's Initials

I acknowledge I have received information that describes my patient rights and responsibilities as well as my rights under state law to make decisions concerning my medical care.

Patient/Legal Guardian Signature Date

Witness Signature Date