General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship of Patient
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	Date

BRIGHTER FUTURES
PEDIATRICS & LACTATION SERVICES, LLC

For Office Use:
___New Patient
___ Update to Current Patient
Staff Initials: _____

PEDIATRIC PATIENT DEMOGRAPHICS

Please Note: your insurance card and driver's license are required upon check-in at each visit.

PATIENT INFORMATION:

Full Name (First, Middle, Last): _____

Nickname: _____ Gender: _____Male ____Female Date of Birth: ____ / _____ / _____ Age: _____

Address: _____ City: _____State: _____Zip: _____

Phone: _____ Cell : _____Email: _____@ _____

Which racial category does the patient most closely identify with?

____ African American ____ American Indian/ Alaska Native ____ Asian ____ Caucasian ____ Hispanic

____ Native Hawaiian/ Hawaiian/ Another Pacific Islander ____ More Than One Race ____Other (please specify)

Ethnicity: What is the patient's ethnicity? ____ Hispanic or Latino ____ Not Hispanic or Latino

What is the patient/ family's language of preference? ___English ___Spanish ___Other: _____ (please specify)

Family Information:

Primary Parent / Legal Guardian (Primary Insurance Policy Holder)

Full Name of Policy Holder (as it appears on insurance card): _____

Gender: ____Male ____ Female Relationship to Patient: _____ Phone #: _____

Date of Birth: ____/ ____/ ____ SSN: _____-_____-_____ Employer: _____

Employer Address, City, State, Zip : _____

Other Parent / Legal Guardian

Full Name (First, Middle, Last): _____ Date Of Birth: _____ / _____/ _____

Gender: _____ Male ____ Female Relationship: _____ Phone #: _____

Marital Status: ____Married ____ Divorced ____Other: _____* With whom does the patient reside? _____

Other Side →

*If all guardians do not reside at the address listed above, please provide a secondary address for statements and information

Address: _____ City: _____Zip: _____ State: _____

Email: _____@ _____

Pharmacy Information:

Name: _____

Phone: _____

Address: _____

Fax: _____

Emergency Contact:

Name: _____

Relationship: _____

Cell Phone: _____

Alt. Phone: _____

_____ _____

Parent/ Guardian Signature Date

Brighter Futures Pediatrics & Lactation Services, LLC

Initial History Questionnaire

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female
Previous Medical Doctor/Birth Hospital: _____ Last Visit: _____
Are the patient's immunizations up to date? ☐ Yes ☐ No Do you have the immunization record? ☐ Yes ☐ No
Dentist Name: _____ Last Visit: _____
Father's Name/DOB: _____ Mother's Name/DOB: _____
Father's Contact Phone: _____ Mother's Contact Phone: _____
Social Security Number: _____ Social Security Number: _____

Allergies

Is your child allergic to any foods, medications, chemicals, plants, other? ☐ Yes ☐ No If yes, please list:
Name Reaction
_____
_____

Current Medications

Please list current medications.
_____
_____
_____
_____

Pregnancy and Birth

Is the patient yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____
Mother's Name: _____ Age at Birth: _____
Check if mother had any of the following complications during pregnancy or delivery:
☐ Tobacco Use ☐ Substance Abuse ☐ Injections ☐ Diabetes
☐ Bleeding ☐ Rashes ☐ Fever ☐ High Blood Pressure
Medications during pregnancy: _____
Baby's Birth Weight: _____ Type of Delivery: ☐ Vaginal ☐ Cesarean
Was baby on time? ☐ Yes ☐ No If no, how early or late was the baby? _____
How many days did the baby stay in the hospital? _____ Complications (List): _____

Please provide our office with copies of any hospital records.

Patient History

Check if your child has had any of the following:

☐ ADD/ADHD	☐ Allergies	☐ Anemia	☐ Autism
☐ Constipation	☐ Depression	☐ Diarrhea	☐ Ear Infection
☐ Eczema	☐ Hearing Loss	☐ Heart Disease	☐ Pneumonia
☐ Rash	☐ Reflux	☐ Seizures	☐ Urinary Problems
☐ Cancer: _____	☐ Chicken Pox: Date: _____		☐ Other: _____

Has the patient had any hospitalizations or surgeries? ☐ Yes ☐ No
If yes, please list date, name of hospital, injury or illness: _____
_____

At what age did your child sit alone? _____
At what age did your child walk alone? _____
At what age did your child say words? _____

Do you have any concerns? Check applicable.
☐ Speech ☐ School
☐ Development ☐ Behavior

Continue to next page

Brighter Futures Pediatrics & Lactation Services, LLC
Initial History Questionnaire

Patient Name: _____ DOB: _____

Family and Social Profile

Mother's Full Name: _____
Mother's Age: _____
Lives with Patient? ☐ Yes ☐ No

Are Mother and Father:
☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Child Care: ☐ Parents ☐ Other (Specify) _____

House built before 1978? ☐ Yes ☐ No
Are there guns in the home? ☐ Yes ☐ No
Are there pets in the home? ☐ Yes ☐ No
Any foreign travel in the past 5 years? ☐ Yes ☐ No
Are there any smokers in the household? ☐ Yes ☐ No
If yes, do they smoke inside the home or outside? ☐ Inside ☐ Outside

Father's Full Name: _____
Father's Age: _____
Lives with Patient? ☐ Yes ☐ No

Sibling Names	DOB	Lives with patient?

Family Medical History

Check any of the following that apply to blood relatives of the PATIENT.
Please list maternal or paternal family members; Parent, Sibling, Grandparent, Aunt or Uncle.

☐ AIDS/HIV/Immune: _____
☐ Alcoholism : _____
☐ Allergies: _____
☐ Anemia: _____
☐ Arthritis: _____
☐ Asthma: _____
☐ Birth Defects/Genetic Disorder: _____
☐ Cancer: _____
☐ Depression/Mental Illness: _____
☐ Diabetes: _____
☐ Drug Abuse: _____
☐ GI Disease _____
☐ Hearing Loss: _____
☐ Heart Murmur/Disease: _____
☐ High Blood Pressure: _____
☐ High Cholesterol: _____
☐ Kidney/Liver Disease: _____
☐ Migraines: _____
☐ Seizures: _____
☐ SIDS: _____
☐ Stroke before age 55: _____
☐ Thyroid Disease: _____
☐ Tuberculosis: _____
☐ Other: _____

FINANCIAL DISCLOSURE POLICY

Thank you for choosing Brighter Futures Pediatrics & Lactation Services, LLC. The following are the financial policies for this office. If you have questions, please contact our office for further assistance. We are committed to provide the best care to your child and your understanding of the following protocols is essential to that goal.

- Your insurance policy is a contract between you and your insurance company
  - It is the parents' responsibility to know and understand their policy. Failure to notify our office of any changes in your insurance policy will result in you being responsible for the bill.
  - Benefits are verified at the time of the visit, however, please note that this is not a guarantee of payment.
  - For services rendered to patients who are minors, the accompanying parent or guardian is responsible for any payments due.
  - It is the parents' responsibility to pay all payments as outlined in the insurance policy.
  - **We collect $50.00 toward the deductible of the year plan at time of the visit, until your deductible is met.**
  - Patient balances are due within 30 days of the office visit, if there are any issues regarding payment, payment arrangements will be made. If payment arrangements are not met, your account will be turned over to a collection agency, and interest rates will apply.
  - **If any laboratory services are necessary (pathologies, wound cultures or blood work), you may receive a separate bill from separate lab companies that are not connected to our practice.**
  - If your insurance plan denies any service, it is your responsibility to pay any balances in full.

CANCELLATION & MISSED APPOINTMENT POLICY

- To serve our patients better, we request your consideration of the provider's time by asking that you give us 24-hour notice if you cannot attend a scheduled appointment. This allows other patients who are waiting for a cancellation to be notified. We understand that sometimes situations arise that out of your control, and a 24-hour advanced notices may not be sufficient. However, in these circumstances, we ask that you notify the office as soon as possible. When a patient repeatedly misses scheduled appointments, it becomes an inconvenience to the practice.
- A 24-hour notice is required.If you cancel or "no show" for your appointment less than 24-hours of your scheduled appointment, you will be charged $25.00 for a missed office visit. This fee **IS NOT COVERED BY INSURANCES.** Therefore, if a patient misses three consecutive appointments without proper notification, he or she may be subject to dismissal from our clinic; at the discretion of the treating provider. A letter will be sent to the patient/parent informing him/her of the decision and/or process.
- **If a patient is 10 minutes or more late for a scheduled appointment; we reserve the right to reschedule the appointment.**

FORMS

Due to the increase of requests for completed forms, i.e. (MVA, disability, durable medical equipment requests, school/daycare forms, etc.) there is a $10.00 fee for completion of forms. Turnaround time for these forms is 48-72 hours. **YOU WILL BE NOTIFIED WHEN THE FORM(S) ARE AVAILABLE FOR PICKUP.**

PAYMENT POLICY

It is my responsibility to confirm that Cynthia L. Zeller, CRNP, DNP, IBCLC, Brighter Futures Pediatrics & Lactation Services, LLC is covered under your insurance plan. I hereby authorize the assignment of benefits (payments) directly to Cynthia Zeller, CRNP, DNP, IBCLC or Brighter Futures Pediatrics & Lactation Services, LLC for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day on which services are rendered. This includes copayments/deductibles with any managed care contract and non-covered services. If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Brighter Futures Pediatrics & Lactation Services, LLC Financial Disclosure Policy.

If my insurance is accepted, I authorize payment of benefits to Cynthia L. Zeller, CRNP, DNP, IBCLC, or will reimburse Cynthia L. Zeller, CRNP, DNP, IBCLC if I am paid directly by my carrier.

I have read, understand and agree to the financial disclosure and cancellation policies above.

_____

Signature Date

_____

Print Patient's Name Patient's DOB

_____

Witness Signature Date

BRIGHTER FUTURES
PEDIATRICS & LACTATION SERVICES, LLC

Cynthia L. Zeller, CRNP, DNP, IBCLC
172 Thomas Johnson Drive, Suite 200
Frederick, MD 21702
(P) 301-304-9390 (F) 240-367-9608

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

TO: _____

_____

I, _____ hereby authorize and requests you to provide:

BRIGHTER FUTURES PEDIATRICS & LACTATION SERVICES, LLC
172 Thomas Johnson Drive, Suite 200
Frederick, MD 21702

With a copy of:

____ Entire record _____ Specific Information: _____

For the following patient(s) DOB:

_____

_____

_____

_____

Reason for Request:

___ Moving out of the area ___ Child's age ___ Insurance change ___ Unsatisfied with services

___ Other _____

_____

Parent/Guardian Signature Date

_____

Address Phone

Brighter Futures Pediatrics & Lactation Services, LLC.
Cynthia L. Zeller CRNP, DNP, IBCLC

Assignment of Benefits/Financial Agreement

I certify that the registration information I provided is true and accurate. I authorize payment of health insurance benefits directly to Brighter Futures Pediatrics & Lactation Services LLC., customary charges for service rendered. Payment is due upon receipt of services. I am responsible for all fees and charges deemed my responsibility according to BFP&LS and my health plan. If I do not provide a VALID insurance card before services are rendered, I will be held financially responsible for all services. I agree that I will pay any outstanding amounts in accordance with BFP&LS rates and terms. Should the account be referred to an outside agency for collection, I will pay reasonable fees and collection expenses. It is also my responsibility to verify with my insurance company, which services are covered and which services require prior authorization. Any errors therein will result in denial of payment by insurance and is my responsibility for the fees. It is BFP&LS policy that prescription refill requests are processed only with proper follow up visits and during business hours.

Patient Name: _____ Date of Birth: _____

Person responsible for Financial Agreement and Terms: _____ Date: _____

Parent/Guardian if patient is under 18 yrs. of age: _____ Date: _____

Acknowledgement of Receipt of Privacy Notice

I Patient (or parent/guardian) of Brighter Futures Pediatrics & Lactation Services, LLC., have been given a copy of the Privacy policy. I understand my rights according to this policy and that HIPPA law grants Brighter Futures Pediatrics & Lactation Services LLC. the authorization to use and disclose my medical records for treatment/care and payment operations.

_____

Signature of Patient or Parent/Guardian Date

Communication Authorization

Brighter Futures Pediatrics & Lactation Services, LLC. may contact me at home/work, at my home address regarding my diagnosis, results, treatment, care, or payment.

YES ____ NO ____ you may call my cell phone or home and leave detailed message #_____
YES ____ NO ____ you may call my cell phone or home and leave number to call back. # _____

Please use email to contact me with detailed Medical information: _____@_____

I understand that I may authorize BFP & LS LLC, provider to share medical/billing information about my care/child's care to the following. For a period of one year unless cancelled in writing earlier. Date: _____

_____ _____
Name/Relationship Phone

_____ _____
Name/Relationship Phone

_____ _____
Name/Relationship Phone

Brighter Futures Pediatrics & Lactation Services, LLC
Cynthia Zeller, CRNP, DNP, IBCLC
172 Thomas Johnson Drive, Suite 200
Frederick, MD 21702
301-304-9390

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payments: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by Secretary of the

Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except that your physician or the physician's practice has taken an action in reliance on the use and disclosure indicated in the authorization.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Your Rights. Following is a statement of your rights with respects to your health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. According to Maryland law, we have the right to charge a fee for copying of medical records. Our fee is charged according to the preparation time and number of pages copied. We also reserve the right to charge a fee for inspection of the medical records.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We have the right to change the terms of this notice and will inform you by mail of these changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Office Phone Number.

This notice was published and becomes effective on/before January 3, 2018

BRIGHTER FUTURES
PEDIATRICS & LACTATION SERVICES, LLC

Immunization Policy

We firmly believe in the effectiveness and safety of our vaccines to prevent serious illness and to save lives. We believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics. We believe that vaccinating children and young adults may be the single most important health promoting intervention we perform as health care providers, and that you can perform as parents or caregivers. We firmly believe, based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox or known a friend or family member whose child had died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. Vaccination of preventable disease is very important to both your child's health and to the public health of our community. Disease rates of vaccine preventable infections have increased when communities have seen decreasing vaccination rates.

As medical professionals, we feel very strongly that vaccinating on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. To ensure the safety of our patients we require that our patients receive:

Required vaccinations for start of Kindergarten:

- Rotavirus: 2 doses by 8 months old
- DTaP, Hib, Polio: 3 doses each by 1 year old
- Pneumococcal: 3 doses by 1 year old
- Hepatitis B: 3 doses by 6 years old
- MMR, Chicken Pox: First dose by 2 years old, Second dose by 6 years old
- Dtap, Polio: dose #4 by 6 years old

Required vaccinations for start of 7th grade:

- Tdap, Meningitis by 13 years old

Hepatitis A and HPV are strongly encouraged but not required at this time.

For those wanting more information we recommend the following websites
www.vaccineinformation.org
www.vaccine.chop.edu
www.vaccinateyourfamily.org

301-304-9390

Well Child Visit Schedule

3-4 Day Old Newborn Visit:
Jaundice Check, Weight Check, History & Physical, Growth & Development,

1 Month Well Child Visit:
Weight Check, History & Physical, Hepatitis B if not given in hospital

4 Month Well Child Visit
History & Physical, Growth & Development, Pediarix, Prevnar 13, HIB, Rotarix

9 Month Well Child Visit
History & Physical, Growth & Development

15 Month Well Child Visit
History & Physical, Growth & Development, DTaP, HIB, Prevnar 13

2 Year Well Child Visit
History & Physical, Growth & Development, MCHAT, Hgb/Hct/Lead

3 Year Well Child Visit
History & Physical, Growth & Development, Vision & Hearing Screens

2 Week Old Newborn Visit:
History & Physical, PKU, Growth & Development

2 Month Well Child Visit:
History & Physical, Growth & Development, Pediarix, Prevnar 13, HIB, Rotarix

6 Month Well Child Visit
History & Physical, Growth & Development, Pediarix, Prevnar 13, HIB

12 Month Well Child Visit
History & Physical, Growth & Development, Lead & CBC, MMR, Varivax, Hepatitis A

18 Month Well Child Visit
History & Physical, Growth & Development, MCHAT (Autism Screen), Hepatitis A

2.5 Year Well Child Visit
History & Physical, Growth & Development

4 Year Well Child Visit
History & Physical, Growth & Development, Vision & Hearing Screens, Kinrix, ProQuad, Hgb/Hct, Urinalysis (UA)

5 Year Well Child Visit
History & Physical, Growth & Development, Vision & Hearing Screens, UA

6-8 Year Well Child Visits
History & Physical, Growth & Development, Vision & Hearing Screens, UA

9-10 Year Well Child Visits
History & Physical, Growth & Development, Vision & Hearing Screens, UA, Cholesterol Screen

11 Year Well Child Visit
History & Physical, Growth & Development, Vision & Hearing Screens, UA, Tdap, Menactra, HPV

12-15 Year Well Child Visits
History & Physical, Growth & Development, Vision & Hearing Screens, UA, Bexsero

16 Year Well Child Visit
History & Physical, Growth & Development, Vision & Hearing Screens, UA, Menactra, Bexsero

17-21 Year Well Child Visits
History & Physical, Growth & Development, Vision & Hearing Screens, UA

Yearly Flu vaccines are recommended yearly. For children through 8 years and younger who have never been vaccinated for Flu, two vaccinations are required one month apart if they never received two in the same season. After that, only one vaccine per season is required.