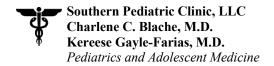
Patient Demographics Form Are you applying for your child to be a new patient? Yes or No						
Child's Name		Birthdate	Sex M / F			
Address	Zip Code	Social Security				
Race Black or African Ameri	can ☐ White (Caucasian) ☐ Asian ☐ Other:					
Ethnicity Hispanic or Latino	☐ Not Hispanic or Latino ☐ Other:					
Preferred language Lnglis	sh Spanish Other:hers and/or sisters (include last name if differen					
Name & birthdates of child's broth	hers and/or sisters (include last name if differen	t). Has your child been seen in	n our practice? □ Yes or □ No			
Name of child's previous doctor						
Name of Mother's OB/GYN and						
Parent's family doctor?	DI ' ' /II ' / I M I / A I C	' 1 M 1' (F 1 1 / I)				
How did you hear about SPC?	□Physician / Hospital □Marketing Ads □ Soc □ Google □ SPC's Website □ Patient □ Signa		am)			
How did you hear about Si C:	□ Related Profession (Physical Therapy etc.):					
	□ Other:					
DEASON FOR CHANCING DE	OOVIDEDS (Only if your shild is a new notice	···• \				
REASON FOR CHANGING PE	ROVIDERS (Only if your child is a new patie					
MOTHER'S NAME WHO IS L	EGAL GUARDIAN	Bi	rthdate			
Social Security #	Marital Status	Emai	1			
		Work				
Employer	Occupation	Phone				
FATHER'S NAME WHO IS LE			rthdate			
Social Security #	Marital Status	Emai	·			
Address	Mobile P	hone				
E1	Occupation	Work				
Employer	Occupation	Phone				
EMERGENCY CONTACT OTHER THAN PARENT						
Name:	- · · · ·		Number:			
Physical Address:	1					
MEDICAL INSURANCE INFORMATION: PROVIDE A COPY OF EACH INSURANCE CARD						
MEDICAL INSURANCE INFO		I INSURANCE CARD				
Primary Policy Holder Nan	ne Primary Insurance	Second	lary Ins./Medicaid			
• •			•			
WE STRONGLY BELIEVE IN VACCINATING OUR PATIENTS ACCORDING TO THE RECOMMENDED AMERICAN ACADEMY OF PEDIATRICS AND CENTER FOR DISEASE GUIDELINES.						
BY SIG	GNING BELOW, YOU ARE AGREEING TO ALLOW	US TO VACCINATE YOUR CHI	LD			
Darant/Carandian Dainta J N	S:		Data			
Parent/Guardian Printed Nam			Date			
I authorize <u>Dr. Blache</u> to release any medical information necessary to process an insurance claim for my son/daughter						
and request the insurance company to make payment to <u>Dr. Blache</u> . I also authorize <u>Southern Pediatric Clinic, LLC staff and/or Dr. Blache</u> to use the contact information listed above.						
Southern I cuiatric Chine, DEC stari and/or Dr. Diache to use the contact information listed above.						
Parent/Guardian Printed Name	Signature		Date			
	0					

Patient Medical History

PATIENT

Last Name	First 1	Name a			MI		Date of Birth
1. Please answer the fol			t vour child's	hirth	1411		Date of Diffil
						Disth	waight?
City and hospital where child was born. Was baby born vaginally or by C- section? Was baby premature? How many weeks?							
	-					-	·
Was baby breech? □ no □							·
Were there any complication		•					
Did baby have any problem	ns after birth	? □ no □ ye	S				
2. Please answer the fol	llowing quest	tions abou	t your child's	social histo	ry.		
Who takes care of your	child most of	f the time?					
Who lives at home with	the child?						
Does child attend dayca	are/school? W	here?					
Does anyone smoke ins							_
3. Please list all medica				zina			
5. I lease list all illeulea	uons mai yu	ur Cilliu 15	currently tar	g			
4 Deer weet -1-9.12			allaumi - =0				
4. Does your child have	•		_		11.41.4		
5. Does your child have □ ADHD □ bl	e a history of ood disorders	•	_			□ ot	hor:
	ood aisoraers onchiolitis/R		□ eczema □ febrile seiz		neumonia sychiatric disorder	⊔ 0t	HEI.
C	ronic ear infe		□ heart cond		rinary tract infection		
	evelopmental		□ kidney pro		sion/eye problems		_
6. If your child has ever	r been hospit	alized or l	• •		• •	nd reasons	
J	F		g ,, ,		. P		
7. If your child has ever been injured please list injuries, approximate dates and any treatment given.							
8. Is there a family hist	ory of any of	the follow	ing? Check a	ıll that apply	& indicate which	member h	ad/has the condition.
	Mom	Dad	Brother	Sister	Mom's parents	s/siblings	Dad's parents/siblings
	IVIOIII	Dua	Diother	Sister .	(please spe	cify)	(please specify)
□ asthma							
□ allergies							
□ eczema							
□ diabetes							
□ obesity □ high cholesterol							
□ hypertension							
□ heart disease							
□ ADHD/ADD							
□ seizures							
□ developmental delay							
□ mental disorder							
□ anemia/blood disorder							
□ thyroid disorder							
□ cancer							
□ other							
Parent/Guardian Pri	nted Name			Sign	ature		Date
I archiv Guardian I III	inca i vaille			Sign			Date



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Patient Authorization for Practice to Release Protected Health Information to Third Parties

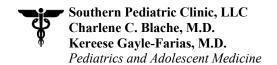
I authorize (office records are comi	ing from):	G:1 G: 1	7.
Address:Phone #:	F #:	City, State:	Zıp:
Phone #:	Fax #:		
To use and disclose the specific pro	Southern Pediatric Clin Charlene Blache, M	nic, LLC 1.D.	low to:
	406-M Northside D Valdosta, GA 316		
	vaidosta, GA 310	02	
The information requested is conta	ined in the medical records of:		
Patient's Name:		DOB:	
Information Requested History and Physical Operative Reports Complete Records Immunization Record Other (specify):	Lab/ Diag	ce Notes X-ray mostic Tests harge Summary hiatric/Psychological l	Information
Purpose of Request			
Changing Doctors	Moving	More c	onvenient location
Changing Insurance	Other (specify):		
When my information is used or di recipient and may no longer be pro authorization in writing except to the My written revocation must be sub	tected by the federal HIPPA Priv he extent that Charlene Blache, M	acy Rule. I have the ri	ght to revoke this
	Charlene Blache, M	1.D.	
	Attn: Revocation No		
	406-M Northside D	rive	
	Valdosta, GA 316	02	
Signature of Patient/Parent or Lega	 ıl Guardian		Date

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Consent & Disclosure of PHI & Treatment of Patient & Statement of Persons Allowed to Accompany Patient to Office Visits

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and for Treatment

Patient's Name:		Date of Birth:				
MOTHER'S NAME WHO IS LEGAL	L GUARDIAN				Birthdate	
FATHER'S NAME WHO IS LEGAL	GUARDIAN				Birthdate	
	ees., may use and disclose PHI about the said of Privacy Practices for full information regar	•	-	treatment, paymo	ent and healthcare	
right to revise its Notice of Pr 2. I have read and understand th questions. 3. Southern Pediatric Clinic, and in person in reference that ass 4. Southern Pediatric Clinic may to above, to anyone specified 6. Southern Pediatric Clinic will court-ordered documents for	Privacy Practices for Southern Pediatric Clinicity Practices at any time and that I will have a Notices of Privacy Practices that are in placed all those associated, may call my home or other than the practice in carrying out TPO, such as any treat my child and order diagnostic tests and by disclose Individually Identifiable Health Information below who brings my child(ren) to the office of I not act as mediator in separation, divorced, any our child. Please make sure we have a copy of the practices and the practices of the property of the practices of the prac	e access to revision and that I may comer designated looppointment reminables for diagnosist ormation (IIHI) the for treatment. Ind/or custody bat on file.	cons. contact the cation and nders and s and trea nat will be ttles. We re	e Privacy Officer d leave a messag patient statemen timent. e used to carry ou must abide by the	e on voice mail or ats. It TPO as referred the laws set forth in	
	IENTS CAN ONLY BE ACCOMPANIED TO MENTED IN THE PATIENT'S CHART. PL					
Name	Relationship to Patient	Disclose	PHI	Accomp Appoin		
		□ yes □	ı no	□ yes	□ no	
		□ yes □	no no	□ yes	□ no	
		□ yes □	ı no	□ yes	□ no	
		□ yes □	ı no	□ yes	□ no	
		□ yes □	ı no	□ yes	□ no	
		□ yes □	ı no	□ yes	□ no	
		□ yes □	no no	□ yes	□ no	
		□ yes □	no no	□ yes	□ no	
agree to my requested restrictions, but if it doe my PHI to carry out TPO. I my revoke my con	tric Clinic restricts how it uses or discloses my Plesn't, it is bound by this agreement. By signing the asent in writing, except to the extent that which the thern Pediatric Clinic may decline to provide treated. Date	nis form, I am con ne practice has alr	senting to eady made	the practice's use	and disclosure of	
Printed Name of Parent/Guard	lian					

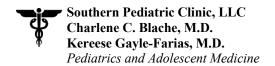


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Office Staff Initials

Financial Consent

		Tillaliciai Colisciit	
	oes not pay within 90 days of billing, your services will vary depending on change Private Pay: You are financially reshanges in the patient's medical condition State Insurance: The cost of our serisenrolls the patient, you are financially ary depending on changes in the patient For those families where parents are uthorizes treatment is responsible for pane non-custodial parent/guardian responsible ayment from the other parent. NOTICE OF PATIENT RESPONSITION Southern Pediatric Clinic will attempt information you and your insurance of your bill. Ultimately it is your responsible.	ervices will be billed to your insurance compourare financially responsible and will be billed ges in the patient's medical condition, progree ponsible of all fees due at time of service. The progress, and physician order(s). Wices will be billed to your insurance compareresponsible and will be billed directly for ser is medical condition, progress, and physician esparated or divorced, the parent who bring syment(s). Payments are due when services are sible for partial or all medical costs, it will be sent to verify your insurance benefits and eligible company provide to us. As a courtesy, we winsibility to see that we are paid appropriately	ne amount of fees for services may vary depending on my. If your state insurance denies coverage, or retrovices rendered. The amount of fees for services will a order(s). Is the child or children to the office visit and re rendered. If the divorced/custodial decree makes the responsibility of the authorizing parent to collect DEDUCTIBLES: It is DEDUCTIBLES: It is DEDUCTIBLES: It is provided the information of the portion of by your insurance company. If the information given
			nains, you will be billed for that balance and are
	responsible for payment within thirty	(30) days unless you set up a payment plan	with our billing specialists.
	provided, you are ultimately respanse also be your responsibility. 2. You authorize payment of any in You authorize the release of med 4. You agree to pay all co-pays, pe	f the payment source as described above. Yo	atric Clinic.
Patio	ent Name		Date of Birth
Resp	ponsible Party Name and Signature		Today's Date
ME	CDICAL INSURANCE INFORM	MATION: PROVIDE A COPY OF	INSURANCE CARD(S)
M	Primary Policy Holder Name	Primary Insurance	Primary Insurance Policy Number
Pri	mary Policy Sex / Date of Birth	Secondary Ins./Medicaid	Secondary Ins./Medicaid Policy Number



Signature of Parent/Guardian or Patient

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Child's Name	DOB
CELL PHONE USE I	POLICY
The purpose of this policy is to outline the acceptable use of cellu devices, including but not limited to, mobiles phones, iPhones, i (collectively referred to as "communication devices") at <i>Southern</i> protect the workers and <i>Southern Pediatric Clinic, LLC</i> , along with to of communication devices may harm others within the office by violence.	Pads, iPods, tablets, or any other wireless device <i>Pediatric Clinic, LLC</i> . These rules are in place to he privacy of each of our patients. Inappropriate use
1. Who this Policy Applies To:	
This Policy applies to patients that are being seen wit	hin the office and their family members.
 2. What devices this Policy Applies To: (Video recording or pi a. All devices that can be used for recording. b. All devices that can be used for communicating with c. All devices that may hinder the quality of care the pa 	others.
3. Permitted Use: The devices mentioned can be used in the lobby if need family members be conscious of others that may be in the	-
 Violations of This Policy: Patients or family members that violate this policy madepending on circumstances. 	ay be asked to leave and are subject to dismissal

I have read and will abide by the terms of this policy regarding the use of communication devices in this office.

Date