CORNERSTONE PEDIATRICS – PATIENT HISTORY

701 Will Halsey Way, Madison, AL 35758

□Brassart □Denny □Johnson □Lawley □McDuffee □Miller □Tatum □Van Cleave

PLEASE FILL ALL INFORMATION. INCOMPLETE FORMS CAN'T BE ENTERED INTO THE COMPUTER.

HAVE ANY OF YOUR CHILDREN BEEN PATIENT's OF CORNERSTONE'S IN THE PAST? ___YES ___ NO

Patient Name_____ Date of Birth_____ Sex_____

Race_____ Ethnicity: Latino/Hispanic Other School _____ Grade_____

Marital Status: (Parents of child) ☐Married ☐Divorced ☐Separated ☐Never Married ☐Widowed

Primary Address of Child_____Zip Code_____

Dad's Name_____ DOB_____ SSN_____

Mom's Name_____DOB_____ SSN_____

Dad's Email_____ Mom's Email_____

Step Dad's Name_____ DOB_____ SSN_____

Step Mom's Name_____DOB_____ SSN_____

Child resides with_____

Other address if parents not in same household:_____
Whose address is this_____

Please list phone numbers in order you prefer us call you. (mom cell 1st, home 2nd, dad cell 3rd, work, etc.)

#1._____☐ mom cell ☐ home ☐ dad cell ☐ _____ #2._____☐ mom cell ☐ home ☐ dad cell ☐ _____
#3._____☐ mom cell ☐ home ☐ dad cell ☐ _____ #4._____☐ mom cell ☐ home ☐ dad cell ☐ _____

Please check processes in which our office can remind you of upcoming appointments: ☐VOICE ☐TEXT ☐EMAIL

Dad's Employer_____ Work Phone_____
Mom's Employer_____ Work Phone_____

Emergency Contact other than parents_____ Phone_____

PREFERRED PHARMACY (name and location)_____

INSURANCE INFORMATION:

Primary Insurance Co_____ Insured's Name_____ DOB___ Group No._____Contract No._____

Secondary Insurance Co_____Insured's Name_____ DOB___ Group No._____Contract No._____

I hereby authorized payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____
Signature Date

PARENT/LEGAL GUARDIAN MUST BE PRESENT AT INITIAL VISIT

HEALTH HISTORY

BIRTH HISTORY

Full Term___ Premature____ Vag___ C-Sec___ Birth Weight_____ Length_____
APGAR Score_____ Blood Type_____ Circumcision: Yes No NA

GENERAL INFORMATION

Current Medicines:_____
Allergies to Medicines: YES or NO If yes, please list:_____
Hospitalizations:_____
Surgeries:_____
Asthma/Bronchitis:_____ Bronchiolitis:_____
Chicken Pox:_____ Ear Infections:_____
Meningitis:_____Pneumonia:_____ UTIs:_____
Tonsillitis/Pharyngitis:_____ Other:_____

NUTRITION INFORMATION

Breastfed_____ Formula_____ Vitamin Supplement_____ Type_____
Soft Foods Added_____Stools_____Appetite_____

DEVELOPMENT HISTORY

Held up Head	Stood Aided	Smiled	Stood Alone
Sat Aided	Walked	Sat Alone	Said Words
Said Sentences	First Teeth	Crept	Toilet Trained
Reached for objects			

FAMILY HISTORY

Mother's Age_____ Race_____ Occupation_____
Father's Age_____ Race_____ Occupation_____

Siblings of child	Age	Sex	Health Status	Patient of Cornerstone?
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____

Do family members (mother, father, siblings, aunts, uncles, grandparents to child) have:

Asthma	Cancer
Diabetes	Heart Disease
High Blood Pressure	Kidney Disease
Mental Illness	Seziures
Sickle Cell Disease	Tuberculosis
Other	

ADDITIONAL PERSON FOR RELEASE OF INFORMATION

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Purpose: To ensure authorization that releases Cornerstone Pediatrics to speak with additional persons regarding patient care.

I, _____, parent/guardian of the above listed children, authorize the following individuals to be able to discuss my child(ren's) care and/or appointments at Cornerstone Pediatrics with the physicians, clinical staff, as well as the front office staff.

_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship

X_____ _____

Signature of Parent/Guardian Date

IMMUNIZATION SCHEDULE

Newborn	**Newborn Screen**
2 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal 13-valent, Rotavirus***
4 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal 13-valent, Rotavirus***
6 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal 13-valent, Rotavirus***
12 Months	**MMR, Varicella, Pneumococcal 13-valent, Hepatitis A***
15 Months	**DTaP, HIB**
18 Months	**Hepatitis A***
4 Year	**DTaP, MMR, Varicella, IPV**
9 Years & Up	**HPV***
11 Years & Up	**Tdap, Meningococcal***
16 Years & Up	**Meningitis B***

It is the policy of all Cornerstone Pediatrics physicians that your child(ren) receive all immunizations required by the AAP. **THIS IS A NON-NEGOTIOABLE POLICY OF THE PHYSICIANS OF CORNERSTONE PEDIATRICS.** Also, it is our policy that you keep all scheduled well check appointments yearly until 18 years of age.

The following immunizations are not required but recommended by the physicians of Cornerstone Pediatrics:

* Hepatitis A
* HPV
* Meningitis B
* Meningococcal
* Rotavirus

If you miss three (3) consecutively scheduled well check appointments, refuse to comply with required immunizations, or excessively abuse scheduled appointments, your child(ren) will be considered for dismissal from this practice for non-compliance.

I acknowledge receipt of the immunization policy of Cornerstone Pediatrics, and by registering my child as a patient of Cornerstone Pediatrics, I agree to comply with the required immunizations.

_____ _____

Parent/Guardian Signature Date Signed

Medical Records Policy

In order to assume care for your child, it is very important that we receive **ALL** previous medical records in our facility. Attached is a Medical Records Request. One request will need to be filled out for **EACH PHYSICIAN** your child has seen in the past. Every attempt will be made by our office to obtain the records. If there is missing information, you will be responsible for ensuring our office receives the missing information. If after 30 days, records are not received, it will then be your responsibility to obtain these records. We greatly appreciate your assistance in helping us provide the best possible medical care for your child.

_____ _____

Parent Acknowledgement Date

Updated: 03/15/2019

Cornerstone Pediatrics - Financial Policy

We are committed to providing you with the best possible medical care. You can help by eliminating the need for us to bill for co-pays. Due to increased co-pays, participating insurance requirements, and compliance issues, we find it necessary to update our financial policy.

PAYMENT:

1) All co-payments, co-insurance, and deductibles are due and payable at the time of service, regardless of who brings the child in for the appointment. Babysitters, grandparents, divorced parents, etc. must be prepared to pay at the time of service. Cornerstone Pediatrics accepts cash, checks, and credit/debit cards.
2) After 3 statements are mailed, any additional statements will incur a finance charge of $5.00 per month.
3) There is a $30 charge for returned checks. After receiving two returned checks, Cornerstone Pediatrics will only accept cash or credit card payments from you.
4) If you need financial assistance or have questions, please contact the Billing Department or Office Manager.
5) If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with Cornerstone Pediatrics, your outstanding balance will be sent to a collection agency and your child(ren) will be dismissed from this practice for non-compliance.
6) Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written within 30 days of your verbal or written request.
7) Anytime a physician is involved in medical decision making an office visit must be charged and co-pay collected if there is one due with your health insurance policy whether the appointment was scheduled or not.

INSURANCE:

1) Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card to each visit
   - Know your co-pay and be prepared to pay your co-pay at each visit
   - Know your insurance benefits (well child, immunization coverage, etc.)
   - Specific coverage issues should be directed to your insurance company's member services department
   - If you are enrolled in a managed care insurance plan, you must receive a referral from our office before seeing a specialist. NO retroactive referrals will be given.
2) If you have insurance that we <u>do not participate with</u> our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3) Cornerstone Pediatrics files <u>secondary insurance</u> as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

MISSED APPOINTMENTS:

1) It is the policy of all Cornerstone Pediatrics physicians that your child(ren) receive all immunizations required by law and that you keep all scheduled well check appointments until the age of 18.
2) If you miss three (3) consecutively scheduled well check appointments or excessively abuse scheduled appointments, your child(ren) will be considered for dismissal from this practice for non-compliance.
3) A $25 reschedule fee may apply for well child checkups rescheduled on the same day. There may be a $25 no show fee if we confirm an appointment and it is not kept.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the Patient Account Manager or Office Manager. I have read and understand Cornerstone Pediatrics Financial Policy. I agree to assign insurance benefits to Cornerstone Pediatrics whenever necessary. In the event of non-payment or default, I am responsible for all costs of collections, including, but not limited to, collection agency fees, court costs, and reasonable attorney fees. Cornerstone Pediatrics reserves the right to change or amend this financial policy at any time and at its discretion.

_____

Signature of Patient or Responsible Party Print Name Date

Child's Name_____ Date of Birth_____

Cornerstone Pediatrics, P.C.

Consent for Treatment and the Use and Disclosure of Protected Health Information

This is a consent form. It asks you to permit Cornerstone Pediatrics to treat, use and disclose information about your health. That information is called Protected Health Information. It is any information we receive or create that identifies (or could identify) you, deals with your physical or mental health, any health care we provide you and/or payment for such health care.

By signing this form, you are consenting to treatment and to our use and disclosure of your protected health information in order to carry out treatment, payment or health care operations.

We have a "Notice of Privacy Practices." The notice describes in detail how we might use or disclose protected health information. The notice also discusses your rights and our duties with respect to protected health information. You have the right to review the notice before signing this consent.

You also have the right to revoke this consent, in writing except where we have previously taken action in reliance on your prior consent.

_____ _____
Signature of Patient or Legal Guardian | Print Name of Legal Guardian

_____ _____
Patient's Name | Date Signed

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Cornerstone Pediatrics' Notice of Privacy Practices.
(please print patient name)

_____ _____
Signature of Patient or Legal Guardian | Date Signed

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (specify)

_____

CORNERSTONE PEDIATRICS, P.C.
701 Will Halsey Way, Madison, AL 35758

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient's Name (print):_____

Birthdate:_____ Phone (home):_____ (work):_____

Address:_____

City:_____ State:_____ Zip:_____

I, the undersigned, authorize and request **Cornerstone Pediatrics, P.C.** to: **___ release to ___ obtain from**

Physician/Parent/Patient:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Please release the following information from the medical records for care/treatment:

_____ Complete Record _____ Lab Results _____ Immunizations _____ Progress Notes _____ X-Ray Results
_____ Other_____
I specifically authorize the release of protected information regarding: ____Drugs/Alcohol ____HIV

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Cornerstone Pediatrics, P.C., 701 Will Halsey Way, Madison, AL 35758.

_____
Patient or Authorized Representative Date

_____
If not patient, relationship to patient

I understand that by signing this release, I will no longer have a relationship with Cornerstone Pediatrics and cannot expect any appointments to be made.

This authorization expires 90 days from date signed.

Please fax records to 256-461-7168 or mail them to the address above. If you have any questions, please call us at 256-461-7440.

Reason for Release of Records:
___ Transferring to another provider locally

Reason transferring:_____

_____

___ Moving out of town

___ Insurance Purposes

___ Other_____

We suggest that you keep a personal copy of any records you provide this office or this office provides you.

CORNERSTONE PEDIATRICS, P.C. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your IIHI; Your privacy rights in your IIHI; our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS, PLEASE CONTACT: Office Manager, 701 Will Halsey Way, Madison, Alabama 35758 (256)461-7440

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, of who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities authorized by law to collect information for the purpose of:
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency(ies)/ authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver, and (iii) the research could not practicably be conducted without access to and use of the PHI.

7. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI to reduce or prevent a serious threat to your health/safety or the health/safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care of the payment for your care, such as family members and friends. NOTE: ALABAMA LAW STATES WE MUST PROVIDE ACCESS TO A CHILD'S MEDICAL RECORDS TO BOTHER PARENTS UNLESS THERE IS A COURT ORDER PROHIBITING ACCESS. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chose by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing to Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "account of disclosures" is a list of certain non-routing disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor is sharing information with the nurse, or the billing department using your information to file your insurance claim. In order to obtain an account of disclosures, you must make your request in writing to Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of the disclosure and may not include dates before April 14, 2003. The first lists you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to Paper Copy of This Notice. You are entitled to a paper copy of our notice. You may ask us to give you a copy of this notice at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Jennifer Bell, Office Manager, 701 Will Halsey Way, Madison, Alabama 35758. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain your records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Jennifer Bell, Office Manager, (256) 461-7440.

Cornerstone Pediatrics
Completion of Forms/Letter Policy

It is the goal of the physicians and staff to accommodate as many requests to the furthest reasonable extent in an accurate and timely manner.

To help us better serve your needs, we request you be aware of the following policies:

1. Forms will be accepted for completion only if the patient's information has been completed on the form. In some cases, we may not be able to complete or certify a form if parents have not completed their part of the form prior to submission. Blank forms will not be accepted.
2. Turnaround time for form completions is no less than 48 hours. While every effort will be made to complete forms as quickly as possible, parents should realize that at certain times of the year we may receive hundreds of health forms in one week. Remember that each form has to be carefully reviewed by a physician before it is released. Parents are strongly advised not to wait until the last moment to look at paperwork they have received from the programs their child is scheduled to attend.
3. Forms will be held at the office for parents to pick up.
4. Forms must be paid for before they are released. We do not bill for payment of forms.
5. Many forms require the information be based on a physical examination completed within 12 months of the date the form is completed. No form will be completed for any patient who has not had a physical examination in more than 12 months.
6. Physical examination requires check of perceptual ability, i.e., hearing and vision screen. We regret that we cannot certify a child fit for any program without appropriate perceptual (hearing and vision) testing. If your form requires those screenings, it is very likely you will be billed for the test as many insurance companies consider these to be a non covered charge.
7. The charge for review and completion of medical forms is $10.00. If the form is brought in and completed at the time of the well child physical examination, there is no charge.
8. All forms are completed by the physician based on information from your child's chart.
9. Payment for completion of a health form is the responsibility of the parent/guardian. This is not considered a billable service by insurance companies.
10. Letters written by the physician for schools, daycares and insurance companies, etc., will vary with the duration of the time necessary to complete. There will be a $10.00 charge for letters completed by the physician.
11. Asthma Actions Plans are best filled out by the doctor that manages your child's asthma. If your child sees an Allergist or Pulmonologist, it is best for them to complete any forms related to asthma (action plans or medication forms). If your doctor at Cornerstone Pediatrics follows your child's asthma and they have not been seen for an asthma recheck in the past 6 months, you may be asked to schedule a visit in order for us to complete the form.