Allison Hatfield, M.D.
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PATIENT INFORMATION QUESTIONNAIRE

CHILD'S INFORMATION (PATIENT):

Child's Last Name: ______________________________ Child's First Name: ______________________
Date of Birth: _________________ Social Security Number: __________________________ Gender: ☐ M ☐ F
Mailing Address:___________________________________ City:____________________ State: ______ Zip: _________
Physical Address: __________________________________ City: ____________________State: ______ Zip: _________
Phone Number: ____ Alternate Phone Number:_____________________

Race: ☐ Black/African American ☐ Hispanic Primary Language: ☐ English
☐ White/Caucasian ☐ Other _________ ☐ Other _____________

MOTHER'S INFORMATION:

First Name: ________________________ Last Name: _____________________________ Date of Birth: _____________
Social Security Number: ____________________ Phone Number: ______________ Alt. Phone Number: ___________
Email address: ____

FATHER'S INFORMATION:

First Name: ________________________ Last Name: _____________________________ Date of Birth: _____________
Social Security Number: ____________________ Phone Number: ______________ Alt. Phone Number: ___________
Email address: ____

GUARDIAN INFORMATION:

Name of Legal Guardian:____
Phone Number: ____ Alternate Phone Number:____________________

INSURANCE INFORMATION:

Type of Insurance: Check one and complete appropriate information:
☐ Self-Pay
☐ Medicaid If Medicaid, which Bayou Health Plan are you enrolled in? ____________________________________
☐ Private Insurance
Insurance Company's Name: _________________________________Name of Insured: _______________________

Insured's Social Security Number: ___________________________ Insured's Date of Birth:_____________________

List the names and ages of any siblings that the above named child has:

1. Name: ______________________________________ DOB: ________________
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

2. Name: ______________________________________ DOB: ________________
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

3. Name: ______________________________________ DOB: ________________
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

4. Name: ______________________________________ DOB: _________________
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ N

PHARMACY INFORMATION

PHARMACY PREFERENCE:

Primary Pharmacy Name: ____
City: ______________________________________

Alternative Pharmacy Name: ____
City: ______________________________________

e-Prescribing Consent:

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MAM) of 2003 listed standards that have to be included in an ePrescribe program. These include:
- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them the patient's prescription has been picked up, not picked up or partially filled.

There are some prescription drugs that may NOT be sent electronically (i.e., ADHD medications) and scripts must be picked up in person and signed for.
By signing this consent form, you are agreeing that Dr. Allison Hatfield, Dr. Sarah Latiolais Ardoin, Dr. Emily Fruge' Simon and Desiree Robison, FNP can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
Understanding all of the above, I hereby provide informed consent to Dr. Allison Hatfield, Dr. Sarah Latiolais Ardoin, Dr. Emily Fruge' Simon and Desiree Robison, FNP to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_________ _________
Initial Date

Permission for Treatment:

I hereby give permission to the providers of Lily Pad Pediatrics or persons designated to them, to interview, examine, and perform necessary procedures and to provide appropriate treatment to the patient.

__________ __________
Initial Date

Acknowledgement of Patient No Show Policy and Timely Arrival to Appointments:

If you are more than **15** minutes late for your appointment, we will have to reschedule your appointment for a later date. If you are unable to keep your appointment, you are required to cancel your appointment with appropriate prior notice (24 hours is appreciated). Failure of you to cancel your appointment without a 24-hour notice is considered a “No Show” for purposes of this policy. If three or more appointments are missed, then you may be dismissed from our practice. We make every effort to see you in a timely manner and we ask that you respect our time and others time by arriving in a timely manner.

By initialing below, I hereby acknowledge that I understand the above Patient No Show Policy and Timely Arrival to Appointments with Lily Pad Pediatrics.

__________ __________
Initial Date

Acknowledgement of patient dismissal should patient become pregnant:

Should the patient become pregnant while she is an active patient with Lily Pad Pediatrics, that patient will be dismissed from the practice and will no longer be seen at Lily Pad Pediatrics.
By initialing below, I hereby acknowledge that I understand the above Patient Dismissal (for pregnancy) Policy with Lily Pad Pediatrics.

__________ __________
Initial Date

Consent for Vaccinations

PARENTS OR LEGAL GUARDIAN MUST BE PRESENT FOR IMMUNIZATIONS

I do hereby give consent for my child, to receive age-appropriate vaccinations. The risks, indications, and side effects of these vaccines have been discussed in detail with me.

In addition, I have been provided a copy and have read, or have had explained to me, information about the diseases and the procedures/vaccines. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the risk associated and have asked that the vaccine/procedure be given to me or to the person listed above, (for whom I am authorized to make this request).

The doctor has explained, and I understand, the potential risks of receiving this care. I further understand that in my physician’s best medical judgment, my consent may result in the need for further treatment or may reduce changes of regaining normal health. I shall hold Drs. Hatfield, Latiolais Ardoin, Simon and Desiree Robison, NP blameless for any reactions associated with this procedure/vaccination.

Vaccinations that are administered in this clinic are as follows (age-appropriate):

- Hepatitis A
- Hepatitis B
- Influenza
- Pneumococcal
- HPV
- Hib
- Rotavirus
- DTap
- Tdap
- MMR
- Polio
- Varicella
- Meningococcal

By initialing below, I hereby acknowledge that I understand the above consent for vaccinations from Lily Pad Pediatrics.

__________ __________
Initial Date

Consent for Telemedicine Treatment:

I consent to telehealth care performed by providers of Lily Pad Pediatrics. This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. I understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I agree to be responsible for any co-payments, deductibles, or other charges from the providers.

By initialing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

_________ _________
Initial Date

I hereby agree to all initialed areas of this consent form

______________________________ ______________________________ _________
Child's name Parent Signature Date

NOTICE OF PRIVACY PRACTICES

I, THE UNDERSIGNED PATIENT/REPRESENTATIVE OF LILY PAD PEDIATRICS, DO HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF THE PRIVACY PRACTICES OF THIS OFFICE TO REVIEW. I UNDERSTAND THAT A COPY OF THIS DOCUMENT WILL ALWAYS BE AVAILABLE TO ME TO REVIEW. I UNDERSTAND THAT ANY QUESTIONS THAT I MAY HAVE CAN BE DIRECTED TO THE PRIVACY OFFICER AND/OR MY PROVIDER.

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I AM SATISFIED TO READ AND CONSULT THE OFFICE COPIES OF THE NOTICE OF PRIVACY PRACTICES THAT ARE ALWAYS AVAILABLE TO ME.

_____ I WOULD LIKE A PERSONAL COPY TO TAKE HOME WITH ME.

IF YOU ARE SIGNING AS THE PATIENT'S REPRESENTATIVE:

PRINT YOUR NAME: ____

DESCRIBE YOUR AUTHORITY: ____

SIGN: ____ DATE: __________________

_____ I GIVE MY PERMISSION FOR LILY PAD PEDIATRICS TO PROVIDE THE FOLLOWING INDIVIDUALS MEDICAL INFORMATION REGARDING THE PATIENT: ***(PLEASE PROVIDE NAMES AND CONTACT NUMBERS)***

____
Name Phone # Relationship

____
Name Phone # Relationship

____
Name Phone # Relationship

____
Name Phone # Relationship