How Did you find out about us?

☐ Insurance ☐ Walk-in

☐ Google ☐ Friend/Family

☐ Referred by: _____

Previous Doctor: _____

Patient Registration Form

Patient Information

TODAY'S DATE:

Patient's Full Name (First, MI, Last, Suffix)**:** _____ **Date of Birth**:_____

Ethnicity: ☐ American Indian ☐ Hispanic or Latino ☐ Asian ☐ Black/African American ☐ Caucasian/Other ☐ **Male** ☐ **Female**

Child resides with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other _____

Street Address: _____

City:_____ **State**:_____ **Zip**:_____

Home Phone: _____ **School/Grade**: _____

Pharmacy Information: _____

Sibling Name(s) & Date of Birth:

1. _____

2. _____

3. _____

Patient Insurance Information

Primary Insurance & Policy ID #: (If Medicaid -List your plan name) _____

Subscriber Name (if not the patient): _____ **Subscriber DOB**: _____

Secondary Insurance & Policy ID #: (If Medicaid -List your plan name) _____

Parent Information

Mother's/Guardian's Name: _____ Date of Birth:_____

Street Address: _____

City:_____ State:_____ Zip_____

Phone Number: _____ Email Address : _____

Occupation: _____

Father's/Guardian's Name: _____ Date of Birth:_____

Street Address: _____

City:_____ State:_____ Zip_____

Phone Number: _____ Email Address : _____

Occupation: _____

Emergency Contacts

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Authorization for Release of Medical Records

1. **Patient's Name:** _____ **DOB:** _____
2. **Patient's Name:** _____ **DOB:** _____
3. **Patient's Name:** _____ **DOB:** _____

I _____, hereby authorize the release of medical information to La Petite Pediatric Clinic, from:
(Parent/Guardian's Name)

Doctor/Hospital/Clinic: _____

Address: _____

City: _____ **State:** _____

Phone: _____

Fax: _____

Reason for request is:

_____ **Physician Change**

_____ **Second Opinion**

_____ **Treatment/Continued Care**

_____ **Other:** _____

Please release the following:

___ **All health information (including growth charts and vaccination records)**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___ Other (specify): _____

___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I Consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the included medical records.

____ Yes, I consent to the release of this information.
____ No, I do not consent to the release of this information.

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

La Petite pediatric clinic

200 Beaullieu Drive
Building 7
Lafayette, LA 70508

Phone: 337-366-8616
Fax: 337-366-8133
Website: www.lapetitepeds.com

Dr. Colleen Sicard, M.D., FAAP
Dr. Geneva LeJeune, M.D., FAAP

CONSENTS AND DISCLOSURES

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights or privacy with respect to your health care information. Our Full Privacy Policy/Patient Policy and Insurance/Billing Policy can be found on our website at www.La Petitepeds.com or you can request a copy.

Only patients who are fully vaccinated per the CDC recommended schedule will be accepted at La Petite Pediatric Clinic.

Dr. LeJeune and Dr. Sicard would be happy to discuss a schedule to catch-up for patients currently delayed.
An up-to-date immunization record is required for new patients prior to scheduling their first visit.

Consent Related to Privacy Notice:

I have reviewed the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change at any time. I may obtain these revised notices by contacting the practice by phone or in person. I understand I have the right to inspect, copy, receive confidential communications from La Petite Pediatric Clinic by alternative means, have the physicians amend and request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but La Petite Pediatric Clinic is not required to agree to my restrictions.

Consent for Care:

I authorize La Petite Pediatric Clinic, Dr. Colleen Sicard M.D., FAAP and Dr. Geneva LeJeune M.D., FAAP and any employee working under the direction of the physicians, to provide medical care for me, or the patient for which I am the legal guardian of. Medical care, services and supplies related to myself/patients health, preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, immunization/vaccine administration, assessment or review of physical or mental health of the body and the dispensing of prescriptions, samples, devices/equipment or other items required. This consent may include contact and discussion with other health care professionals for care and treatment. I give consent to La Petite Pediatric Clinic to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner, on the staff of La Petite Pediatric Clinic to any below listed minor(s). I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to all such diagnoses, treatments and hospital care which a licensed physician at La Petite Pediatric Clinic recommends.

Appointments/Cancellation Policy:

I understand that an appointment is a contract of time reserved for your treatment. (Appointment dates/times can be accessed in the Patient Portal.) I agree to cancel all appointments within a reasonable time, unless due to an emergency. I understand that 3 “no-shows” for appointments may result in the dismissal from our clinic. I also understand and agree that La Petite Pediatric Clinic reserves the right to charge a $25 fee for appointments cancelled without notice of at least 1 business day. Same day appointments that are cancelled, as well as no-shows for an appointment, may be charged a $50 fee.

Patient/Parent/Guardian Responsibility:

I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed and is responsible for payment of medical services. I acknowledge my responsibility for payment of all services provided by La Petite Pediatric Clinic in accordance with the practice’s fees and terms. In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Authorization to Communicate:

I understand that La Petite Pediatric Clinic utilizes various communication methods including voice calls, portal, email and fax for the purposes of sharing clinical/ medical results, scheduling appointments, sending appointment reminders and communicating/ discussing financial responsibilities. By signing this form, I am granting permission to La Petite Pediatric Clinic to utilize all phone numbers/addresses that I have supplied to contact me regarding this current visit and any future visits for the above stated purposes. I further understand that I have a right to revoke this authorization at any time by communicating this request to La Petite Pediatric Clinic.

Release of Information:

I authorize La Petite Pediatric Clinic to release medical or other information to my primary care or referring physicians, the insurance companies, the Louisiana Department of Health and Hospitals (Medicaid and SSI), or any third party acting on my behalf or La Petite Pediatric Clinic’s behalf which is needed for benefits to be paid under my insurance or other contracts applicable to claim for treatment and/or process insurance claims generated in the course of examination or treatment and allow a photo copy of my signature to be used to process insurance claims. I hereby indemnify and release La Petite Pediatric Clinic from all responsibility relative to the release of such information. I understand that La Petite Pediatric Clinic will make any disclosures that are required by law to meet mandatory reporting requirements.

CONSENTS AND DISCLOSURES CONTINUED

We pride ourselves on providing only the highest quality care for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced based clinical outcome information. However, insurers rarely keep pace with guidelines or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary.

I (the patient/responsible party) assume responsibility to ensure that the financial obligation is fulfilled for the health care services received. I understand that I am responsible for all balances, co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. I understand that if I have an insurance co-payment, co-insurance or deductible charge I am expected to make that payment when checking in for my appointment. It is my responsibility to verify applicable coverage prior to receiving the services. Payments are accepted in the form of cash, by check or by credit card with a courtesy fee of 4%. We also accept Health Savings Account (HSA) cards for payment. Copayments are a contractual requirement from the insurance company and cannot be written off by our office.

I understand that a wellness visit consists of an exam and any vaccines that are required by age. I agree that any additional concerns will constitute a "sick" visit in addition to the wellness visit and may result in a charge. If you do not advise the front office staff and do not pay the co-pay, co-insurance, or deductible charge you/patient will be billed.

As a courtesy, La Petite Pediatric Clinic will file the necessary forms so that you receive the full benefits of your medical coverage. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by the responsible party. Insurance is a contract between you and your insurance company and/or your employer and your insurance company. Although our office will make a good faith effort to assist you in obtaining your benefits, it's at the discretion of your insurance company to pay for the services we have provided to you.

La Petite Pediatric Clinic provides a variety of payment options. For your convenience, we accept all major credit cards and checks. Credit card payments are subject to an additional 4% convenience fee and returned checks will be subject to a $35 returned check fee. If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment. By signing this agreement, you agree that your account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Patients Without Insurance Coverage/Non-Covered Expenses:

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount only applies the day of service. The same discount will be applied to any non- covered charges for patients with insurance, if paid at the time of service. This discount cannot be applied toward the "patient responsibility" portion of covered charges, as those charges are already discounted through the contract we maintain with your insurer.

I acknowledge receipt of the Non-Covered Services List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in office, by my insurer. I agree to pay the amount of the charge as stated in the event that my insurer does not pay for these services.

I have read and understand ALL the above Policies/Consents and agree to accept full responsibility as described above.

Patient Name(s) & Date of Birth(s): **1**. _____

2. _____

3. _____

_____ _____

Patient/Legal Guardian Signature **Date**

La Petite Pediatric Clinic complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. La Petite Pediatric Clinic cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-408-2431. TTY: 711.

Services and Self-Pay Discounted Pricing

Wellness:
We consider the following to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount.

Sports Physicals:
When done at the same time as a well child check-up, sports forms are completed free of charge. We will also complete them free of charge if your child has been seen for a well child check in the past six months. There will be a $10 fee for forms needed in < 3 business days. Many of these forms require a vision test, so if it was not performed at the time of the check-up your child will be asked to return for a nurse visit. There will be a $15 fee for performing the visual acuity test. If your child has never had a checkup with our practice and/or their last checkup was greater than 6 months ago, we are happy to schedule a visit for a sports clearance.

Vision Screening:
Snellen Testing- This is a simple screening performed with the use of a Snellen eye chart used to measure visual acuity on older children.
Plus Optix Vision Screener- This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia (or 'lazy eye') occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye.

Hearing Screening:
Otoacoustic Emissions Testing is an important hearing test and can be used on newborns through adulthood. It does not require a soundproof room or the ability of the child to understand instructions or respond to sounds, which makes it more accurate screening tool for picking upon hearing issues at any age. Not only do we believe that hearing screens should be performed every year, but testing is required for most preschools, public and private schools, and for some sports.

Developmental Testing:
Developmental screening (including standard pediatric developmental screening done at well visits, Connors forms, Edinburgh post-partum depression screening, MCHAT tool to detect autism, and more) are very important in the assessment of any development delays or potential problems.

Fluoride Varnish:
Both the American Academy of Pediatrics and the American Dental Association agree that fluoride varnishes should be applied at every well child visit beginning from the first tooth eruption until a child begins seeing the dentist regularly. We are happy to offer this service to help protect your child's teeth from cavities.

Ear piercing:
Piercing is available for patients 6 months and older who's vaccines are up to date. This service is **not** covered by any health insurance options. The fee includes the piercing, earrings of your choice and bottle of aftercare solution. Our earrings are either medical grade titanium or stainless surgical.

IN OFFICE TEST	FEE
Rapid RSV	$25.00
Rapid Flu	$25.00
Rapid Strep	$15.00
Urinalysis	$10.00
Pregnancy Test	$10.00
Strep PCR	$40.00
Flu PCR	$60.00
RSV PCR	$50.00
Lead	$10.00
Capillary blood glucose	$10.00
Covid PCR	$75.00

VISIT/TEST	FEE
Well Visit	$90.00
Sick Visit	$75.00
Sports Physical	$40.00
Vaccine Administration (1)	$5.00
Vision Screening- Snellen Test	$10.00
Vision Screening- Plus Optix	$15.00
Hearing Screening	$10.00
Developmental Testing	$10.00
Earrings	$90.00
Fluoride Varnish	$10.00
Wart Treatment	$75.00
Umbilical Granuloma	$25.00