

40920 US HWY 280  
Sylacauga, AL 35150  
Phone: 256-208-0060  
Fax: 256-208-0755



398 Chesser Dr. Suite 7  
Chelsea, AL 35043  
Phone: 205-678-1286  
Fax: 205-618-9696

**Patient Information:**

Child's Name: Last \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
Child's Birthday: \_\_\_\_\_ Child's Social Security Number: \_\_\_\_\_  
Child's Sex: \_\_\_\_\_ Child's Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Patient lives with: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
How would you like to be reminded of your child's appointment? **Please Rate your method 1, 2, & 3** \_\_\_\_\_ Text \_\_\_\_\_ Phone Calls \_\_\_\_\_ E-Mail \_\_\_\_\_

Parent/Guardian: _____ Birthdate: _____ SS#: _____ Address: _____ <input type="checkbox"/> Check if same as patient address _____ Phone (H) _____ Phone (C) _____ Phone (W) _____ Email _____ Circle your relation to the patient: Genetic? Y <input type="checkbox"/> N <input type="checkbox"/> Mother/Father    Step-parent    Foster Parent    Guardian	Parent/Guardian: _____ Birthdate: _____ SS#: _____ Address: _____ <input type="checkbox"/> Check if same as patient address _____ Phone (H) _____ Phone (C) _____ Phone (W) _____ Email _____ Circle your relation to the patient: Genetic? Y <input type="checkbox"/> N <input type="checkbox"/> Mother/Father    Step-parent    Foster Parent    Guardian
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<b>Siblings:</b>	Last Name,	First Name	Gender	Date of Birth
_____			F M	_____
_____			F M	_____
_____			F M	_____
_____			F M	_____

**Consent For Treatment:** I consent to necessary treatment, including drugs, medicine, performance of operation and conduct x-ray, or other studies that may be used by the attending physician, nurse or staff.

**Authorization For Release Of Information:** I authorize Pathway Pediatrics to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. I consent for Pathway Pediatrics to import my medication history from my insurance company/pharmacy.

**Assignment of Benefits:** I hereby authorized payment directly to Pathway Pediatrics of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Pathway Pediatrics charges for the services. I understand that I am financially responsible to Pathway Pediatrics for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverage are subject to coordination of benefits.

**Guarantee of Account:** For services furnished by Pathway Pediatrics I hereby guarantee the payment of all accounts for services rendered. **For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney's fee and a collection fee of 50% of the balance due.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Communication Authorization Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other persons with whom we can discuss you/your child's care and share protected health information to.

**Please list below any people with whom you authorize our office to discuss aspects related to your child's care.**

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**I have received a copy of the Privacy Practices from Pathway Pediatrics: Yes \_\_\_\_\_ No \_\_\_\_\_ Declined copy \_\_\_\_\_**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Electronic Prescription Form

I, \_\_\_\_\_, whose signature appears below, authorize Pathway Pediatrics, Inc. Providers to view the external prescription history via the RxHub service for the patient listed below.

**By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.**

\_\_\_\_\_ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

\_\_\_\_\_  
(Patient Name)

**Preferred Pharmacy:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**My signature certifies that I read and understand the above and that I authorize the access.**

\_\_\_\_\_  
(Signature of Patient/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Guardian's Relationship to patient)



## Insurance Information

Person responsible for account: \_\_\_\_\_ D.O.B \_\_\_\_\_

Card Holder's Social Security Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PRIMARY** Insurance Company: \_\_\_\_\_

Policy/Contract ID number: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_

Person responsible for account: \_\_\_\_\_ D.O.B \_\_\_\_\_

Card Holder's Social Security Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**SECONDARY** Insurance Company: \_\_\_\_\_

Policy/Contract ID number: \_\_\_\_\_

Policy holder's name: \_\_\_\_\_

## Easy Pay Agreement

**This service will allow you to pay co-pays, deductibles, and patient balances left by your insurance company easily and conveniently.**

With this service you authorize Pathway Pediatrics, Inc to use this credit card as the form of payment for balances accrued, including lab test, co-pays, coinsurances, and deductibles. This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. We will obtain verbal consent prior to payment processing. **This agreement will expire on the expiration date listed below.** The card holder may revoke this consent at any time in writing.

<p> <b>Visa</b> <input type="checkbox"/>    <b>MasterCard</b> <input type="checkbox"/>    <b>Discover</b> <input type="checkbox"/> </p> <p> <b>Credit Card Holder's Name:</b> _____ <b>DOB:</b> ___ / ___ / ___  <small>(Please Print)</small> </p> <p> <b>Last Four Digits of Account Number:</b> _____ </p> <p> <b>Expiration Date:</b> _____ </p> <hr/> <p> Please fill out information below for any other person/s you authorize this credit card for: </p> <p> <b>Patient Full Name:</b> _____ <b>DOB:</b> ___ / ___ / ___  <small>(Please Print)</small> </p> <p> <b>Patient Full Name:</b> _____ <b>DOB:</b> ___ / ___ / ___ </p> <p> <b>Patient Full Name:</b> _____ <b>DOB:</b> ___ / ___ / ___ </p>
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Credit Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This Authorization applies to the following information:

All Information/ Complete Medical Records.

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information. This authorization will expire in 90 days.

Only the follow records or types of Information: \_\_\_\_\_

Treatment Dates: From (\_\_\_/\_\_\_/\_\_\_) to (\_\_\_/\_\_\_/\_\_\_)

The Information may be release as follows:

From Pathway Pediatrics, Inc.  
40920 US HWY 280  
Sylacauga, AL 35150

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Or \_\_\_\_\_

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To: Pathway Pediatrics, Inc.  
398 Chesser Dr, Suite 7  
Chelsea, AL 35043  
Fax: 205-618-9696

To: Pathway Pediatrics, Inc  
40920 US HWY 280  
Sylacauga, AL 35150  
Fax: 256-208-0755

**Purpose of the release**

Continuity of Treatment  Other (Please Specify): \_\_\_\_\_

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subjected to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety 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 this authorization in writing at any time. If I revoke this 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 the payment for the patient's health care 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 records copies, please ask about the coy fee by law that may apply. I represent that I have the authority to voluntary grant permission for the information to be released as described above.

\_\_\_\_\_  
(Patient/Parent/Legal Guardian Printed Name)

\_\_\_\_\_  
(Patient/Parent/Legal Guardian Signature)      Date

\_\_\_\_\_  
(Witness Signature for Patient/Parent/ Legal Guardian)      Date

## Vaccine Agreement

At Pathway Pediatrics we are dedicated to provide the best care for every child we see. Because the health of our patients is our highest priority, and because we believe in the safety and efficacy of vaccines, we require all our patients to vaccinate with required childhood immunizations. All of our providers have followed this schedule with their own children. We require our patients to adhere to the recommended schedule for childhood vaccines.

You will be notified if your child has not completed the routine vaccinations as scheduled. You will have the opportunity to bring your child in for a well visit and/or immunization visit after notification. If you do not bring your child in for immunizations after notification, Pathway Pediatrics reserves the right to dismiss your child from its practice. It will be at the discretion of Pathway Pediatrics to dismiss patients on a case by case basis.

It is of utmost importance for the safety of your child and for other children in our practice that your child stay current with immunizations. If you have questions regarding immunizations, please ask to speak with a nurse or provider.

I agree to follow the recommended guidelines for immunizations for my child and will adhere to Pathway Pediatrics policy on immunizations as outlined above:

Parent signature \_\_\_\_\_ Date: \_\_\_\_\_

Child's name \_\_\_\_\_

\_\_\_\_\_



# Do you have our Patient Portal?

We made an investment in your patient experience because we want you to have your health information right at your fingertips.

**Here are some of the things you can take advantage of when you have the Patient Portal:**

- Request your appointments and medication refills online
- Receive appointment reminders on your cell phone and via email
- Secure communication between yourself and our staff
- Pay your bills online
- Decrease in-office wait time by completing forms online

**Access the Patient Portal online, or download the mobile app. Download the app in either the App Store for iPhone users or the Google Play Store for Android. Search for "InteliChart" in either store or use one of the QR codes below. Then download the app to your phone.**



**APPLE**



**ANDROID**

Contact our office for your patient specific pin to complete portal registration.