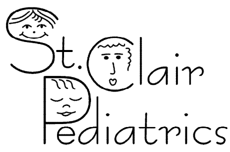


New Patient Packet

Greg T. Garrison, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

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

Contacting Us After Hours: All of our providers participate in our after-hours call service. If you have an urgent question and cannot wait to discuss it during regular office hours, call the office at 618-624-9970. The answering machine will inform you which provider is on call and provide instructions on how to reach them. After hours calls should be reserved for ***urgent questions only***.

<u>Questions During Office Hours</u>: 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.

<u>Scheduling Appointments</u>: 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.

<u>Insurance & Billing</u>: We accept most insurance plans. (For a complete list, please visit our website at www.stclaitpediatrics.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.

<u>Payment</u>: 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.

<u>Cancellation Policy</u>: If you are unable to make it to your scheduled appointment time and need to cancel, please notify the office as soon as possible. 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 24 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.

<u>Add On Appointments</u>: 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.

<u>Returned Check Fee</u>: 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.

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

<u>Request for Prescription Refills, Shot Records, or Physical Forms for School</u>: 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.

<u>Immunization Records</u>: 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, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

Patient Name: ______________________ Date of Birth: ___/___/___

Street Address: ______________________ Gender: ☐ Male ☐ Female

City / State / Zip: ______________________ Primary Care Physician: ______________

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

Name of Mother: ______________________ Date of Birth: ___/___/___

Street Address: ______________________ Home Phone: (   )   -

City / State / Zip: ______________________ Cell Phone: (   )   -

Drivers License No: ______________________ SSN: -   -

Name of Father: ______________________ Date of Birth: ___/___/___

Street Address: ______________________ Home Phone: (   )   -

City / State / Zip: ______________________ Cell Phone: (   )   -

Drivers License No: ______________________ SSN: -   -

Primary Insurance Information

Insured Name: ______________________ Date of Birth: ___/___/___

Name of Employer: ______________________ Copay: ________ Preventive Coverage? ☐ Y ☐ N

Policy ID: ______________________ Group Number: ______________

Secondary Insurance Information

Insured Name: ______________________ Date of Birth: ___/___/___

Name of Employer: ______________________ Copay: ________ Preventive Coverage? ☐ Y ☐ N

Policy ID: ______________________ Group Number: ______________

Emergency Contact Person: ______________________ Daytime Phone: (   )   -

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

Medical History Questionnaire

Greg T. Garrison, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

Patient Name: ______________________________ **Date of Birth**: ______________
Last First MI (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:
☐ Group B Strep ☐ Hospitalizations ☐ Tobacco/Alcohol/Drug Abuse ☐ Fetal Movement Problems
☐ High Blood Pressure ☐ Gestational Diabetes ☐ Bleeding/Spotting ☐ Infections
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)
Feeding: Breast / Bottle Complications: ______________________________

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? ______________

Family Medical History Check if child's natural parents, siblings, aunts, uncles or grandparents have had any of the following. Please also indicate which family member has that medical problem.

☐ High Blood Pressure ______________
☐ High Cholesterol ______________
☐ Heart Attack / Stroke before age 55 ______________
☐ Sudden Death (cardiac, etc.) ______________
☐ Diabetes ______________
☐ Allergies ______________
☐ Eczema ______________
☐ Asthma ______________
☐ Cancer ______________
☐ Emotional Problems ______________
☐ Sight / Hearing Problems ______________
☐ Gastrointestinal disease ______________
☐ Kidney disease ______________
☐ Liver Disease ______________
☐ Epilepsy / Seizures ______________
☐ Headaches ______________
☐ Developmental Delay ______________
☐ Autism Spectrum Disorder ______________
☐ Hyperactivity / ADHD ______________
☐ Alcohol / Drug Addiction ______________
☐ Blood Disorder ______________
☐ None of the above

Acknowledgement of Receipt of Privacy Practices

Greg T. Garrison, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

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 Provider

- ☐ Greg T. Garrison, MD
- ☐ Jill A. Johnston, MD
- ☐ Kevin M. Ponciroli, MD
- ☐ Ginny M. Peter, C.P.N.P.
- ☐ Kelly M. Harres, C.P.N.P
- ☐ Brittanie R. Bardon, C.P.N.P

____
Signature

____
Date

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

________________________________ ________________________________

________________________________ ________________________________

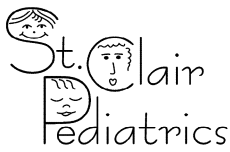
________________________________ ________________________________

________________________________ ________________________________

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: ____

Reason for transfer: Moving Away Non-participation with Insurance Transitioning to Family Practice/Internal Medicine

Issues with our practice Would you like for our Office Manager to contact you? Y N

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

Secure E-mail Agreement

Greg T. Garrison, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

E-mail us at mydocs@stclairpediatrics.com

In our continuing effort to better serve our patients and their families, we have set up an e-mail address through which you may communicate your child's protected health information with our office. It is your right to be informed about the risks of communicating via e-mail with your child's healthcare provider and about how we plan to use our secure e-mail service to maximize your child's medical management while maintaining his or her privacy as mandated by the American Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Definitions for this Agreement

User: any parent/guardian or other person given access to the e-mail address listed in this Agreement.

Protected Health Information (PHI): information, including demographic information that may identify the patient, that relates to the past, present, or future physical or mental health of an individual.

What types of communication should be sent via e-mail?

Subjects appropriate for e-mail

- Prescription refills
- Lab results
- Referral requests
- Billing questions
- Requests to have forms or immunization records completed
- Non-urgent, chronic disease management questions

Subjects that will not be discussed through e-mail

Sensitive materials such as:

- HIV-related issues
- Other sexually transmitted diseases
- Mental health issues
- Substance abuse issues

(These topics should be discussed with your child's physician in person.)

What are the benefits of using e-mail?

E-mail allows quick and detailed communication with our office for non-urgent matters.

E-mail allows retention and clarification of advice provided in clinic.

E-mail is useful for information you would have to commit to writing if it were given to you orally.

What are the risks of using e-mail?

E-mail is not appropriate for urgent matters or emergency situations. E-mail, by its very nature, is a delayed communication. Our e-mail is not accessed and read continuously (see "Office policies regarding e-mail" on page 2). We cannot guarantee that any particular e-mail will be read and responded to within any particular period of time.

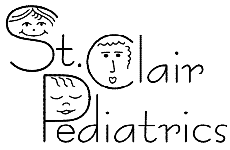
E-mail is sent at the touch of a button. Once sent, an e-mail message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur.

What are the benefits of the secure e-mail service known as SecureSend used by St. Clair Pediatrics?

To comply with the guidelines regarding patient and medical records privacy set forth by HIPAA, we have engaged a third-party provider to manage our secure e-mail system: Lux Scientiae (for more information on the company, please visit www.LuxSci.com). The company uses HIPAA-compliant encrypting technology (SecureSend) to ensure security of messages sent using its system. To access these messages, the User will be required to enter two passwords. The first is a User-specific password created by each User during the on-line registration of his/her e-mail address. The second is a randomly-generated password included in each e-mail. This ensures that only the person registering a valid e-mail address has access to a child's PHI.

Everyone may use this service regardless of the type of e-mail program they have (i.e., Outlook Express, Internet Explorer, etc.). Message links embedded in the body of each e-mail direct you to a secure internet website. NOTE: You **do** need internet access to view secure e-mail messages.

In general, e-mail can be circulated, forwarded, and broadcast to unintended recipients. Using the SecureSend web portal, you con only send an email to those accounts set up through Lux Scientiae's SecureSend (which, for us, is mydocs@stclairpediatrics.com).



Secure E-mail Agreement

Greg T. Garrison, MD
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Kevin M. Ponciroli. MD

Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

Office policies regarding e-mail

Response time: E-mail will be checked only during normal office hours, 4 times per day (or more). We will make every effort to respond to e-mails within 24 hours. An e-mail sent after 12:00 PM on Friday will not receive a response until the following Monday.

E-mail access: E-mail will be managed primarily by the clinical and nursing staff. All staff members will have password-protected access to the general e-mail service. Pertinent questions and concerns will be discussed with your child's physician before the staff responds.

E-mail responses: If the question you submit can be responded to in a short and concise manner, the staff will reply via e-mail. However, for questions that require a more detailed response, the staff will contact you via telephone. Please make sure to include your phone number on all e-mails you send to us.

Office security: All desktop workstations in the office are equipped with password-protected screen savers.

E-mail security: We will not forward patient-identifiable information to a third party without your express permission. We will not use registered e-mail addresses in marketing schemes or give out your address to third parties.

Your teenager will also be allowed to use this service: Any child over the age of 13 may sign himself/herself up for the e-mail service. This allows your child to continue to communicate with his/her physician openly, honestly, and confidentially about all subject matters.

E-mail directions

E-mail must be concise: Please limit each e-mail message to one issue. This allows us to maximize message triage efficiency. Please schedule an appointment for your child if the issue is too complex or sensitive to discuss via e-mail.

All e-mails must include: The e-mail's subject line should include the reason for your e-mail followed by your child's name (i.e. "Refill Request, Joe Smith"). The body of the e-mail should include your child's date of birth and the phone number(s) where you can be reached in case the office staff needs to speak with you.

Before transmitting the e-mail: Please double-check the message and any attachments to verify that no unintended information is included.

E-mails will become a part of your child's medical record: All e-mails will be printed and/or filed in your child's medical record.

Signing up and using the Service

Step 1: Read this Agreement and complete page 3. This Agreement will only be accepted in person at our office.

IMPORTANT: We will only reply to e-mails from Users that have submitted this Agreement in person.

Step 2: Log on to securesend.stclairpediatrics.com (a link can also be found on our main web page, www.stclairpediatrics.com).

Step 3: Set up your account by clicking on "Register your email address for secure sending." Enter your name, e-mail address and password. This password is the one you will use to log onto securesend.stclairpediatrics.com with your e-mail address. You then need to create a security question and password. These will be used to access a secure e-mail sent you by mydocs@stclairpediatrics.com.

To send an e-mail: Log onto securesend.stclairpediatrics.com with your e-mail address and password. You can then "Send a New Secure Message" to mydocs@stclairpediatrics.com by clicking "Compose."

To access an e-mail sent to you from mydocs@stclairpediatrics.com: The e-mail you receive will contain the line: "Click here to access your message." After clicking the link, you will be taken to a web portal, which will request two passwords. The first is the correct response to the security question you created during account registration. The second is specific to the e-mail sent to you and can be located in the body of the e-mail. You will then be taken to the actual e-mail sent to you by mydocs@stclairpediatrics.com.

IMPORTANT: Anyone can send a non-secure e-mail to mydocs@stclairpediatrics.com. The only way to ensure the information you send is secure is by logging onto securesend.stclairpediatrics.com.

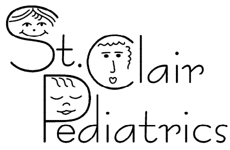
Disclaimers

We are not liable for breaches of confidentiality caused by the User or any third party or for any information lost due to technical failures.

It is your responsibility to inform us of changes to your e-mail address.

This agreement describes procedures that govern an individual's use of our secure e-mail system and defines the steps that must be taken by patients or their representatives who wish to correspond via e-mail with St. Clair Pediatrics. This policy applies to the informational uses of e-mail and does not cover the ethical, legal, and regulatory issues associated with e-mail consultations.

We reserve the right to deny a User's request to communicate with him/her via e-mail.



Secure E-mail Agreement

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Brittanie R. Bardon, CPNP

Please Remember

If you have an urgent matter or an emergency situation, you should not rely on e-mail to request assistance or to describe the urgent matter or emergency situation. Instead, you should act as though provider/patient e-mail is not available to you and seek assistance by means consistent with your needs (for example, contacting the office or the on-call physician via telephone or taking your child to the emergency room).

E-mail on your computer, your laptop, and/or your PDA has inherent privacy risks – especially when your e-mail access is provided through your employer or when access to your e-mail is not continuously password protected.

In order to process and respond to your e-mail in a timely and accurate manner, individuals at St. Clair Pediatrics other than your health care provider will read your e-mail message. Your message is not a private communication between you and your child's treating physician.

Neither you nor the person reading your e-mail can see the facial expressions or gestures or hear the voice of the sender. E-mail can be misinterpreted.

Please provide the following information:

User's Name: ______________________________

User's E-mail Address: ______________________________

User's Mailing Address: ______________________________

User's Phone Number: ______________________________

For which patients do you authorize us to communicate PHI to the above e-mail address?

Patient's Name	Patient's Date of Birth	User's Relationship to Patient

I have read, understood, and agree to the statements in pages 1 through 3 of this Agreement. I certify the e-mail address provided on this Agreement is accurate, and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address. I understand the use of e-mail is not appropriate for urgent matters or emergency situations. I understand any e-mail sent to mydocs@stclairpediatrics.com will be read primarily by the office staff and is not a private communication between myself and my child's physician. I agree to hold harmless St. Clair Pediatrics and individuals associated with it from any and all claims and liabilities arising from or related to this Agreement.

______________________________ ______________

Signature of Parent or Legal Guardian Date

Immunization Policy

Greg T. Garrison, MD
Jill A. Johnston, MD
Kevin M. Ponciroli. MD
Ginny M. Peter, CPNP
Kelly M. Harres, CPNP
Brittanie R. Bardon, CPNP

Swansea Office: 4941 Benchmark Center Drive • Suite 100 • Swansea, Illinois 62226
Columbia Office: 1000 Eleven South • Suite 4G • Columbia, Illinois 62236
Phone (618) 624-9970 • Fax (618) 624-9973

In order to ensure the health and safety of our patients and their families, the providers of St. Clair Pediatrics require that all of our patients receive immunizations in accordance with the current vaccination schedule. This schedule follows the recommendations of the American Academy of Pediatrics (AAP), the Advisory Committee for Immunization Practices (ACIP), the Center for Disease Control and Prevention (CDC) and the World Health Organization (WHO). We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of vaccines. We firmly believe that delaying or "splitting up" the vaccinations puts your child and the patients at our practice at risk of contracting serious illnesses and possible death.

Vaccination Schedule

Birth:	Hepatitis B
2 months:	Pediarix, Hib, Prevnar, Rotarix*
4 months:	Pediarix, Hib, Prevnar, Rotarix*
6 months:	Pediarix, Prevnar
12 months:	MMR, Varicella, Hepatitis A*
15 months:	DTaP, Hib, Prevnar
18 months:	Hepatitis A*
4-6 years:	Kinrix, Proquad
11-15 years:	Tdap, Meningococcal, Gardasil*
16-18 years:	Meningococcal
Yearly:	Influenza*

**Not required by state daycares or schools, but highly recommended*

Pediarix=Hepatitis B, DTaP, Polio
Kinrix=DTaP, Polio
Proquad=MMR, Varicella
DTaP=Diphtheria, Tetanus, Pertussis
MMR=Measles, Mumps, Rubella
Varicella=Chicken Pox
Hib= Haemophilus influenza type b
Prevnar=Pneumococcal
Tdap=Tetanus, Pertussis
Gardasil=HPV (Human Papilloma Virus)

I have read and understand the above policy and agree to vaccinate my child as outlined above.

__________________________________ ____________________
Patient Name Date of Birth

__________________________________ ____________________
Parent/Legal Guardian Signature Date