Pediatric Alliance of Decatur, LLC

Dr. Benjamin Brooks, MD, FAAP | Dr. Christina Branham, MD, FAAP
2220 North Monroe Street · Suite 3 · Decatur, IL 62526
phone (217) 423-7337 · fax (217) 423-7338
www.PedsAllies.org

Welcome to Pediatric Alliance of Decatur

We are pleased and excited that you have chosen our practice to provide your child's primary care, and we are looking forward to working with your family. Please complete the following information packet and submit the completed documents to our office staff prior to or at the time of your first visit. If you have questions regarding any of the information contained in the packet, please do not hesitate to contact us. These documents are also available on our website, www.pedsallies.org, which is currently being updated.

Our Promise to You

Our goal is to provide quality, personal, up-to-date, courteous, timely, professional and informative pediatric care. Dr. Brooks and Dr. Branham can be reached during office hours at 217-423-7337, or in cases of emergency the doctors can be paged through our answering service at 217-875-8561.

Parent Responsibilities

Missed appointments and same-day cancellations. We value our patients and wish to provide them care to the best of our ability. Missed appointments and same-day cancellations interfere with continuity and coordination of care, as well as the practice's ability to provide such care. Last minute conflicts and oversights happen to everyone. Please see our financial policy for details on penalties for missed appointments. We are obligated to take a firm stance on this matter to discourage missed appointments.

Tardiness. When arriving fifteen minutes or more late for an appointment, there will be two options. One will be rescheduling the appointment for another date and time. The other option is to wait in the waiting room for a possible opening, which cannot be guaranteed. Even after waiting, rescheduling may become the only option. More than fifteen minutes late is considered a missed appointment (see our financial policy for details on missed appointments and same-day cancellations).

Non-compliance. Certain recommendations may be flexible – Dr. Brooks and Dr. Branham work hard to provide options in medical management when appropriate. However, in some instances, failure to comply with the medical plan despite his/her strong urgings may result in dismissal of the patient.

Well Child visits. Wellness is a standard of quality care that our office recommends as well as the American Academy of Pediatrics. As a result, it is our duty to make reasonable attempts to get patients scheduled for well child check-ups. If patients fail to comply, our office may need to terminate our professional relationship with the patient and any sibling patients.

ER abuse and "doctor-hopping". Dr. Brooks and Dr. Branham are comfortable with second-opinions and specialist opinions when needed. Seeking primary care, non-urgent care from the ER, urgent care setting or other primary physician without recommendation from Dr. Brooks or Dr. Branham causes confusion and poor coordination of care. Let the doctor know if you have an emergency.

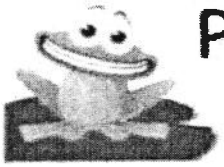
Keep up- to- date on your contact information. A reliable phone number and address on the chart is the parent/guardian's responsibility. Please keep us current. We may need to contact you about a lab result, appointment reminders or changes in the schedule.

Account balance. Ultimately, bills are the parent/guardian's responsibility. We do our best to bill insurance for you **IF** we are provided with proper billing information, but you will be expected to pay your balance. Please keep us updated on changes with health insurance coverage.

Food and drink. NO food or drink is allowed in the clinic, with the sole exception of infant formula.

We cannot accept your child as a patient if you do not plan to have them vaccinated.
In addition, we do not follow any sort of "alternate vaccine schedule".

A parent/guardian must accompany a patient to office visits through age 18 – no exceptions.



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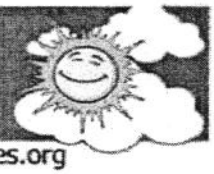

____Dr. Branham ____Dr. Brooks

DEMOGRAPHICS

Patient Name:_____ Male___ Female___ DOB:___/___/___

Address:_____

SS#:___-___-___ Race (circle one): African American Hispanic Asian Caucasian Other_____

Parent/Guardian Name:_____ Relationship to Patient:_____

Address if NOT living with patient:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

DOB:___/___/___ SS#:___-___-___ Email:_____

Employer Name:_____ Employer Ph:_____

Secondary Parent/Guardian Name:_____ Relationship to Patient:_____

Address if NOT living with patient:_____

Home Ph:_____ Cell Ph:_____ Work Ph:_____

DOB:___/___/___ SS#:___-___-___ Email:_____

Employer Name:_____ Employer Ph:_____

Emergency Contact Name (not living with patient):_____

Relationship to Patient:_____ Emergency Contact Phone:_____

HEALTH INSURANCE

Primary Insurance:_____ Effective Date:___/___/___
Address:_____
Name of Insured:_____ Relationship to Patient:_____
DOB:___/___/___ Policy/ID#:_____ Group #:_____

Secondary Insurance:_____ Effective Date:___/___/___
Address:_____
Name of Insured:_____ Relationship to Patient:_____
DOB:___/___/___ Policy/ID#:_____ Group #:_____

Please provide your insurance card(s) so we may scan a copy onto the patient's chart.

The above information is true and correct. This information is subject for review and verification. I understand that I must provide written documentation to support this information and services can be terminated if I do not provide the documentation or if I falsify information. I agree to immediately notify your office of any changes with my health insurance information.

Print Parent/Guardian Name	Parent/Guardian Signature	Date

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Name _____ Birth Date ____/____/____ Age _____

School Attending/Grade _____ Form Completed By _____

Birth History

Birth weight: _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications? ☐ Yes ☐ No

If yes, explain _____

Was a NICU stay required? ☐ Yes ☐ No If yes, explain _____

During pregnancy did mother: Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No What _____ When _____

Did mother take prenatal vitamins during pregnancy? ☐ Yes ☐ No

Delivery: ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Initial feeding: ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital? ☐ Yes ☐ No

General

Do you consider your child to be in good health? ☐ Yes ☐ No

Explain _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No

Explain _____

Has your child seen a subspecialist (eg: cardiology, dermatology, GI)? ☐ Yes ☐ No

Explain _____

Has your child had any surgery? ☐ Yes ☐ No

Explain _____

Has your child ever been hospitalized overnight? ☐ Yes ☐ No

Explain _____

ALLERGIES: COMPLETE ALL INFO BELOW

Household – Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Highest School Grade

Parent's Marital Status: Married Separated Divorced

If any siblings are not listed, please list their names, ages, & where they live.

_____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody

☐ Lives with foster parents ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Are there smokers in the home? ☐ Yes ☐ No

Are there pets in the home? ☐ Yes ☐ No If yes, what? _____

What is the household water supply? ☐ City water ☐ Well water

Are there guns in the home? ☐ Yes ☐ No If yes, are guns locked? ☐ Yes ☐ No

Does the child attend daycare? ☐ Yes ☐ No If yes, where? _____

Past History – Does your child have, or has your child ever had:

Chickenpox	☐ Yes	☐ No	☐ Don't Know	When _____
Frequent ear infections or hearing loss	☐ Yes	☐ No	☐ Don't Know	Explain _____
Seasonal allergies	☐ Yes	☐ No	☐ Don't Know	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ Don't Know	Explain _____
Asthma	☐ Yes	☐ No	☐ Don't Know	Explain _____
Any heart problem or murmur	☐ Yes	☐ No	☐ Don't Know	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ Don't Know	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ Don't Know	Explain _____
Recurrent constipation	☐ Yes	☐ No	☐ Don't Know	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ Don't Know	Explain _____
Chronic or recurrent skin problems (eg: acne, eczema)	☐ Yes	☐ No	☐ Don't Know	Explain _____
Convulsions or seizures	☐ Yes	☐ No	☐ Don't Know	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ Don't Know	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ Don't Know	Explain _____
Developmental delay	☐ Yes	☐ No	☐ Don't Know	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ Don't Know	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem(s) _____

Biological Family History – Have any family members had the following:

Asthma/allergies **(circle all that apply)**	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Anemia or bleeding disorders	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Diabetes	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Seizures	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Drug or alcohol abuse **(circle all that apply)**	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Mental illness/depression **(circle all that apply)**	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Developmental disability or birth defects	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Hypertension/blood pressure medication	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Sudden, unexpected death <55 years old	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____
Prison time	☐ Yes	☐ No	☐ Don't Know	Who _____	Comments _____

Additional family history _____

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Consent for Release of Information

Patient Name: _____ DOB: _____

Address: _____

I, _____ (Parent/Guardian), authorize Christina Branham, MD and Benjamin Brooks, MD to receive records pertaining to the above mentioned patient from: _____

_____

Please Include:

___ Entire Chart ___Vaccine Record ___Problem List

___ Labs & Xray Readings from the last 12 months ___ Most recent three progress notes/well child visits

___ Copy of Growth Chart (weight,height, & head circumference)

___This authorization specifically authorizes you to disclose records of alcohol and/or substance abuse

___ This authorization specifically authorizes you to disclose information regarding mental health services.

___This authorization specifically authorizes you to disclose information regarding infectious disease, sexually transmitted diseases, HIV or AIDS.

Signature_____ Date: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the previous health-care provider has already taken actions in reliance on it. If not previously revoked, this authorization will expire 6 months from the date of my signature, or as otherwise specified by date, event or condition(s) as follows: _____

_____

I understand that information disclosed may be subject to re-disclosure and is no longer protected by Federal Privacy Regulations. I understand this authorization is voluntary and I understand that I may receive a copy of this authorization upon request.

Parent/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

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Financial Policy

Thank you for choosing Dr. Brooks or Dr. Branham as your child's health care provider. Our goal is to provide and maintain high quality care while fostering a positive patient-physician relationship. Please read carefully and sign and date where indicated.

- The parent/guardian must pay in full for services at the time of the visit if the patient does not have medical insurance or if the patient has an insurance plan with which our doctors do not participate.

- Make sure we have current, active insurance information on file at all times, as well as current phone numbers and a current address Please notify us immediately if your insurance coverage changes, if your phone number changes or if you move.

-It is your responsibility to understand what coverage your insurance plan provides.

- Co-payments are due at the time of service. We accept cash, check, Visa, MasterCard and Discover.

- Balances remaining after payment is made by your insurance company will be billed to you within 30 days. Full payment is expected immediately upon receipt of the statement.

- A $20.00 service charge will be added to the patient's account for a returned (NSF) check.

- Charges incurred as a result of a liability claim are the patient's responsibility. We will bill insurance using the information provided, however, litigation is usually lengthy and the doctors must be paid in a timely manner.

- Questions about statements should be directed to our biller. She can be reached at 217-423-7337. If you are having trouble paying a bill, please call our office to discuss the situation, as financial considerations should never prevent children from receiving the care they need.

- Our office does not bill Molina Healthcare or Medicaid as a secondary form of insurance.

- For accounts that become delinquent, our office reserves the right to refer them to a collection agency. It is the responsibility of the patient/guarantor to pay all late fees, collection fees and attorney fees in addition to the total amount originally owed. As a result, the patient and siblings will need to seek medical care elsewhere.

- FMLA (Family Medical Leave Act) paperwork can be completed with 10 days' notice. There is a $15.00 fee for completion of these forms.

- If you transfer to another physician, we will provide a copy of the patient's medical record to the new physician one time at no charge. 2 weeks' notice is required.

- If you require a personal copy of your child's medical record, we can provide one to you for a fee. The fee is determined by the volume of the record and requires 30 days' notice.

- You agree to photographs being taken of your child to be used for identification purposes only. The photographs will be stored electronically in the patient's medical record.

- For medication refills, please call during regular business hours; 48 hours' notice is required.

Divorced Parents: The parent that signs this financial policy is the person responsible for full payment which includes payment of co-payments at the time of service. Our office will not become involved in marital disputes.

Missed Appointments:
For Well Child Appointments, Sick Visit Appointments and Follow-Up Appointments:
If you are unable to keep your appointment please call our office at least 24 hours before the scheduled appointment time. If you miss an appointment of this type, a non-negotiable fee of **$40.00** will be billed to your child's account. Any upcoming appointments for the patient and his/her siblings will be cancelled and you will have 30 days to pay the fee. If the fee is not paid within the 30 day period, the patient and all siblings are subject to dismissal from the practice. The 3rd instance of this will result in dismissal from our practice. The 3 appointments will be cumulative between siblings.

For appointments that require more preparation and time with the doctor - ADHD/Behavior Evaluations, more complicated concerns and follow-ups (the term "complicated" is determined by our staff):
If you are unable to keep your appointment, please call our office at least 24 hours before the scheduled appointment time. If you miss an appointment of this type, a non-negotiable fee of **$75.00** will be billed to your child's account. Any upcoming appointments for the patient and his/her siblings will be cancelled. You will have 30 days to pay the fee. If the fee is not paid within the 30 day period, the patient and all siblings are subject to dismissal from the practice.

If you miss your child's first appointment in our office or fail to provide 24 hours' notice for your cancellation of his/her appointment, you will not be able to reschedule the appointment. We will no longer consider your child a patient at our office and you will need to seek medical care elsewhere for him/her and any siblings.

Please list your children's names below, sign and date. Thank you.

_____

_____

_____

_____

_____

_____

Parent/Guardian Signature **Date**

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Permission/Consent for Treatment

Patient Name:_____ DOB:_____

I,_____, give permission to the following individuals to bring my child to the doctor or act in my absence as the guardian:

1._____Relationship:_____

2._____Relationship:_____

3._____Relationship:_____

This consent includes assessment and treatment by Dr. Benjamin Brooks and/or Dr. Christina Branham or Covering Physician in their absence. Furthermore, I also grant the above mentioned individuals, on my behalf, the authority to sign consent for any and all immunizations, lab procedures and/or procedures as may be deemed necessary by the doctors. This agreement shall stand indefinitely unless I, the guardian of the listed patient(s) of Pediatric Alliance, deem otherwise. In such case, this written statement shall be removed.

CONSENT FOR TREATMENT: I authorize and consent to the performance of medical or surgical treatment and/or laboratory testing considered necessary or advisable by Benjamin Brooks, MD or Christina Branham, MD and their office staff care professionals.
Initials: _____

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of medical and surgical benefits to Benjamin Brooks, MD or Christina Branham, MD or services rendered by these physicians in person or under their supervision. I understand I am financially responsible for any balance not covered by my insurance. I also understand that if this bill goes to collections and an attorney, I am fully responsible for all reasonable costs for collection and/or attorney fees that are incurred, as well as court costs.
Initials: _____

RELEASE OF INFORMATION: I authorize the medical practice of Pediatric Alliance to release information to any hospital, referring physician or physician being referred by this practice.
Initials: _____

RELEASE OF INFORMATION TO SIGNIFICANT OTHERS: I hereby authorize Benjamin Brooks, MD and Christina Branham, MD with and/or their staff to verbally discuss my case and condition with the individuals listed hereunder:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

I agree that a photocopy of this agreement shall be as valid as the original. **PARENTS PLEASE NOTE:** This legality must be completed for each child separately on their respective charts. **Parent/Guardian**

Signature: _____ **Date:**_____

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PRIVACY PRACTICES

I, the undersigned, acknowledge that I have received a copy of the latest "Notice of Privacy Practices" from Dr. Benjamin Brooks and Dr. Christina Branham.

This document describes:

- How the physician practices and their business associates may use and/or disclose my "protected health information."
- My rights related to my "protected health information."

I understand terms of the "Notice of Privacy Practices" are subject to change. I may keep updated on these changes by:

- Reading the latest revision on the web-site of the physician practice.
- Reading the latest revision posted in the doctor's office.
- Requesting a copy of the latest revision.

I know I have the right to refuse to sign this receipt. If I do not sign, the physician's office staff will document their efforts to obtain a signed receipt from me.

Initials: _____

By signing below, I acknowledge that I have read, understand and agree to these policies.

Parent/Guardian Signature:_____ Date:_____

Patient's Name:_____ DOB:_____