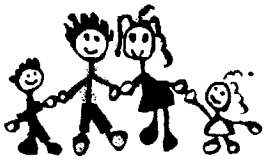
NEW PATIENTS

You must complete the following steps before an appointment can be made:

1. Complete, sign, and return by mail or hand deliver the following papers:
    a. Patient Information Sheet
    b. Billing Policy
    c. Patient History
    d. Authorization for Release of Medical Information: include the previous doctor's name, address, phone number, and if available, the fax number. This will allow us to get records in a timely manner.
    e. Patient Record of Disclosures (HIPAA): must complete the top half of first page and sign the 3rd page on the bottom.
    f. Designation of Authorized Adult Representative(s): any person who is not the legal guardian, who might call about or bring the child in, must be listed here.

2. Include a copy of your current insurance card (include both front and the back of the card) **IF THIS IS NOT INCLUDED WITH NEW PATIENT PACKET WE WILL NOT PROCESS THE NEW PATIENT PACKET UNTIL IT IS RECEIVED.**
3. Call your insurance company to change your child's Primary Care Physician (PCP) to Dr. Stacie Laff , Dr. Lindsey Krumholz or Dr. Sarah Price. This must be done before your child can be seen in the office. Your insurance company may send you a new card. We will need a copy of the NEW card. If your card lists the PCP (Primary Care Physician), it must have either Dr. Stacie Laff , Dr. Lindsey Krumholz or Dr. Sarah Price.
4. Send in or hand deliver any shot records or previous doctor's records you have available with the packet.
5. Review and make sure you have completed the above information before you return it to our office via mail, fax, or hand delivery.
6. Include any guardianship papers, custody papers and child's birth certificate
7. **Our office requires that all patients receive all AAP (American Academy of Pediatrics) recommended vaccines and all school required vaccines. We will not accept any patients that do not vaccinate.**
8. Once the packet is received complete with information requested, we will enter it into the system. We will then be able to make an appointment for your child. If you have not heard from us within two business days, please call our office.



T.L.C. Pediatrics, Ltd.

Stacie Laff, M.D. Lindsey Krumholz M.D. Sarah Price, M.D.
4600 Memorial Drive, Suite 280 Belleville, IL 62226 Phone: 618-257-2800 Exchange: 618-398-9730

PATIENT INFORMATION

Date_____

Patient (First, Middle, Last Name)_____Birthdate_____Sex_____

Patients Primary Address (Street)_____(City)_____(Zip)_____

Name of Father/Guardian (First, Middle, Last)_____Phone/Cell #_____

Social Security No._____Driver's License No._____ Date of Birth_____

Home Address (Street)_____(City)_____(Zip)_____

Father's Employer_____ Occupation_____

Business Address_____Business Phone_____Ext_____
Street City Zip

PATIENT'S insurance under Father: _____ID#_____Group #_____

Insurance Address_____Primary____Secondary____

Name of Mother/Guardian (First, Middle, Last)_____Phone/Cell#_____

Social Security No._____Driver's License No._____ Date of Birth_____

Home Address (Street)_____(City)_____(Zip)_____

Mother's Employer_____ Occupation_____

Business Address_____Business Phone_____Ext_____
Street City Zip

PATIENT'S insurance under Mother: _____ID#_____Group #_____

Insurance Address_____Primary____Secondary____

Local Emergency Contact Person who will be home (Other than Parents):

_____
Full Name Address Phone Relationship to Child

Name of Pharmacy_____Phone Number_____

Other Siblings

Name_____DOB_____ Sex____ Name_____DOB_____ Sex____

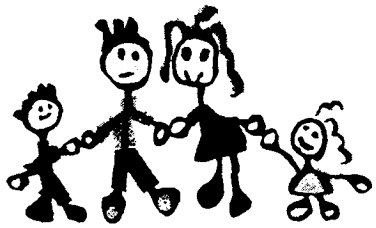
Name_____DOB_____ Sex____ Name_____DOB_____ Sex____

Name_____DOB_____ Sex____ Name_____DOB_____ Sex____

----------SIGNATURE ON FILE----------

By signing below, I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand I am responsible for my bill. I authorize my provider to act as my agent in helping me obtain payment from my Insurance Company. I authorize payment direct to my provider. I permit a copy of this authorization to be used in place of the original. I understand all services are rendered on a paid basis only. If collections become necessary, I shall pay all costs including attorney fees.

Name of Person Filling Out Form_____Signature_____Date_____
(Please Print)



T.L.C. Pediatrics, Ltd.

4600 Memorial Drive, Suite 280 • Belleville, IL 62226
Phone: 618-257-2800 • Exchange: 618-398-9730
www.tlcpediatricsltd.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient Full Name _____ Date of Birth _____

Street Address _____ Social Security Number _____

City/State/Zip _____ Home Phone Number _____

At the request of the individual, I_____, do hereby authorize

Name of Company/Agency/Facility/Person _____

Street Address _____

City/State/Zip _____

To Release:

__Discharge Summary	__Pathology Report	__Emergency Report
__History & Physical	__Laboratory Reports	__Shot Records
__Progress Notes	__Radiology Reports	__Operative Notes
__ECG/EEG/Cardiac Cath	__Other _____	

__I do __I do Not Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: **TLC PEDIATRICS, LTD**
4600 MEMORIAL DRIVE, STE 280
BELLEVILLE, IL 62226 fax#618-257-9802

PURPOSE OF DISCLOSURE:

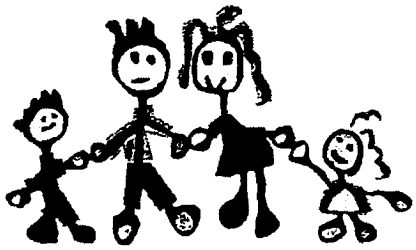
__Referral to specialist	__Insurance	__Workers Comp	__Change of Doctor/Provider
__Legal Investigation	__Personal	__Continuing Care	__Disability Determination

__Other (Please Specify)_____

Please provide the best telephone number in the event we need to contact you (home, work or cell)_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but it will not affect any information prior to written notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it and then would no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual or guardian or personal representative of patients estate _____ Relationship to patient _____ Date _____



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Phone: 618-257-2800 • Exchange: 618-398-9730
Fax: 257-9802

DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S)
And emergency contacts (other than parents)

In my absence, I hereby give permission to the following person(s) to bring my child or children to TLC Pediatrics LTD to seek medical care.

PATIENT NAME _____

DATE OF BIRTH _____

Name (First and Last)	Phone	Relationship to child

I understand that care will be provided by the physicians and the practice staff, including the administration of any medications and/or vaccinations deemed necessary by the physicians at the time. I will make every effort to call TLC Pediatrics LTD office with any questions I have about my child's care following any visit where I am not present. I understand that until I provide written notice to the practice of any changes to the designation of authorized adult representatives, TLC Pediatrics LTD may rely on the consent provided herein.

_____

Signature of parent/ guardian or assigned representative — Relationship to child

_____

Print Name — Date

TLC Pediatrics LTD. Billing Policy

The following sets forth the general billing policy of TLC Pediatrics, LTD. Please review this information and sign where indicated.

(1) I understand it is my responsibility to provide the TLC Pediatrics, LTD. office with current billing information and accurate contact information, i.e. address, phone numbers and all current insurance information, at the time of check in. It is my responsibility to notify your office of any changes in this information.

(2) I understand it is my responsibility to know my insurance benefits. This includes deductibles, co-insurance, co-pay and general medical coverage. I understand that it is my responsibility to pay my portion of the charges prior to services being rendered by TLC Pediatrics and to notify my insurance company(s) of any other insurance coverage I may have prior to services being rendered. I understand that these are contractual obligations that I have with my health plan. TLC Pediatrics also has a contractual obligation with my health plan to collect co-pays at the time of service. If you cannot make your co-pay at the time of service, you will be asked to sign a copayment agreement. If the co-pay is not paid according to the agreement, a $5 late fee will be assessed.

(3) I understand a charge will be billed to my insurance company for visits on Federal Holidays and weekends.

(4) I understand if the bank returns a check used for payment on my account, to TLC Pediatrics, I will be charged a bounced check fee of the maximum sum allowed by the State of Illinois, and all future payments must be paid with cash, money order, cashier's check, or credit card (Visa/Discover/Master Card). I will no longer be permitted to use personal checks to pay TLC Pediatrics, LTD.

(5) I understand there is a standard form fee of $15 to complete PE forms, sports forms, daycare forms, camp forms, disability paperwork or FMLA forms associated with my child's care. The standard form fee is due prior to completion of the form.

(6) I understand if TLC Pediatrics receives a request for transfer of my child's records to another doctor's office, I will be responsible for a medical records transfer fee not to exceed the current amount allowed by the State of Illinois.

(7) I understand I will be billed for any amounts due from me including, but not limited to, coinsurance, non-covered charges, deductibles and maximum benefits reached. I further understand I have a financial responsibility to pay these amounts. Bills are expected to be paid upon receipt. If I fail to pay all amounts due promptly, any balance due is subject to be sent to an outside collection agency. In such an event, I understand I will be responsible for a collection fee of up to 50% of the outstanding balance, plus any interest and legal expenses associated with the collection efforts.

(8) I understand if I am scheduled for a well visit/physical and other medical concerns are addressed, my insurance company will be billed for both a well visit and sick visit. This could result in an additional charge or co-pay from my insurance company.

My signature below confirms that I have read this policy and understand its terms.

_____ _____

Legal Signature Date

_____ _____

Relationship to Patient Patients Name

11-08-12

T.L.C. Pediatrics

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

_____ Home Telephone

_____ O.K. to leave a message

_____ Leave message with call-back number only

_____ Work Telephone _____

_____ O.K. to leave message with detailed information

_____ Leave message with call-back number only

_____ Written Communication

_____ O.K. to mail to my home

_____ O.K. to mail to my work/office address

(grandparent/babysitter)

_____ Other _____

_____

_____ _____

Patient Name (please print) Birthdate

_____ _____

Signature of Parent or Guardian Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and Requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must be keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom	Description of Disclosure	By Whom Disclosed
	Address or Fax #	Purpose of Disclosure	

T.L.C. PEDIATRICS LTD.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

T.L.C. Pediatrics LTD. Uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in medical records that are the physical property of **T.L.C. Pediatrics.**

How T.L.C. Pediatrics, May Use or Disclose Your Health Information.

For Treatment. **T.L.C. Pediatrics** may use your health information to provide you with medical treatment or services. For example, information obtained by a healthcare provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment, this information is necessary for healthcare providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. **T.L.C. Pediatrics** may use your health information when referring you to other healthcare professionals and facilities.

For Payment. **T.L.C. Pediatrics** may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. **T.L.C. Pediatrics** may use your information to contact you about account balances. **T.L.C. Pediatrics** may use your information to access financial assistance programs for you that may help to defray the costs associated with your care or treatment.

For Healthcare Operations. **T.L.C. Pediatrics** may use and disclose health information about you for operational purposes; for example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the healthcare we provide.

Required by law. **T.L.C. Pediatrics** may use and disclose information about you as required by law. For example, **T.L.C. Pediatrics** may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties;

Appointment Reminders and Treatment Calls. **T.L.C. Pediatrics** may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contact is made via telephone, messages will be left on answering machine with limited information.

Notification. **T.L.C. Pediatrics** may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family. **T.L.C. Pediatrics** health professionals and staff, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Business Associates. In some cases, **T.L.C. Pediatrics** contracts with business associates to provide services on its behalf. An example includes arrangements with business associates **T.L.C. Pediatrics** to provide collection

services. **T.L.C. Pediatrics** may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, **T.L.C. Pediatrics** requires the business associate to safeguard your information.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for organ or tissue donation purposes.

Research. **T.L.C. Pediatrics** may use your health information for drug or research studies when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research. **T.L.C. Pediatrics** may use information to identify qualified candidates for research. **T.L.C. Pediatrics** may use information to make contact with you to determine your interest in the research study/clinical trials.

Health and Safety. Your health information may be disclosed to avert a serous threat to the health of safety of you or any other person pursuant to applicable law.

Food and Drug Administration (FDA). **T.L.C. Pediatrics** may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or past marketing surveillance, information to enable product recalls, repairs, or replacement.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure if your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent **T.L.C. Pediatrics LTD** taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request restriction on certain uses and disclosures or your information; however, **T.L.C. Pediatrics** is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record;
- Request that your health record be amended;
- Request communications of your health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information.

Complaints

You may complain to **T.L.C. Pediatrics** and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of T.L.C. Pediatrics

T.L.C. Pediatrics is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.

T.L.C. Pediatrics reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you upon your request at your next visit to our practice.

Contact Information
If you have any questions or complaints, please contact:
Stacie Laff, Privacy Officer
4600 Memorial Dr. Suite 280
Belleville, Illinois 62226
618-257-2800
Effective January 1, 2007

My signature acknowledges I have received a copy of this Notice of Privacy Practices

_____

Patient, Parent or Guardian Signature Date

PATIENT HISTORY

T.L.C. Pediatrics, Ltd.

4600 Memorial Drive, Suite 280 • Belleville, IL 62226 • Phone: 257-2800

NAME _____ DATE _____

ADDRESS _____

PHONE # _____ BIRTHDATE _____ SEX _____

Mother's name _____ Age _____

Occupation _____

Father's name _____ Age _____

Occupation _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____

A. PREGNANCY AND BIRTH

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? Yes No
3. Did she take any medications other than vitamins and iron? Yes No
4. Was the baby on time? Yes No
5. What was the birthweight? _____
6. Did the baby have any trouble starting to breathe? Yes No
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) Yes No
   What kind? _____

B. PAST MEDICAL HISTORY

1. Where has your child gone for check-ups until now? _____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, foods, insect bites? Yes No
   Which ones? _____
5. Has your child had reactions to any immunizations? Yes No
   Which ones? _____
6. Any hospitalizations other than for birth? Yes No
   For what? _____
7. Any serious injuries? Yes No
   What kind? _____
8. Are any medications taken regularly? Yes No
   Which ones? _____

C. FAMILY HISTORY

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex and general health of brothers and sisters _____
4. Have any of your children died? Yes No

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? Yes No
4. Do any foods disagree with him/her? Yes No
5. For the first 6 months, is or was he/she breast-fed or bottle-fed? (Circle one)
6. If still on formula, which one do you use? _____ _____
7. Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? Yes No
2. Any eye problems? Yes No
3. Has he/she had any problems with teeth? Yes No
4. Does he/she have frequent colds or sore throats? Yes No
5. Is there asthma, pneumonia, or recurrent cough? Yes No
6. Does he/she have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems: _____

F. DEVELOPMENT/BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1½ years old? _____
4. How does the child compare to others his/her age?
5. Does he/she have any trouble sleeping? Yes No
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? Yes No
8. Does he/she get along with other children? Yes No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others

G. SAFETY/ENVIRONMENT

1. Do you live in a private house, apartment, mobile home, other? (Circle one)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor in the house? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Are there any smokers in the household? Yes No
6. Are there any problems with the condition of your home (Peeling paint, insects, rats, or mice)? Yes No
7. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

If Yes, please provide copy to nurse.

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Phone: 618-257-2800 • Exchange: 618-398-9730
www.tlcpediatricsltd.com

Patient Portal User Agreement

Patient information

Name _____ DOB _____

Address _____

Email _____ Phone number _____

TLC Pediatrics understands the need for communication between health care professionals and patients. TLC Pediatrics is committed to providing patients and other authorized personnel the ability to use a secure and confidential patient portal that provides the following functionality:

1. Access to visit summaries, future appointment dates, labs, patient education, questionaire, refill request, and statements.
2. Ability to contact office for non-urgent or emergent issues.
3. Secure communication with health care professional.

The TLC patient portal utilizes technology to deliver secure communications between patients and TLC Pediatrics. The term "patient portal" refers to the part of TLC Pediatrics information system that provides access to patients' health information and allows for secure communication, including prescription, referral and appointment requests. "Electronic communication" means e-mail or text messaging with patients outside of a patient portal.

Patient portal policy

The following policies and limitations apply to the use of TLC Pediatrics' patient portal.

1. Patient portal communication is not for emergency purposes. If you are having an emergency, dial 911 or go to your local hospital.

2. Correspondence via patient portal is supplemental to physician/patient encounters. TLC Pediatrics will not provide patient portal based diagnosis and treatment.

3. Sensitive subject matter, such as HIV/AIDS, STDs, mental health, behavioral health, drug treatment, or genetic testing information cannot be discussed through the patient portal

4. Other electronic communication with the healthcare professional, such as non-patient portal email or text messaging is prohibited.

5. Communications sent via patient portal must be courteous, respectful, appropriate, fact-based and truthful.

6. Communications should be responded to within two business days. You agree not to use this portal if you need a response sooner or on an urgent basis. If your need is urgent you must contact the practice directly.

7. You agree not to share your password with anyone and that you are solely responsible for protecting your password.

8. You agree that access to the site is provided on an "as is available" basis and that our practice cannot guarantee you will be able to access the portal at any time. Internet based communications are inherently insecure since no technology guarantees privacy or security of information sent over the internet. You agree to use caution when providing information via this portal, and acknowledge that keeping messages secure is your responsibility.

Conditions of participation

Access to TLC Pediatric patient portal is restricted to the above-named patient. This service is optional, and we reserve the right to suspend or terminate the service and/or your access to it at any time. If the practice suspends this service, you will still have access to copies of your medical record and other health information, upon request. The patient acknowledges that he/she agrees to comply with the [practice name's] Patient Portal Policy outlined above.

Parent/Guardian name: _____

Patient/Guardian signature: _____

Date: _____