Welcome To Pediatric Group, LLC

PATIENT INFORMATION DATE____________________

Name First______________Middle______________Last____________________

Birthdate___________Social Security#___________________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____

Mom's # (Mobile)__________________________(Work)____________________

Dad's # (Mobile)__________________________(Work)____________________

In the event of an emergency, who should we contact? (other than yourself)

Name______________________Relationship__________Phone #______________

WHO IS RESPONSIBLE FOR THIS BILL? (This section must be completed)

Full Name___________________________Relationship to Patient______________

Social Security#_______________________Birthdate___________________________

Mailing Address_______________________City___________State___Zip_______

Phone #____________________Email Address_____________________________

PRIMARY INSURANCE

Name of Insured_______________________Relationship to Patient____________

Social Security #______________________Birthdate___________________________

Mailing Address_______________________City___________State___Zip_______

Employer_____________________________Phone #_________________________

Employer Address______________________City___________State___Zip______

Insurance Company_________________________Insured ID#_________________

Insured Group #___________Co-Pay Amount________Deductible Amount_________

SECONDARY INSURANCE

Name of Insured_______________________Relationship to Patient____________

Social Security #______________________Birthdate___________________________

Mailing Address_______________________City___________State___Zip_______

Employer_____________________________Phone #_________________________

Employer Address______________________City___________State___Zip______

Insurance Company_________________________Insured ID#_________________

Insured Group #___________Co-Pay Amount________Deductible Amount_________

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARDS!

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., Bindu Reddy, M.D.,
Jeremy Gerwe, M.D., Ronald Chediak, M.D.,
Ahmed Youssef, M.D.
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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
1007 S. 42nd St., Ste. 1, Mt. Vernon, IL 62864
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 cares for 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 authorization for that person or persons you choose to seek treatment for your child when you are unable to come with your child. **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

PEDIATRIC GROUP, LLC

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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.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient
Name:____

Date of Birth:____________________

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:

The Pediatric Group 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 the Pediatric Group.

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 the Pediatric Group.

I have the right to revoke this authorization at any time by writing to the Pediatric Group. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

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.

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.

This authorization expires one year from the date of my signature below.

THIS AUTHORIZATION DOES NOT AUTHORIZE THE PEDIATRIC GROUP 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:____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I,_____________________________, hereby acknowledge receipt of the physicians' 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___________________________________ Date_______________