



Jennifer Midgett, LLC / Premier Pediatrics of Louisiana

325 W. 8th St., Deridder, LA 70634
Tel: 337-221-3075 Fax: 337-221-3076
www.premierpediatricsla.net

Welcome to Jennifer Midgett LLC / Premier Pediatrics of Louisiana!

We are glad that you have chosen us to provide your primary care, and we are looking forward to working with you and/or your family. To complete the following information, you will need Insurance Cards, Driver's license, Social Security Numbers, Health Information, etc. all in relation to the patient.

PATIENT INFORMATION

First Name: Last Name: DOB: / /
Gender: Male [ ] Female [ ] Age: Social Security #: - -
Address:
City: State: Zip:
Home Phone: ( ) Cell Phone: ( )
Permission to leave message? Home: YES [ ] NO [ ] Cell: YES [ ] NO [ ] E-Mail: YES [ ] NO [ ]

PREVIOUS PROVIDER INFORMATION

Doctor or Office: Location:
Office Phone: ( )

PHARMACY INFORMATION

Pharmacy Name:
Address: Phone #: ( )

PARENT/GUARDIAN INFORMATION

Parent/Guardian (First, M.I., Last): DOB: / /
Relationship to Patient: Social Security #: - -
E-Mail:
Home Phone: ( ) Cell Phone: ( )
Permission to leave message? Home: YES [ ] NO [ ] Cell: YES [ ] NO [ ] E-Mail: YES [ ] NO [ ]

INSURANCE INFORMATION

Select all insurance types that apply. [ ] Private (Blue Cross, Cigna, ETC.) [ ] Medicaid [ ] Tricare/US Family/Champ VA

Primary Insurance: Policy Holder Name:
Policy Holder Sex: Male [ ] Female [ ] Policy Holder DOB: / /
Policy Holder SSN#: - - Relation to Patient:
ID #: Group #:

Secondary Insurance: Policy Holder Name:
Policy Holder Sex: Male [ ] Female [ ] Policy Holder DOB: / /
Policy Holder SSN#: - - Relation to Patient:
ID #: Group #:

**INITIAL HISTORY QUESTIONNAIRE**

Patient Name (First, M.I., Last) : \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Completed By: \_\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**HOUSEHOLD**

# of BROTHERS: \_\_\_\_\_ # of SISTERS: \_\_\_\_\_ # of Pets: \_\_\_\_\_  Inside # of Pets: \_\_\_\_\_  Outside

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

- Joint custody  Lives with adoptive parents  Other  
 Single custody  Lives with foster family

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

\_\_\_\_\_

**BIRTH HISTORY**

Don't know birth history

**Were there any problems in the pregnancy?** *Please check all that apply.*

Yes  No  Unknown

- Bleeding  Diabetes  High Blood Pressure  Hospitalization  Premature Labor  Pre-eclampsia  Surgery  Toxemia  
 Infection(s), please specify: \_\_\_\_\_  Other: \_\_\_\_\_

**Were any medications or drugs used in the pregnancy?** *Please check all that apply.*

Yes  No  Unknown

- Prenatal vitamins  Folic Acid  Prescription medication  Other drugs  Alcohol  Smoking  
 If yes to any marked above, please specify: \_\_\_\_\_

**Delivery**

Mother's age at delivery: \_\_\_\_\_ Length of pregnancy: \_\_\_\_\_ weeks Labor:  Spontaneous  Induced, reason: \_\_\_\_\_

Delivery:  Vaginal  C-Section Were there any problems during delivery?  No  Yes, describe: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Days spent in the hospital: \_\_\_\_\_

**Were there any medical concerns when the child was a newborn?**  No  Yes  Unknown

- Breathing problems  Jaundice  Low muscle tone  Feeding problems  Birth defect (*specify*): \_\_\_\_\_

**Did your child spend time in the NICU?**  No  Yes, explain: \_\_\_\_\_

**GENERAL PATIENT MEDICAL INFORMATION**

Does the patient have ANY serious illnesses or medical conditions? (*If yes, please list below*)

Explain: \_\_\_\_\_  Yes  No  Unknown

Has the patient had ANY surgeries or hospital stays? (*If yes, please list below*)

Explain: \_\_\_\_\_  Yes  No  Unknown

Is the patient allergic to ANY MEDICATION? (*If yes, please list below*)

Explain: \_\_\_\_\_  Yes  No  Unknown

Is there any important family medical history that we should be aware of? (*If yes, please list below*)

Explain: \_\_\_\_\_  Yes  No  Unknown

**FAMILY MEDICAL INFORMATION**

Does the patient have any Family Members with the following problems? (*If yes, please indicate relationship.*)

Explain: \_\_\_\_\_  Yes  No  Unknown

Is there any other information that would be helpful for treating your child?

Explain: \_\_\_\_\_  Yes  No  Unknown

**Authorized Individuals for Consent to Treat**

The purpose of this consent is to give a trusted person of your choosing permission to talk about the medical needs/treatments for the patient. This consent also allows the following individuals to attend appointments for care of minor patients in the event the parent or guardian cannot be present.

I authorize the following list of individuals to consent for treatment of myself or my child. I understand that by providing the following information about the individuals, I am allowing Jennifer Midgett, LLC / Premier Pediatrics of Louisiana to verify to the best of their ability the identity of the individual. If at any time I wish to remove a name from this list of persons authorized to consent for medical care of myself or my child, I may do so by requesting a new form, filling it out, and signing again.

**Please list 2 trusted individuals, to whom you give consent to attend and/or discuss the medical care of the patient. Identification will be required at the time of the appointment if the patient is accompanied by any of the following individuals.**

<i>First and Last Name of Individual</i>	<i>Relationship to Patient</i>	
<i>First and Last Name of Individual</i>	<i>Relationship to Patient</i>	
<b>Signature of Parent / Guardian</b>	<b>Name of Parent / Guardian</b>	<b>Date</b>

**VACCINE ADMINISTRATION RECORD OF CONSENT OR REFUSAL TO VACCINATE**

All parents/guardians and patients should be informed about the risks and benefits of preventative and therapeutic procedures, including vaccinations. The American Academy of Pediatrics strongly recommends discussion of vaccines risk and benefits. The Federal Law also mandates the discussion of vaccine risk and benefits be discussed by the provider and parents/guardians and patient with access to Vaccine Information Sheets.

As a Primary Care Provider, it is our job to inform you completely of all known information in regard to any treatments, preventative and therapeutic procedures including vaccines. When information is provided, the parent/guardian and patient can make the best decision for the patient’s care and treatment.

All vaccine information such as immunization schedules, past and current information, and vaccine information sheets can be obtained in our office and online through the CDC’s Vaccination website for your convenience.

**Vaccination status does not determine patient care at Premier Pediatrics of Louisiana. We welcome all walks of life at our clinic!**

Childhood vaccines include but aren’t limited to the following: Hep B, DTaP, Tdap, DT, Hib, PCV, IPV, MMR, Varicella, Flu, Meningococcal, Hep A, Rotavirus, HPV.

**Below please list your vaccination status for your patient**

- Yes, I vaccinate.       No, I do not vaccinate.       Unsure, I have questions about vaccines.

<b>Signature of Parent / Guardian</b>	<b>Name of Parent / Guardian</b>	<b>Date</b>
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## OFFICE POLICIES AND PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

(Originally Effective 05/2018, Rev. 11/2023)

### Policies and Consents

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance about our Office Policies allows for a good flow of communication and enables us to achieve our goals together. **Please read each section carefully and initial after each section.** If you have any questions, do not hesitate to ask a member of our staff. Thank you.

### Appointment Policy

We value the time we have set aside to see and treat patients and do not double book appointments. We strive to minimize wait times; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

### Appointment Types & Definitions

- **Routine Office Visit.** Non-emergent routine care. Scheduled as follows.
- Follow-Up (ER/Urgent Care, Specialist, etc.) – Scheduled at minimum 24-48 hours after discharge depending on availability.
- Physicals (sports, school, child welfare, etc.) – Scheduled within 1-5 days depending on availability.
- Medication Management (Adjustments, Controlled Substances, Refills) – Scheduled within 1-5 days depending on availability.
- Referrals (Visit required to send any referrals to specialist.) – Scheduled within 1-5 days depending on availability.
- **Wellness/Kid Med Visits.** Non-emergent routine care for marking developmental milestones. Scheduled within 7 days depending on availability and need. May include the following: Milestone Forms, Labs, Screenings, Vaccinations, etc. Well visits are scheduled at the following ages: Newborn, 1<sup>st</sup> Week, 1 month, 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month, 2-18 years (yearly).
- **Nurse Visits.** Allergy shots and Weight checks. Scheduled 1-2 times weekly.
- **Walk-In & Emergency Care.** Care required for same day interventions such as injuries, infections, or urgent intervention to prevent a rapid decline in health. Unscheduled visit and will work into scheduled as allowed or directed to the appropriate emergency care facility.

### Forms, Scheduling, Cancellations, No-Shows, & After-Hours Services

- **Forms.** Our office sends out your forms before your appointment. These are to be completed and reviewed before your scheduled appointment. Also please be aware that all insurance requires that your insurance data be checked/updated prior to each encounter. If this is not done, your insurance may deny your claim.
- **Scheduling.** Please schedule your appointment to secure your time with the provider. While we do accept walk-in patients, it is not advised as we must work you into a busy schedule. Appointments for additional patients should be made by phone prior to coming to the office. If you would like another patient to be seen, please schedule appointments for both in advance by phone prior to coming to the office. We will attempt to accommodate you and your patient's needs if possible. Schedule an appointment by calling 337-221-3075.
- **Appointment Times & Late Arrivals.** Patients who have arrived on time will be seen ahead of those who arrive late. We give a 15-minute grace period for late arrivals. Call at least 30 minutes ahead if you are going to be late for your appointment. We will do all that we can to accommodate your appointment and to minimize the need to reschedule your appointment.
- **Cancellations & No-Shows.** In the event you must cancel your appointment, please do so 24 hours before your appointment. Unforeseen emergency cancellations will be addressed on an individual basis. Any patient that arrives more than 15 minutes after the scheduled appointment time will be considered a No-Show. In these cases, a no-show charge for the lost appointment can be applied to the patient's account in the sum of \$30. No-Show fees are billed directly to the patient and not the insurance and must be paid before the next visit. The no-show charge can be waived at the office's discretion.
- **After-hours & Weekend Services.** Please limit after-hour calls and/or messages to urgent issues and emergencies only. For refills, appointment requests, and other nonurgent matters, please call the office during regular hours. A charge of \$30 will be applied for after-hours services that do not lead to an office, urgent care, or ER visit. In the event a staff member or provider is unavailable, please take all urgent matters to the nearest Urgent Care or Emergency Room.

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**Signature of Parent/Guardian**

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**Name of Parent/Guardian**

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**Date**



**Insurance Policy & Financial Responsibility** (Please understand the following:)

1. It is your responsibility to keep us updated with your correct insurance information. *If the insurance company you designate is incorrect, you will be responsible for payment of the visit /services and to submit the charges to the correct plan for reimbursement.*
2. If we are your Primary Care Provider, make sure our facility information appears on your insurance cards. If your insurance company has not yet been informed that we are your primary care provider, your visit may be denied by the insurance company, leaving you responsible for the bill.
3. **It is your responsibility to understand your insurance benefit plan.** For instance, you should know which services are covered (i.e., wellness visits, immunizations, simple procedures, lab services, etc.). For example:
  - Not all plans cover annual healthy (wellness) visits, sports physicals, hearing & vision screenings, in clinic labs (urine, viral swabs, etc.). If these are not covered, you will be responsible for payment unless otherwise specified.
4. According to your insurance plan, you are responsible for any and all co-payment/cost-shares, deductibles, and coinsurances.
5. **Co-payments** are due at the time of service. In the event a co-payment is missed, you will receive a secure text message and e-mail from our billing system alerting you to the amount owed after being billed to your insurance. Make sure to check with your insurance for up-to-date co-pay amounts.
6. **Self-Pay/Cash Pay** patients are expected to pay for services in FULL at the time of the visit.
7. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement by the following business Monday.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **15** business days of your receipt of your bill.
9. If previous arrangements have *not* been made with our billing department, any patient with an account balance outstanding longer than 28 days will be required to pay the outstanding balance before being seen again in the office. Any balance outstanding longer than 90 days will be forwarded to the collection agency.
10. For all appointments, prior balances require to be paid in full. We accept cash, checks, and credit/debit cards.

\_\_\_\_\_  
**Signature of Parent /Guardian**

\_\_\_\_\_  
**Name of Parent /Guardian**

\_\_\_\_\_  
**Date**

**Forms & Medical Records**

1. Any additional forms (school, camp, sports, work, etc.) that must be completed by the provider require a 3-day turnaround time.
2. All medical records requests are processed within 15 business days of a written request.
3. If you transfer to another provider, we will fax a copy of your patient's demographics, face sheet/chart sheet, and immunization record free of charge if we have received the medical record request from your new provider.
4. A copy of your medical records is available to you for a flat fee of \$5 on a disc or a per page fee if printing is needed. Please be aware that per page fees range from \$5 to \$25 depending on the chart size. You will be required to fill our Medical Record Request Release Form.

\_\_\_\_\_  
**Signature of Parent /Guardian**

\_\_\_\_\_  
**Name of Parent /Guardian**

\_\_\_\_\_  
**Date**

**Referral Policy**

Please understand the following protocol:

1. **Appointment & Approval.** All referrals require an in-office visit for specialist needs and approval from the provider. Specialists will require up-to-date detailed office notes, labs, etc. If these are not provided, the specialist will refuse to schedule the patient.
2. **Specialist Selection.** While we try to accommodate in your choice of specialist, this may not always be an option due to in-network insurances, etc. However, we do have a list of specialists we referral to often that will work with your insurance.
3. **Processing Time.** Referrals take time to process on all ends. Please be patient with staff and facilities as it is being processed. Standard referral times can take up to 2 weeks.

\_\_\_\_\_  
**Signature of Parent /Guardian**

\_\_\_\_\_  
**Name of Parent /Guardian**

\_\_\_\_\_  
**Date**

**Medication Refills**

1. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly to ensure medication needs are met.
2. Medication refills for controlled substances require an appointment, unless otherwise specified such as medications for ADD/ADHD which requires an office visit every other month.

\_\_\_\_\_  
**Signature of Parent / Guardian**

\_\_\_\_\_  
**Name of Parent / Guardian**

\_\_\_\_\_  
**Date**

**Practice & Patient / Family Relationships**

The relationship between patients and our medical practice is based on trust and should serve to promote patients' and/or their families well-being while respecting the dignity and rights of both the patient/families and our medical practice.

Successful medical care requires participation and taking an active role in the healing process. Providing an accurate history to treat the patient is essential. Inaccurate or withheld information can be harmful to a patient's health. Maintaining a respectful relationship with all involved in the patient's care should also be maintained to avoid conflicts in the patient's healthcare chain. Discrimination & disruptive behavior will not be tolerated by the Practice & Provider. The practice & provider should maintain a professional and caring relationship with the patient/family as it is key to taking an active role in the healing process. Maintaining an open line of communication with the patient is essential to promoting good health and wellbeing. Maintaining a respectful relationship with the authorized patient/family is equally important while avoiding conflicts in the patient's healthcare chain.

*We are here to provide the best care we can to our patients should the need arise. As always, we welcome the opportunity to care for you and appreciate your trust in the services we provide.*

\_\_\_\_\_  
**Signature of Parent / Guardian**

\_\_\_\_\_  
**Name of Parent / Guardian**

\_\_\_\_\_  
**Date**

**CONSENT FOR CARE AND TREATMENTS**

*TO THE PATIENT/PARENT/GUARDIAN: You have the right to be informed about the condition(s) and recommendations for diagnostic, medical, surgical, and/or any other treatments for the above-named patient. This is to ensure the best possible decision regarding care for the patient. All possible benefits, risks, and/or hazards involved are always available to the patient/parent/guardian. This consent form is simply an effort to obtain permission to treat the patient with necessary evaluations that may lead to appropriate treatment for any possible identified condition(s).*

*This consent provides Jennifer Midgett LLC / Premier Pediatrics of Louisiana and its staff with your permission of the following:*

- Perform reasonable, appropriate, and necessary medical treatment in the form of the following, but not limited to, medical evaluations, examinations, laboratory testing, diagnostic screenings, possible treatments, use of Paper and Electronic Health Records (audio/visual/paper/electronic, etc.), obtaining pharmacy records, coordination of care, etc.
- Bill for medical services to either the insurance company associated with patient or to the patient/parent/guardian for care received. In the event the insurance company does not pay all costs of care, the responsibility of medical cost will be billed to the patient/parent/guardian for services rendered.
- Discuss medical information with my HIPAA trained PCP and staff of PPLA, specialists/referral provider/staff, insurance company/staff, pharmacy/staff, laboratory/staff, hospital/staff, and medical personnel working as my representative for care coordination. Any other authorized individuals will be listed specifically in the Authorized Individuals section.

**Controlled Substance Treatment Agreement & Consent**

The purpose of this agreement and consent is to protect your access to controlled substances and protect the provider's ability to prescribe for you. There are various types of controlled substances that can be beneficial to a patient's health when used appropriately. The most common type of controlled substances used by our office are Stimulants (narcotic) treatment for ADD/ADHD and occasionally narcotic pain medication for patients transitioning care to a specialist. In the event a controlled substance is considered, the patient is required to have an agreement and consent to protect both the patient and the provider. Due to the potential of abuse or

diversion, strict accountability is necessary when being used or with the possibility of being used. For this reason, the following policies are agreed to by you (patient/parent/guardian), as consideration for any condition, the willingness of the provider who will write your prescription.

**General Information**

- All controlled substances must come from the patient’s Primary Care Provider (PCP), unless specific authorization is obtained for an exception from my PCP or the patient’s specialist.
- The patient/parent/guardian will take/administer prescribed medication appropriately as directed by the patient’s PCP.
- The patient/parent/guardian will not increase/decrease medication without the approval of the patient’s PCP.
- The patient/parent/guardian will not obtain medications from other providers. (Under certain circumstances, the patient is allowed to obtain narcotics from providers such as Specialist, Hospital/Emergency Room, and Urgent Care and will notify Jennifer Midgett LLC / Premier Pediatrics of Louisiana immediately upon doing so.)
- The patient/parent/guardian will not share medication with anyone, including family members.
- The patient/parent/guardian will not sell the medication.
- The patient/parent/guardian will not get replacement for any lost or stolen medication regardless of the circumstances.
- The patient/parent/guardian will not get early refills.
- The patient/parent/guardian will notify Jennifer Midgett LLC / Premier Pediatrics of Louisiana if alcohol and/or illicit drug abuse occurs during the use of the medication.
- The patient/parent/guardian agrees to periodic random drug screening tests.
- The patient/parent/guardian agrees to random pill counts.
- The patient/parent/guardian agrees to participate in adjunctive management programs such as psychological testing, counseling and therapy, behavioral health services, school-based interventions, and job modifications if recommended by the provider.
- The patient/parent/guardian will not request prescription refills when the clinic is closed, after hours, holidays, or weekends.
- *Females:* The patient/parent/guardian will notify Jennifer Midgett LLC / Premier Pediatrics of Louisiana immediately to discuss tapering off medications in the event of pregnancy and understands that failure to do so may result in discharge from the practice. The patient/parent/guardian will not hold the practice, provider, or any staff member responsible for any harm that may occur to the patient and/or the patient’s unborn child.

**After reading the above information, the patient/parent/guardian agrees to the following:**

- The patient/parent/guardian is responsible for maintaining and attending all scheduled appointments regarding medication including adjustments, concerns, and refills.
- The patient/parent/guardian understands that this PCP may stop prescribing controlled medication or change the treatment plan if the patient/parent/guardian fails to follow the above recommendations.
- The patient/parent/guardian agrees to ask the PCP about questions or concerns if any may arise.
- The patient/parent/guardian has read this information thoroughly and understands the purpose and responsibilities of this agreement and consents to treatment for present or future needs.

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*Patient’s First & Last Name*

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*Patient’s Date of Birth*

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**Signature of Parent/Guardian**

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**Printed Name of Parent/Guardian & Relationship**

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**Date**



Jennifer Midgett, LLC / Premier Pediatrics of Louisiana

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MEDICAL RECORD REQUEST & AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

\_\_\_\_\_  
Name of Provider / Clinic / Organization

**Premier Pediatrics of Louisiana**  
\_\_\_\_\_  
Name of Provider / Clinic / Organization

\_\_\_\_\_  
Street Address

**325 W. 8<sup>th</sup> Street**  
\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

**DeRidder, LA 70634**  
\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

**337-221-3075**  
\_\_\_\_\_  
Phone

**337-221-3076**  
\_\_\_\_\_  
Fax

I AUTHORIZE the FULL MEDICAL RECORD to be disclosed.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

**EXPIRATION of this Authorization:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

**ADDITIONAL PATIENT INFORMATION:** If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
**Patient or Parent/Guardian Signature**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Name of Patient or Parent/Guardian**

\_\_\_\_\_  
**Date**