SUNSHINE CHILDREN'S CLINIC

VIBHA VIG, M.D.

CANTON CLINIC
156 RIVER OAKS DR STE A
CANTON, MS 39046
P:601-855-5287 F:601-855-5130
STEFANIE PEPPER, FNP-C
JESSICA RAMSEY, FNP-C

CARTHAGE CLINIC
1010 HWY 16 EAST
CARTHAGE, MS 39051
P:601-267-0544 F:601-267-5092
APRIL MCLELLAN, FNP-C
HANNAH COOPER, FNP-C

YAZOO CLINIC
230 WYETH LANE
YAZOO CITY, MS 39194
P:662-746-8962 F:662-746-8964
ALISSA DAMIENS, FNP-C
JANAE WHITE, FNP-C

PATIENT INFORMATION

Patient's full name: _____ Date: _____ Age: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Email: _____

Provider: _____ Pharmacy: _____ Allergies: _____

Hispanic or Latino? ○ Yes ○ No ○ Decline to Specify Ethnicity: _____

PARENT OR GUARDIAN INFORMATION

Race: _____ Language: _____

Guardian's name: _____ Date of Birth: ____/____/_____ SSN: _____-____-_____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____

Mother's name: _____ Date of Birth: ____/____/_____ SSN: _____-____-_____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____

Father's name: _____ Date of Birth: ____/____/_____ SSN: _____-____-_____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone: _____ Secondary Phone: _____

FINANCIAL INFORMATION

Who will be financially responsible for you? ○ Self ○ Someone else

*If you chose "Someone else", please fill out the following:

Name: _____ Relationship: _____Phone Number: _____

Method of Payment: ○ Insurance ○ Self-Pay

Relationship to Policy Holder: _____
Primary Insurance: _____ Secondary Insurance: _____
Policy Number: _____ Policy Number: _____
Group Number: _____ Group Number: _____

SUNSHINE CHILDREN'S CLINIC

LIST CHILD/CHILDREN'S NAMES AND BIRTHDAYS

CHILD'S NAME	BIRTHDAY

PLEASE LIST ANYONE AUTHORIZED TO BRING IN YOUR CHILD FOR MEDICAL CARE.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
	MOTHER	
	FATHER	

I AUTHORIZE THE ABOVE PEOPLE TO BRING MY CHILD IN FOR MEDICAL CARE, PICK UP PRESCRIPTION AND/OR FORMS, OR TO DISCUSS MY CHILD'S CARE WITH MEDICAL STAFF.

PRINTED PARENT NAME: _____

PARENT SIGNATURE: _____ DATE: _____

SUNSHINE CHILDREN'S CLINIC

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining g reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Sunshine Children's Clinic.

- The right to request on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTAND PATIENT CONSENT FOR USE AND DISCLOSURE OF PHI

SUNSHINE CHILDREN'S CLINIC

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

With my consent, Sunshine Children's Clinic may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to my child's clinical care including laboratory results among others.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____ Relationship to Patient:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: **Initials:** **Reason**:

SUNSHINE CHILDREN'S CLINIC

CONSENT FOR TREATMENT

I _____(Guardian's Name), hereby voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by the authorized designees of Sunshine Children's Clinic, as may in their professional judgement be necessary to provide for the medical care of _____ (Child's Name).

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

I hereby give my consent to Sunshine Children's Clinic, who will be caring for my child.

Name of Child: _____ Date of Birth: _____

Guardian Printed Name:_____ Relationship:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

FINANCIAL AGREEMENT

All services rendered are the payment responsibility of the patient or guarantor. As a courtesy, we will bill your insurance carrier. The patient or guarantor is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. I understand that I will be responsible for any costs resulting in my account being turned over to a collection agency or attorney and I understand the full importance of this declaration.

Guarantor Signature:_____ Date:_____

Witness:_____ Date:_____

SUNSHINE CHILDREN'S CLINIC

VIBHA VIG, M.D.

CANTON CLINIC
156 RIVER OAKS DR STE A
CANTON, MS 39046
P:601–855–5287 F:601–855–5130
STEFANIE PEPPER, FNP–C
JESSICA RAMSEY, FNP–C

CARTHAGE CLINIC
1010 HWY 16 EAST
CARTHAGE, MS 39051
P:601–267–0544 F:601–267–5092
APRIL MCLELLAN, FNP–C
HANNAH COOPER, FNP–C

YAZOO CLINIC
230 WYETH LANE
YAZOO CITY, MS 39194
P:662–746–8962 F:662–746–8964
ALISSA DAMIENS, FNP–C
JANAE WHITE, FNP–C

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

Address:_____

Phone Number:_____

I hereby authorize the release of Medical Records or information pertinent to:

- Outpatient Records
- Immunization Records
- ER Visit Dated:_____
- Referrals To:_____
- Lab/Path Reports
- Operative Reports
- Hospitalizations
- Newborn Records
- All Medical Records

From _____ to Sunshine Children's Clinic

From Sunshine Children's Clinic to _____

I HEREBY RELEASE SUNSHINE CHILDREN'S CLINIC FROM ANY AND ALL LEGAL LIABILITIES THAT MAY ARISE FROM RELEASE OF THIS MEDICAL INFORMATION. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME.

Patient or Guardian Signature:_____ Relationship to Patient:_____

Date:_____ Witness Signature:_____

PLEASE NOTE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON OR GUARDIAN OF WHOM IT PERTAINS.

SUNSHINE CHILDREN'S CLINIC

PHOTO RELEASE FORM

I, _____, (Parent) grant Sunshine Children's Clinic, my permission to use photographs taken of _____ (child) for any legal use, including but not limited to: publicity, illustration, advertising, and web content.

Furthermore, I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

- ◯ Yes, I grant permission to photograph my child
- ◯ No, I do not want photographs taken of my child.

Parent/Guardian Signature: _____

Child's Name: _____

Date: _____