BROOKHAVEN CHILDREN'S CLINIC, PA
C. MITCH HOLLAND, M.D., FAAP
DAVID S. BRADEN, M.D. FAAP, FACC
JENNIFER COOK, R.N., CPNP
LUCY SELLERS, R.N., CFNP

601 BROOKMAN DR. SUITE A
BROOKHAVEN, MISSISSIPPI 39601
TELEPHONE (601) 835-2100

BCC - CHART #

PATIENT INFORMATION

DATE_____

PATIENT'S NAME _____

RACE _____ SEX _____ BIRTHDATE _____ S.S. # _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____ SCHOOL _____

FATHER'S NAME _____ S.S. # _____

RACE____ BIRTHDAY _____ PHONE _____ CELL_____

EMAIL ADDRESS _____

EMPLOYED BY _____ OCCUPATION_____

EMPLOYER'S ADDRESS _____ PHONE _____

MOTHER'S NAME _____ S.S. # _____

RACE____ BIRTHDAY _____ PHONE_____ CELL_____

EMAIL ADDRESS _____

EMPLOYED BY _____ OCCUPATION_____

EMPLOYER'S ADDRESS _____ PHONE _____

REFERRED BY _____ ADDRESS _____

ELIGIBILITY DATE OF MEDICAID _____ MEDICAID NO. _____

NAME OF INSURANCE _____

POLICY NO. _____ GROUP NO. _____

Has anyone in your immediate family ever been to the Brookhaven Children's Clinic? _____

If yes, Who? in Hospital _____ In Office _____

DOES PATIENT HAVE ANY ALLERGIES: _____

If you do not have a phone, give a neighbor's phone _____ or a relative's phone no. _____

GRANDPARENT'S NAMES _____

ADDRESS _____ PHONE _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment below. SIGNED X_____ DATE _____	I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. X_____ SIGNED (Insured or Authorized Person)

HIPAA Privacy Notice Acknowledgement

Brookhaven Children's Clinic, PA
601 Brookman Drive, Ste. A
Brookhaven, MS 39601
601-835-2100

Acknowledgement Form:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name _____ DOB _____

Parent/Guardian's Signature _____ Date _____

SIGNATURE ON FILE

Medicaid will follow Medicare policy and allow providers to obtain a lifetime authorization from the Medicaid recipient to submit Medicaid claims. This authorization may be retained in the provider's office and should read basically as follows:

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER

Medicaid Recipient's Name:_____

Medicaid I.D. Number: _____

I request that payment of authorized Medicaid benefits be made on my behalf to **BROOKHAVEN CHILDREN'S CLINIC**. I authorize any holder of medical or other information about me to release to the Division of Medicaid or the Fiscal Agent any information needed to determine these benefits or the benefits payable for related services.

— This Authorization is Good for my Lifetime —

Recipient's Signature:_____ Date:_____

When the authorization is obtained, the provider should indicate "SIGNATURE ON FILE" in the patient's signature space on the claim form.

If you are submitting a signed claim form or if you are maintaining signature on file, the patient's signature requirement remains the same. .Be sure the patient signs his/her name. If the patient cannot write his/her name, he/she should sign by mark and have a witness sign the patient's name and indicate by whom the name was entered. If the patient is a minor or otherwise unable to sign, any responsible person such as a parent or guardian must enter the patient's name and write "By", sign his/her own name and address in the space, show his/her relationship to the patient and explain briefly why the patient cannot sign.

Form #6287

C. Mitch Holland, M.D., FAAP
David S. Braden, M.D., FAAP, FAAC,FASE
Jennifer Cook, R.N., CPNP
Lucy Sellers, R.N., CFNP

CHILD MEDICAL CARE AUTHORIZATION

This is to acknowledge that (**NAME/RELATIONSHIP**)_____

_____

is authorized to obtain whatever medical attention is necessary should my child(ren) _____ need medical care while in their custody.

This authorization is valid for one (1) year from date signed.

Insurance Information:

Insurance Carrier _____
Policy No. _____

Policy Holder _____
Phone No. _____

Medical Information:

Doctor _____ Phone _____
Dentist _____ Phone _____

Known Allergies/Allergic Reactions:

_____
_____

_____ _____ _____

(Parent/Guardian Name) **(Signature)** **(Date)**

Privacy Notice

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

Brookhaven Children's Clinic abides by the following policies:

Description of Uses and Disclosures of your Health Information

Information regarding your health will be used and disclosed for treatment, payment, and health care operations of the Brookhaven Children's Clinic. We take steps to safeguard your protected health information and only allow employees with proper authorization access to it. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your protected health information. This information may be used or disclosed with other health care providers as necessary to provide your health care treatment. Brookhaven Children's Clinic may use and disclose protected health information to another health care provider for the payment and health care operation activities of the entity receiving the information. The use and disclosure of this protected health information for the purposes of health care operations will only be released to another health care provider that has an established relationship with you, the subject of the information; and will only be released with the agreement that it will be used and disclosed by the receiving party in such a manner that pertains to your physician/patient relationship. All uses and disclosures of the protected information must be conducted in accordance with the provisions of Privacy Final Rule CFR 45 section 164.506 (c).

Protected Health Information will be released to law enforcement officials in accordance to state and local officials in response to an order, a subpoena, or other lawful process.

Brookhaven Children's Clinic intends to use your information specifically to contact you to provide appointment reminders and to provide you with other information necessary to providing medical care.

Your Individual Rights

You have the right to place restrictions on certain uses and disclosures of protected health information, the right to receive communications of and inspect and copy your protected health information, the right to amend certain protected health information in your individual file, and the right to receive an accounting of disclosures of your protected health information.

Duties of Brookhaven Children's Clinic

The clinic has the duty as required by law to maintain the privacy of protected health information and to provide individuals with notice of it legal duties and privacy practices. This clinic has the duty to abide by the terms of this privacy notice and reserves the right to change the terms of this notice and provide any new notice provisions or revisions to you in writing within 72 hours of the change.

Complaints

You have the right to voice a complaint if you feel that your rights regarding the privacy of your health information has been violated and may call 601-835-2100 and speak to the Office Manager.

This notice is effective as of February 1, 2003

Form#6711

Pediatric Continuing Care Enrollment Form

I, _____, parent/responsible party, for the Medicaid eligible person(s) listed below, agree to participate in this program under the following circumstances and stipulations:

I understand that:

(1) The enrollment period with **BROOKHAVEN CHILDREN'S CLINIC**, a Pediatric Continuing Care Doctor, is for a 1-year period which will automatically be renewed unless I give notice in writing at least thirty (30) days prior to the enrollment-end date;

(2) I should always call my Pediatric Continuing Care Doctor first in any medical emergency. He will provide or arrange for medical care for my child on a 24-hour day, 7-day-a-week basis;

(3) My Pediatric Continuing Care Doctor may have to refer my child to another specialist for diagnosis and treatment, and I have the freedom of choice of such providers;

(4) If my child loses his/her Medicaid eligibility, participation in this and all other Medicaid services terminates;

(5) I may change doctors under the following circumstances:

(a) The doctor no longer participates in the Pediatric Continuing Care Plan, or
(b) The doctor is ineligible for Medicaid participation;
(c) I give a 30-day notice to end my agreement for Continuing Care coverage with this doctor.

(6) My Pediatric Continuing Care Doctor cannot refuse to treat my child on the basis of race, sex, religion, age, national origin, color or handicap.

Children who will be covered under this plan:

Name_____ Name_____

Date_____ Date_____

Name_____

Date_____

David S. Braden
C Dr Holland

_____ _____

Parent/Responsible Party Pediatric Continuing Care Doctor

_____ _____

Witness Witness

Form # 6288