

WELCOME TO PEDIATRIC GROUP, LLC

PATIENT INFORMATION

DATE _____

Name First _____ Middle _____ Last _____

Birthdate _____ SS# _____ Male/Female _____

Mailing Address _____ City _____ State _____ Zip _____

Mother _____ Father _____

Resides with Mother _____ Father _____ Both Parents _____

Sibling Names _____

PHONE NUMBERS Preferred Contact Method: Phone _____ Text _____ Email _____

Home # _____ Work # _____ Cell # _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Phone # _____

WHO IS RESPONSIBLE FOR THIS BILL?

Full Name _____ Relationship to Patient _____

SS# _____ Birthdate _____

Mailing Address _____ City _____ State _____ Zip _____

Phone# _____ email address _____

PRIMARY INSURANCE

Name of Insured _____ Relationship to Patient _____

SS # _____ Birthdate _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Address _____ Phone # _____

Insurance Company _____ ID # _____

Group # _____ Co-Pay Amount _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD!

SECONDARY INSURANCE

Name of Insured _____ Relationship to Patient _____

SS # _____ Birthdate _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Address _____ Phone # _____

Insurance Company _____ ID # _____

Group # _____ Co-Pay Amount _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD!

TREATMENT CONSENT: I hereby consent and give my permission to the doctor (and doctor's assistants or designed replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Date: _____ Signature: _____

ALL INSURANCE ASSIGNMENTS AUTHORIZATION AND RELEASE OF

INFORMATION: I certify that I have insurance coverage with the above named company and assign directly to Pediatric Group, LLC all Insurance/Medicaid benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance/Medicaid. I authorize the use of my signature on all Insurance/Medicaid submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining Insurance/Medicaid benefits or the benefits payable for related services.

Date: _____ Printed Name: _____ Signature: _____



Pradeep Reddy, M.D., Hind Al-Sharif, M.D.
Bindu Kotrakona, M.D., Jeremy Gerwe, M.D.
Carline, Mbeumo, M.D.
Annie Imboden, CPNP, Sara Ford, CNNP,
Michelle Wharton, CFNP, Kathy Herren, PA-C,
Angela Henson, PA-C, Leanne DeNeal, PA-C

3412 Office Park Drive, Marion, IL 62959
310 W. St. Louis St., West Frankfort, IL 62896
28 Veteran's Drive, Harrisburg, IL 62946
900 E. Walnut St. Ste. 6, Carbondale, IL 62901
Phone: 618-993-0404 Fax: 618-993-1717
www.pediatricgroupllc.com

Designation of Another Person to Consent for Treatment

It is best that children are brought for treatment by a parent or legal guardian. However, there may be times when someone other than you takes care of your child. That person may be a baby-sitter or family member. If your child must be seen at Pediatric Group, LLC during these times, we need your authorization for that person or persons you choose to seek treatment for your child when you are unable to accompany your child to the office. **The person you name must be 18 years of age or older.**

I, (parent/legal guardian) _____, cannot always accompany my child, (child's name) _____, to Pediatric Group, LLC. Therefore, I give permission to the following persons to bring my child to Pediatric Group LLC for treatment:

This permission will remain in effect until revoked in writing or completing a new designation form.

Signature of Parent or legal guardian

Date

Signature of Witness

Date



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Sarah Ford, NNP-BC
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Leanne DeNeal, PA-C

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, _____, hereby acknowledge receipt of the physicians' HIPAA Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physicians have reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Patient's
Name _____

Signed by _____

Date _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____	Date of Birth: _____
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I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with IL State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. **PEDIATRIC GROUP LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to PEDIATRIC GROUP LLC.**
2. **This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to PEDIATRIC GROUP LLC**
3. **I have the right to revoke this authorization at any time by writing to PEDIATRIC GROUP LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.**
4. **Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.**
5. **Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.**
6. **This authorization expires one year from the date of my signature below.**
7. **THIS AUTHORIZATION DOES NOT AUTHORIZE PEDIATRIC GROUP LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.**

Signature of patient or representative authorized by law	Date
Relationship to Patient	Interpreter, if utilized
Witness Signature	

PEDIATRIC GROUP, LLC
3412 Office Park Drive, Marion, IL 62959
28 Veteran's Drive, Harrisburg, IL 62946
310 West St. Louis Street, West Frankfort, IL 62986
900 E Walnut, Suite 6 Carbondale, IL 62901
(618)993-0404 Fax: (618)993-1717

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I, _____, understand that as part of my or my child's health care, Pediatric Group, LLC originates and maintains paper and/or electronic records describing health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my or my child's care and treatment.
- A means of communications among the many health professionals who contribute to my or my child's care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my or my child's health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Pediatric Group, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pediatric Group, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pediatric Group, LLC change their notice, a copy will be provided.

I wish to have the following restrictions to use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's Signature

Date

[] Consent received by _____ on _____ and added to medical record.