

**801 North Street East**

**Talladega, Alabama 35160**

**Phone 256-362-3005**

**Name - First:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle initial:** \_\_\_\_\_\_ **Last:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip: \_**\_\_\_\_\_\_\_\_\_\_\_

**Sex (please circle):**  Male Female **Social Security #:** \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone: (**\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ **Cell Phone: (**\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ **Cell Carrier:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Receive Text Messages?** Yes or No

**Race (please Circle One):** Indian Asian Black Hispanic White Other

**Insurance Primary:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Secondary: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insured Date of Birth:** \_\_\_\_/\_\_\_/\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Consent for treatment I give Smart Care Pediatric clinic for examination and treatment, including drugs, medicine, performance of operations, or other studies that may be done by the attending physician, nurse practitioner, medical assistant, or staff as needed (indicated for my care) Authorization of Benefits I authorize Smart Care pediatric clinic to furnish any medical information requested by insurance companies including Medicare with whom I have coverage any public agency which may be accessing payment in my care, or my employer who is providing payment of my medical bills due to an on- the- job injury. Assignment of Benefits I hereby authorize payment directly to Smart Care pediatric clinic for benefits otherwise payable to me including major medical insurance and Medicaid also payment for surgical benefits but not to exceed the Smart Care pediatric clinic for the services. I understand that I am financially responsible to Smart Care Pediatric clinic for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits. GUARANTEE OF ACCOUNT- For services furnished by Smart Care Pediatric clinic I hereby Guarantee the payment of all accounts for services rendered for me and all the family members I am responsible for. For payments of said accounts for services, I hereby wave all claims of exemption under the state of Alabama and agree to pay, if necessary, all coasts of collection, including attorneys fee and court cost.

**ACKNOWLEDGMENT**

I have received the correct affective notice of privacy practices. This also serves as a PHI document release should I request treatment be sent to other medical facilities in the future. Smart Care Pediatric Clinic will only call the phone numbers provided by you unless you give instructions to remove contact information from your file. No emails or text messages will be sent from out office. This consent/ authorization remains in effect until revoked in writing.

**I give permission to release and discuss medical information to the following people:**

**1)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**2) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**3) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_/\_\_\_\_/**20**\_\_\_\_\_

**IF PATIENT IS 18 OR UNDER COMPLETE THIS SECTION:**

**Responsible party Name: \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SS#** \_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ **Sex (Please circle one):** Female Male **DOB:** \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Home/Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ **EXT: \_**\_\_\_\_\_\_\_

**Relationship: \_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Following People may bring my child, \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_ **(name of patient) to Smart Care Pediatrics**

**1)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **2) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_/\_\_\_\_\_\_/**20**\_\_\_\_\_

**Past Medical History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Surgery:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations (CHECK ONE) Up to Date** \_\_\_\_\_ **Delayed** \_\_\_\_\_ **I have elected to not immunize my child** \_\_\_\_\_

**Reasons for delay or not being Immunized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTH HISTORY**

**Pregnancy or birth Complications?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Full term or Preterm?** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Twins?** YES NO

**How many Weeks/months?** \_\_\_\_\_\_\_\_\_\_ **Type of Delivery (please circle one):** Vaginal Cesarean

**Birth weight**\_\_\_\_\_\_\_\_\_\_\_\_ **Breast Fed or Bottle Fed (circle one), until what age?** \_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

**I give my permission for Smart Care Pediatric Clinic to treat my child,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **(Please print)** **according to the standards of care defined by the America Association of pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating provider.**

**Parent/Guardian (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Appointment Cancellation/ no-show Policy**

Thank you for trusting your medical care to Smart Care Pediatric Clinic. When you schedule an appointment with Smart Care Pediatric Clinic, we set aside enough time to provide you with their highest quality care should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

**PLEASE SEE OUT APPOINTMENT CANCELLATION/ NO SHOW POLICY BELOW:**

Effective September 23, 2020, any established patient who fails to show or cancels/ reschedules an appointment and has not contacted office with at least 24 hours’ notice will be considered a No Show and charged a $25.00 fee.

Any established patient who fails to show or cancels/ reschedules an appointment with no 24 hours’ notice a second time will be charged a $50.00 fee.

If a third no show or cancellation/ reschedule with no 24-hour notice should occur the patient may be considered for dismissal from Smart Care Pediatric Clinic.

The fee is charged to the patient, not the insurance company, and is due at the time of the patient’s next office visit.

As a curtesy when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our business office who may be able to waive the no show fee. You may contact Smart Care Pediatric Clinic 24 hours a day 7 days a week at the number below. Should it be after regular business hours Monday through Friday or a weekend, you may leave a message, messages left on your physician’s nurse line are acceptable.

**Smart Care Pediatrics 256-362-3005**

**I have read and understand the Medical Cancellation/ No Show Policy and agree to the terms.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature (Parent/Guardian)**   **Relationship to Patient**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name** **Date**



**801 North Street East**

**Talladega, Al 35160**

**256-362-3005**

**Authorization for Treatment in Absence of Parent or Guardian**

**I,** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(please print)**, do hereby consent and authorize Smart Care and its providers and staff to examine and/ or treat my child in my absence. I affirm that I have legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who had the legal right and exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/ or treatments.

I give the providers and staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. Listed below are people who can bring my child in my absence for well child and/or sick visits, as well as getting vaccines. If we are unable to contact6 the guardian, the people listed below are authorized to be contacted by the provider’s staff.

|  |  |  |
| --- | --- | --- |
| **NAME** | **RELATIONSHIP TO PATIENT** | **PHONE NUMBER** |
|  |  |  |
|  |  |  |
|  |  |  |

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

A picture containing text, clipart

Description automatically generated  
801 North Street E  
Talladega, AL 35160  
256-362-3005 -Office  
256-531-9443 – Fax

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize release of my medical/health information to the receiving facility as indicated below:

**FROM:** **TO:**  
Facility: **Smart Care Pediatrics** Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Attention: **Smart Care Pediatrics** Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: **801 North Street E** Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City, State, Zip: **Talladega, AL 35160** City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone: **256-362-3005 Fax**: **256-531-9443**  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_

**This Authorization applies to the following information (please circle one):**

* **ALL INFORMATION** – I understand that the following information may contain psychological, alcohol/drug abuse, and/or HIV information and I expressly consent to release of the information.
* Only the following information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Treatment dates from: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_ or **ALL DATES** (please circle)

**Purpose of the release (please circle one)**

* At request of patient/personal representative
* Continuity of treatment
* Assessment
* Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the information released to the party listed above will be in accordance with their notice of privacy practices and will be limited to information necessary to fulfill the need or purpose for the disclosure. As a result of my signing this authoritarian, I understand an individual or organization that receives this information may not be covered and therefore the information no longer is protected under HIPPA, a federal privacy law. This authorization is valid for (90) days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I may decline to sign this authorization. I understand I may revoke authorization; the revocation will not apply to information that has already been released in response to this authorization. I understand the patient’s health care and payment for the patient’s healthcare will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it and I may receive a copy of this form after I sign it. (Before requesting medical record copies, please ask about the copy fee, by law, that may apply.) I hereby release, hold harmless and agree to information to be released as described above.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Patient’s Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Patient’s Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (This authorization will expire in 90 days unless otherwise specified)