

Welcome to St. Clair Pediatrics

St. Clair Pediatrics offers general pediatric services for children from birth to age 18. We aim to provide the best quality of care and support for you and your children. Our pediatricians are highly skilled, experienced physicians practicing only pediatrics, and we have an excellent staff of caring, well-trained nurses and registered medical assistants. Our office is open six days a week, including a half-day on Saturday. Nursing advice is available during office hours, and one of our doctors is available by phone 24 hours a day 7 days a week for other urgent questions. Our office provides the following services:

- **Newborn Care**: Our doctors are on staff at Memorial Hospital and St. Elizabeth's Hospital and will begin your child's care within 24 hours of his/her birth at these institutions. We believe in close monitoring of newborns, especially within the critical first several weeks of life. Your first several visits will focus on feeding issues (breast or bottle feeding), weight gain, early infant development, and keeping your child healthy.
- **Well-child Visits/Sports Physicals**: Some of the most important aspects of your children's care are ensuring their overall health and monitoring their continued development at every stage of life. At each check-up we discuss not only physical health, but also issues of growth and development, nutrition, safety, and social problems.
- **Sick Visits**: We understand the urgency involved in dealing with sick children and make every effort to schedule same-day sick appointments. Our physicians will take the time needed to explain your children's diagnosis and treatment options. We believe in the rational use of antibiotics and are aware of the risks associated with their over-use. Our doctors prescribe antibiotics only when they are indicated and educate parents in situations when they are not needed.
- **Vaccinations**: We are dedicated to ensuring your children stay protected from all serious vaccine-preventable diseases. Our office offers many of the newer vaccines as they become available (such as Rotateq, Menactra and Gardasil) and tries to limit the number of shots your children get through the use of combination vaccines (like Pediarix and Proquad).
- **Laboratory Services**: Our office has the ability to test for a variety of diseases including anemia, lead toxicity, kidney and urinary tract diseases, strep throat, RSV, and influenza.
- **Electronic Medical Record (EMR)**: Our office utilizes an EMR that creates computerized printouts for prescriptions and information sheets for parents. Everything you receive from our office will be easy to read and pertinent to your children's care. With our EMR, our patients' charts are always in the office and can be accessed by multiple staff members, allowing quicker response times to phone calls and parental questions.

Other Office Information

Office Hours: The office is open 8:30 AM to 5:00 PM Monday through Friday and 8:30 AM to noon on Saturday. The office is closed daily for lunch from 12:00-1:30 PM.

Contacting the Doctor After Hours in Case of an Emergency: Dr. Greg Garrison, Dr. Jill Johnston, and Dr. Kevin Ponciroli share call. If you have an emergency and need to reach one of the doctors during lunch hours or after hours, call the office at 618-624-9970. The answering machine will inform you which physician is on call and provide instructions on how to reach them. After hours calls should be reserved for ***emergencies only***.

Questions During Office Hours: During office hours, the nursing staff and doctors will be happy to answer questions. Please allow us time to check the messages and return the calls. If there is a prescription to be called in, please allow us time to complete the request and call the pharmacy prior to picking up the prescription to ensure that the medication is ready.

Scheduling Appointments: You may call or visit the office to schedule your child's next exam. Routine physicals should be scheduled from four to six weeks in advance. Please remember that many schools require physical exams for general admittance and/or participation in school-sanctioned sporting activities. By reviewing school calendars and scheduling these appointments well in advance, you can avoid a last minute rush. If your child becomes acutely ill, we will schedule an appointment based on urgency. We understand that illness is never convenient. For any ailment requiring immediate attention, please call us before coming to the office and we will arrange for you to be seen as soon as possible.

Insurance & Billing: We accept most insurance plans. (For a complete list, please visit our website at www.stclairpediatrics.com.) It is your responsibility to verify network participation, covered benefits, and eligibility on your plan. It is also your responsibility to update our office of all insurance and address changes at the time of service.

Payment: All co-pays are due at time of visit. The person bringing the child in for services is responsible for payment. You may pay with cash, check, American Express, Visa, MasterCard, or Discover.

Cancellation Policy: If you are unable to make it to your scheduled appointment time and need to cancel, please call at least 2 hours ahead of time. If it is after hours, please call and leave a message with the receptionist. Press 1 to reach her extension. If you miss an appointment or cancel less than 2 hours prior to your scheduled appointment time, you will be charged a \$15.00 fee. After a total of three no shows per family, you will need to find another doctor.

Add On Appointments: If you ask the doctor to see another child in addition to the one scheduled for the appointment, you may be charged a fee of \$15.00 plus the standard co-pay.

Returned Check Fee: There will be a \$20.00 fee applied to all returned checks. After a total of 3 returned checks per family, you will no longer be allowed to pay with checks. All unpaid returned checks will be turned over to the States Attorney's office for prosecution.

Copies of Medical Records: Requests for copies of medical records must be in writing. Please allow plenty of time to copy and print records. Various fees may apply.

Request for Prescription Refills, Shot Records, or Physical Forms for School: You may call, fax, e-mail, or request in person copies of prescription refills, shot records, or physical forms for school. Please allow 24 hours for the request to be completed.

Immunization Records: Please bring up-to-date immunization records with you to your children's well exams. We cannot give any additional vaccinations until we have a copy of all shots given. In addition, we are unable to release school physical forms without an up-to-date shot record.



Patient Information Form

Greg T. Garrison, M.D.
Jill A. Johnston, M.D.
Kevin M. Ponciroli, M.D.
Ginny Minnigerode, C.P.N.P.

Patient Name: _____

Street Address: _____

City / State / Zip: _____

How did you hear about our office? Established Patient / Friend / Neighbor Yellow Pages Insurance Co. Walk-in

Name of Mother: _____

Street Address: _____

City / State / Zip: _____

Drivers License No: _____

Name of Father: _____

Street Address: _____

City / State / Zip: _____

Drivers License No: _____

Primary Insurance Information

Insured Name: _____

Name of Employer: _____

Policy ID: _____

Secondary Insurance Information

Insured Name: _____

Name of Employer: _____

Policy ID: _____

Emergency Contact Person: _____

List name, sex and birth date of all siblings: _____

Please bring patient's insurance card to every visit. Parents/Guardians are responsible for notifying our office of changes of address and/or insurance coverage. Please note that whomever brings the patient(s) to their appointment is responsible for paying the Insurance Co-pay if applicable. When writing a personal check, please have Drivers License or State ID available.

Authorization To Release Medical Information: I hereby authorize St. Clair Pediatrics to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. I hereby authorize payments directly to St. Clair Pediatrics of the medical benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due St. Clair Pediatrics. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

Signature of Patient or Legal Guardian

Date

Date of Birth: ____ / ____ / ____

Gender: Male Female

Primary Care Physician: _____

Date of Birth: ____ / ____ / ____

Home Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____

SSN: ____ - ____ - ____

Date of Birth: ____ / ____ / ____

Home Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____

SSN: ____ - ____ - ____

Date of Birth: ____ / ____ / ____

Copay: _____ Preventive Coverage? Y N

Group Number: _____

Date of Birth: ____ / ____ / ____

Copay: _____ Preventive Coverage? Y N

Group Number: _____

Daytime Phone: (____) ____ - ____



Medical History Questionnaire

Greg T. Garrison, M.D.
Jill A. Johnston, M.D.
Kevin M. Ponciroli, M.D.
Ginny Minnigerode, C.P.N.P.

Patient Name: _____
Last First MI

Date of Birth: ____/____/____
(MM/DD/YYYY)

Is the patient adopted? Yes No If yes, in what country was the patient born? _____

Allergies to medication, food or environment: _____

Pre-existing medical conditions: Asthma Heart Disease Allergies Eczema Diabetes Autism ADHD
Other: _____

Current medications (and dosages): _____

List any hospitalizations or surgeries: _____

Check any that occurred during the pregnancy with this child:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Group B Strep | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Tobacco/Alcohol/Drug Abuse | <input type="checkbox"/> Chronic Nausea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> X-rays | <input type="checkbox"/> Bleeding/Spotting | <input type="checkbox"/> Excessive Weight Loss |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Rubella | <input type="checkbox"/> Infections | <input type="checkbox"/> Fetal Movement Problems |
| <input type="checkbox"/> RH Factor Incompatibility | <input type="checkbox"/> Accidents or Falls | <input type="checkbox"/> Amniocentesis | <input type="checkbox"/> Prescribed Medications |

Other: _____

Birth History Term (>37 weeks) Born Premature @ ____ weeks Single Multiple Birth
Mother's age at child's birth: _____ Father's age: _____ Birth Weight: _____ Birth Length: _____
Hospital: _____ Labor: Induced Spontaneous Delivery: Vaginal Cesarean Breech (feet first)
Apgar Scores: ____/____ Complications: _____

Infancy Check any that occurred: Jaundice Dehydration Chronic Diarrhea Failure to Thrive
 Allergies Colic Vomiting Feeding Problems

Growth and Development Did growth occur at a normal rate? Yes No
Indicate in what month the milestone was reached:
Walked unsupported: _____ Spoke words: _____ Spoke sentences: _____ Toilet trained: _____
Describe any current growth or fine/gross motor difficulties: _____

Social Factors Who lives with this child? _____

Mother's Occupation: _____ Father's Occupation: _____

Does anyone living with this child smoke? Yes No Pets in home? Yes No What kind? _____

Where does this child live? Home Apartment Other How old is this residence? _____

Do parents work with (check all that apply): Metal Chemicals Ceramics Lead Paint Stripping
Check type of heat source in the home: Electric Gas Oil Kerosene Wood Stove

Family Medical History Check if child's natural parents, siblings, aunts, uncles or grandparents have had any of the following:
 High Blood Pressure Allergies Emotional Problems Mental Retardation / Autism GI / Kidney / Liver diseases
 High Cholesterol Eczema Sight / Hearing Problems Alcohol / Drug Addiction Sickle Cell Anemia
 Early Heart Attack / Stroke (before age 55) Asthma Diabetes Hyperactivity / ADHD Hemophilia
 Cancer Epilepsy / Seizures Headaches None of the above



Acknowledgement of Receipt of Privacy Practices

Greg T. Garrison, M.D.
Jill A. Johnston, M.D.
Kevin M. Ponciroli, M.D.
Ginny Minnigerode, C.P.N.P.

I, _____, have received a copy of this office's **Notice of Privacy Practices** that were placed in effect on **April 14, 2003**.

Please select Primary Care Physician

- Greg T. Garrison, MD
- Jill A. Johnston, MD
- Kevin M. Ponciroli, MD

Signature

Date

This notice is valid for all family members that receive medical services at this practice. Please list your children's names below.

_____	_____
_____	_____
_____	_____
_____	_____

Please select all that apply:

- I give this practice and its representatives consent to leave messages on my voicemail or answering machine.
- I do not give this practice and its representatives consent to leave messages with my voicemail or answering machine.
- I give this practice and its representatives consent to leave messages with the following person(s). _____ & _____.
- I do not give this practice and its representatives consent to leave messages with anyone other than parents or legal guardians.

Signature

Date



St. Clair Pediatrics, LLC

Authorization for Release of Health Information

Patient Name: _____
Last First MI

Date of Birth: _____
MM/DD/YYYY

I authorize and request: _____
Name of Physician or Medical Facility

Street Address

City State Zip

To release to: _____
Name of Physician or Medical Facility

Street Address

City State Zip

Medical Records covering the periods from: _____ to _____
MM/DD/YYYY MM/DD/YYYY

Requested medical information is needed for: _____

I understand that my medical records or the medical record of the patient for whom I am signing may include Alcohol/Drug abuse, Psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. St Clair Pediatrics, LLC, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

Patient Signature or Legal Representative

Relationship to Patient

Date