** COMPLETE ENTIRELY **

ALL CHILDREN'S CLINIC, P.C.
PATIENT INFORMATION

Patient Name ____________________ SS# ____________________ M/F ________

Street Address ____________________ Date of Birth ____________________

City ____________________ State ____________ Zip ____________ Race __________

Telephone: (home)________________ (mobile) ________________ (work) ______________

Email: ____________________ Pharmacy ____________________

Referred By ____________________

Mother's Name ____________________ Date of Birth ____________ SS# ____________

Father's Name ____________________ Date of Birth ____________ SS# ____________

Other Contact ____________________ Telephone # ____________________

PARENT EMPLOYER INFORMATION

Employer Name ____________________ Telephone # ____________________

Employer Address ____________________ City/State ____________ Zip ____________

Parent's Occupation ____________________

INSURED PERSON (IF NOT PATIENT)

Name ____________________ Telephone # ____________________

Street Address ____________________ City/State ____________ Zip ____________

Relationship to Patient ____________________

INSURANCE

I HAVE NO INSURANCE AND I WILL BE PAYING BY ( ) CASH ( ) CHECK FOR OFFICE VISIT THERE WILL BE A THIRTY FIVE DOLLAR CHARGE FOR RETURNED CHECKS.

Medicaid # (IF APPLICABLE) ____________________

Primary Insurance Company Name ____________________

ID # ____________________ Group # ____________________ Telephone # ____________

Secondary Insurance Company Name ____________________

ID # ____________________ Group # ____________________ Telephone # ____________

Please present your insurance card and driver's license to the receptionist to be copied. We will call to verify the type of coverage you have before you see the doctor. All payments including copays and deductibles are due at the time of visit.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I, the undersigned, have insurance with ____________________ and assign directly to All Children's Clinic, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I hereby assign the clinic/doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic.

____

Signature of Insured/Guardian/Parent Date

ASSIGNMENT OF ACCOUNT TO A COLLECTION SERVICE OR AN ATTORNEY

If this account is assigned to a collection service or an attorney for collection, All Children's Clinic, P.C., shall be entitled to cost of collection which may amount to forty (40%) percent of balance and attorney's fees.

____

Signature of Insured/Guardian/Parent Date

All Children's Clinic, PC AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

If any sections are incomplete this form may be invalid

PATIENT INFORMATION:

Name: ______________________________ Date of Birth: ____________________

Address: ______________________________ Phone Number: ____________________

City: ____________________ State: ______________ Zip: ______________

RELEASE INFORMATION FROM:
All Children's Clinic, PC

Senatobia Office
103 Halls Cove
Senatobia, MS 38668
P: (662) 562-9003
F: (662) 562-4007

Southaven Office
3674 Goodman Rd E
Southaven, MS 38672
P: (662) 890-7747
F: (662) 890-3566

Hernando Office
930 Magnolia Hills Cove
Hernando, MS 38632
P: (662) 449-9230
F: (662) 449-9224

TO:
Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip: ________

Phone: ______________ Fax: ______________

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From:
Name: ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: ________

Phone: ______________ Fax: ______________

PURPOSE FOR THE RELEASE OF INFORMATION:
- ☐ Transferring to another Practice
- ☐ Attorney Use
- ☐ Personal Use
- ☐ Visit to Specialist
- ☐ Other (describe) ____________________

There is a fee for ACC to print and send records, this fee is waived if sending directly to another physician's office. This fee is determined by the state. Please call our medical records department to get current fee schedule.

DESCRIPTION OF INFORMATION BEING RELEASED:
Specific Date(s) of services:
From________________ To____________________
I would like:
- ☐ An abstract (pertinent information related to the above listed date(s)
- ☐ Complete Health Record
- ☐ Billings Records
- ☐ Other: ______________________________

SENSITIVE INFORMATION RELEASE:
I understand if my medical record or billing record contains information that references drug/alcohol abuse, psychiatric care, mental health treatment, HIV/AIDS, I agree to its release.
I hereby authorize All Children's Clinic, PC to use or disclose protected health information regarding my child's care and treatment. I understand that information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state law.
I have the right to revoke this authorization at any time. I understand that my release shall not constitute a breach of my right to confidentiality. The authorization expires 90 days from the below date, and it covers only treatment prior to that date.

If the patient is 18 years of age or older, the patient must sign and date the form unless incapable of signing.
If the patient is 17 years of age or younger, a parent of legal guardian must sign and date the form.

Signature: ______________________________ ☐ Self ☐ Parent/Guardian ☐ Other: ____________

Date: ______/______/_______

ALL CHILDRENS CLINIC VACCINE POLICY STATEMENT

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. The recommended vaccines and the vaccine schedule are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

This said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky. The boy contracted smallpox and died at the age of 4, leaving Franklin with a lifetime of guilt and remorse. In his autobiography, Franklin wrote: "In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox…I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chicken pox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating.

But such an attitude, if it becomes widespread, can only lead to tragic results. After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many Europeans chose not to vaccinate their children. As a result of under immunization, Europe experienced large outbreaks of measles, with several deaths from disease complications. In 2012, there were more than 48,000 cases of pertussis (whooping cough) in the United States, resulting in 22 deaths. Most victims were infants younger than six months of age. Many children who contracted the illness had parents who made a conscious decision not to vaccinate. In 2015, there was a measles outbreak in Disneyland, California (probably started by an infected park

visitor who had traveled from the Philippines). The outbreak eventually spread to 147 people and, again, many were too young to have been vaccinated.

When you don't vaccinate, you take a significant risk with your child's health and the health of others around them. By not vaccinating, you also take selfish advantage of thousands of others who do vaccinate their children, thereby decreasing the likelihood that your child will contract a vaccine-preventable disease. We feel that refusing to vaccinate is self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However**, should you have doubts, please discuss these with your healthcare provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at All Children's Clinic.** Such additional visits will require additional co-pays on your part. Please realize that you will also be required to sign a "Refusal to Vaccinate" acknowledgement in the event of lengthy delays.

Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated. Infants will receive all age-appropriate recommended vaccines as well as booster doses by two years of age. Children will receive additional doses by the time they are seven years old and will be given recommended 11-12 year preteen vaccinations by the time they are 13 years old. We will complete 16-year teen vaccinations before each child's 17th birthday. And we will also give your child/teen an annual influenza vaccination unless they receive it at a school clinic or pharmacy.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health-care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating your child on schedule with currently available vaccines is absolutely the right thing to do to protect all children and young adults. Thank you for taking the time to read this policy. Please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Signature ______________________________________ Date __________________