Allison Hatfield, M.D.
Sarah Latiolais Ardoin, M.D.
Emily Fruge' Simon, M.D.
Allison Wilson, FNP

153 Town Boulevard
Opelousas, LA 70570
(337)942-4453
(337)948-0900

PATIENT INFORMATION

CHILD'S INFORMATION (PATIENT):

Child's Last Name: _____ Child's First Name: _____
Date of Birth: _____ Social Security Number: _____ Gender: ☐ M ☐ F
Mailing Address:_____ City:_____ State: _____ Zip: _____
Physical Address: _____ City: _____State: _____ Zip: _____
Phone Number: _____ Alternate Phone Number:_____

Race: ☐ Black/African American ☐ Hispanic Primary Language: ☐ English
☐ White/Caucasian ☐ Other _____ ☐ Other _____

MOTHER'S INFORMATION:

First Name: _____ Last Name: _____ Date of Birth: _____
Social Security Number: _____ Phone Number: _____ Alt. Phone Number: _____
Email address: _____ Domiciliary Parent: Y N N/A *Please provide documentation*

FATHER'S INFORMATION:

First Name: _____ Last Name: _____ Date of Birth: _____
Social Security Number: _____ Phone Number: _____ Alt. Phone Number: _____
Email address: _____ Domiciliary Parent: Y N N/A *Please provide documentation*

GUARDIAN INFORMATION: *Please provide guardianship documentation*

Name of Legal Guardian:_____
Phone Number: _____ Alternate Phone Number:_____

INSURANCE INFORMATION:

Type of Insurance: Check one and complete appropriate information:
☐ Self-Pay
☐ Medicaid If Medicaid, which Bayou Health Plan are you enrolled in? _____
☐ Private Insurance
Insurance Company's Name: _____Name of Insured: _____

Insured's Social Security Number: _____ Insured's Date of Birth:_____

Siblings of the above named child:

1. Name: _____ DOB: _____
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

2. Name: _____ DOB: _____
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

3. Name: _____ DOB: _____
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

4. Name: _____ DOB: _____
   Is this child a patient at Lily Pad Pediatrics? ☐ Yes ☐ No

Acknowledgement of "Patient No Show" Policy and Timely Arrival to Appointments:

If you are more than **15** minutes late for your appointment, it may be rescheduled for a later date. If you are unable to keep your appointment, you are required to cancel your appointment with appropriate prior notice (24 hours is appreciated). Failure to cancel the appointment without a 24-hour notice is considered a "No Show" for purposes of this policy. If three or more appointments are missed, the patient may be dismissed from Lily Pad Pediatrics.

By initialing below, I hereby acknowledge my understanding of the above Patient No Show Policy and Timely Arrival to Appointments statement.

_____ _____
Initial Date

Acknowledgement of Patient Pregnancy Dismissal:

If a patient becomes pregnant while she is an active patient with Lily Pad Pediatrics, she will be dismissed from the practice.
By initialing below, I hereby acknowledge my understanding of the above Patient Dismissal (for pregnancy) Policy with Lily Pad Pediatrics.

_____ _____
Initial Date

Consent for Telemedicine Treatment:

I consent to telehealth care performed by providers of Lily Pad Pediatrics. This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the providers' professional judgment. I understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I accept responsibility for any co-payments, deductibles, or other charges incurred for this service.

By initialing this form, I acknowledge I have read this information and agree to Telehealth treatment.

_____ _____
Initial Date

I hereby agree to all initialed areas of this consent form

_____ _____ _____
Child's name Parent Signature Date

Consent for Treatment:

I hereby give permission to the providers of Lily Pad Pediatrics, or persons designated by them, to interview, examine, and perform necessary procedures and to provide appropriate treatment to the above-named patient.

I understand and agree that during the course of treatment, the necessity may arise to request medical records from or provide medical records to other providers to ensure continuity of care. These records may include, but are not limited to, the following:
*Progress and/or visit notes
*Lab results
*Imaging (xray, CT, MRI, etc)
*Hospital records
*Medication lists

I hereby authorize Lily Pad Pediatrics, LLC to request, obtain, or provide medical records as needed to ensure continuity of care:

Patient name: _____ Date of birth: _____

_____ _____
Print Name Date

_____ _____
Signature Relationship to Patient

Well-child visits

In accordance with recommendations from the American Academy of Pediatrics, Lily Pad Pediatrics encourages routine well-child visits.

Childhood is a time of rapid growth and change. Children have more well-child visits when they are younger. This is because development is faster during these years.
Each visit includes a complete physical exam. At this exam, the health care provider will check the child's growth and development in order to find or prevent problems.The provider will record your child's height, weight, and other important information. Hearing, vision, and other screening tests will be part of some visits. So will immunizations.
Even if your child is healthy, well-child visits are a good time to focus on your child's wellness. Talking about ways to improve care and prevent problems helps keep your child healthy.

Information

At your well-child visits, you will get information on topics such as:

Sleep
Safety
Childhood diseases
What to expect as your child grows

Write down your questions and concerns and bring them with you. This will help you get the most out of the visit.

Your provider will pay special attention to how your child is growing compared to normal developmental milestones. Your child's height, weight, and head circumference are recorded on a growth chart. This chart remains part of your child's medical record. Talking about your child's growth is a good place to begin a discussion about your child's general health. Ask your provider about the body mass index (BMI) curve, which is the most important tool for identifying and preventing obesity.
Your provider will also talk about other wellness topics such as family relationship issues, school, and access to community services.

PREVENTIVE HEALTH CARE SCHEDULE recommended by American Academy of Pediatrics:

After the baby is born, the next visit should be 2 to 3 days after bringing the baby home (for breastfed babies) or when the baby is 2 to 4 days old (for all babies who are released from a hospital before they are 2 days old).

After that, it is recommended that visits occur at the following ages:

By 1 month
2 months
4 months
6 months
9 months
12 months
15 months
18 months
2 years
2 1/2 years
3 years
Each year after that until age 21

Also, you should call or visit a provider any time your baby or child seems ill or whenever you are worried about your baby's health or development.

Elements of the physical exam:

- Auscultation (listening to heart, breath, and stomach sounds)
- Heart sounds
- Infantile reflexes and deep tendon reflexes as the child gets older
- Neonatal jaundice -- first few visits only
- Palpation
- Percussion
- Standard ophthalmic exam
- Temperature measurement (see also normal body temperature)

Nutrition advice:

- Appropriate diet for age -- balanced diet
- Breastfeeding
- Diet and intellectual development
- Fluoride in diet
- Infant formulas
- Obesity in children

References

Hagan JF Jr, Navsaria D. Maximizing children's health: screening, anticipatory guidance, and counseling. In: Kliegman RM, St. Geme JW, Blum NJ, Shah SS, Tasker RC, Wilson KM, eds. *Nelson Textbook of Pediatrics*. 21st ed. Philadelphia, PA: Elsevier; 2020:chap 12.
Kelly DP, Natale MJ. Neurodevelopmental and executive function and dysfunction. In: Kliegman RM, St. Geme JW, Blum NJ, Shah SS, Tasker RC, Wilson KM, eds. *Nelson Textbook of Pediatrics*. 21st ed. Philadelphia, PA: Elsevier; 2020:chap 48.
Kimmel SR, Ratliff-Schaub K. Growth and development. In: Rakel RE, Rakel DP, eds. *Textbook of Family Medicine*. 9th ed. Philadelphia, PA: Elsevier Saunders; 2016:chap 22.

Review Date 1/24/2023

Updated by: Neil K. Kaneshiro, MD, MHA, Clinical Professor of Pediatrics, University of Washington School of Medicine, Seattle, WA. Also reviewed by David C. Dugdale, MD, Medical Director, Brenda Conaway, Editorial Director, and the A.D.A.M. Editorial team.

Well-child visits are scheduled upon check out or via phone call. Please notify the office as soon as possible if unable to attend. All appointments canceled less than 24 hours in advance are subject to No-Show Policy; certain exceptions may apply (emergencies, etc).

_____	_____	_____
Patient Name	Patient DOB	Parent/Guardian Initial

PHARMACY INFORMATION

PHARMACY PREFERENCE:

Primary Pharmacy Name: _____

City: _____

Alternative Pharmacy Name: _____

City: _____

e-Prescribing Consent:

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MAM) of 2003 listed standards to be included in an ePrescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them the patient's prescription has been picked up, not picked up or partially filled.

There are some prescription drugs that may NOT be sent electronically (i.e., ADHD medications) and written prescriptions must be picked up in person and signed for.

By initialing this consent, you are agreeing that Dr. Allison Hatfield, Dr. Sarah Latiolais Ardoin, Dr. Emily Fruge' Simon, and Crystal Dupre', FNP and Allison Wilson, FNP may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Dr. Allison Hatfield, Dr. Sarah Latiolais Ardoin, Dr. Emily Fruge' Simon and Crystal Dupre', FNP, Allison Wilson, FNP to enroll the patient in the ePrescribe Program. I have been given the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Initial Date

Consent for Immunization:

PARENT OR LEGAL GUARDIAN MUST BE PRESENT FOR IMMUNIZATIONS

I do hereby give consent for my child to receive age-appropriate vaccinations. The risks, indications, and side effects of these vaccines have been discussed in detail with me.

In addition, I have been provided a copy and have read, or have had explained to me, information about the diseases and the procedures/vaccines. I have been given a chance to ask questions that were answered to my satisfaction. I understand the risk associated and have asked that the vaccine/procedure be given to me or to the person listed above, for whom I am authorized to make this request.

The doctor has explained, and I understand, the potential risks of receiving this care. I further understand that in my physician's best medical judgment, my consent may result in the need for further treatment or may reduce changes of regaining normal health. I shall hold Drs. Hatfield, Latiolais Ardoin, Simon, and Crystal Dupre, NP or Allison Wilson, NP blameless for any reactions associated with this procedure/vaccination.

Vaccinations that are administered in this clinic are as follows (age-appropriate):

- Hepatitis A
- Hepatitis B
- Influenza
- Pneumococcal
- HPV
- Hib
- Rotavirus
- DTap
- Tdap
- MMR
- Polio
- Varicella
- Meningococcal

By initialing below, I hereby acknowledge that I understand the above consent for vaccinations from Lily Pad Pediatrics.

_____ _____

Initial Date

NOTICE OF PRIVACY PRACTICES

I, THE UNDERSIGNED PATIENT/REPRESENTATIVE OF LILY PAD PEDIATRICS, DO HEREBY ACKNOWLEDGE I HAVE BEEN GIVEN A COPY OF THE PRIVACY PRACTICES OF THIS OFFICE TO REVIEW. I UNDERSTAND A COPY OF THIS DOCUMENT WILL ALWAYS BE AVAILABLE FOR REVIEW. I UNDERSTAND ANY QUESTIONS I MAY HAVE MAY BE DIRECTED TO THE PRIVACY OFFICER AND/OR MY PROVIDER.

PLEASE CHECK ONE OF THE FOLLOWING:

_____ I AM SATISFIED TO READ AND CONSULT THE OFFICE COPY OF THE NOTICE OF PRIVACY PRACTICES THAT ARE AVAILABLE TO ME.

_____ I WOULD LIKE A PERSONAL COPY TO TAKE HOME.

PATIENT/ PATIENT'S REPRESENTATIVE:

PRINT YOUR NAME: _____

DESCRIBE YOUR AUTHORITY: _____

SIGN: _____ DATE: _____

The following individuals may accompany the patient to medical appointments as well as receive medical information regarding the patient: Please provide names, contact details, and indicate if person is authorized to schedule/cancel appointments or make changes to medical record.

_____ ☐Schedule/Cancel Appt ☐Change Record
Name Phone # Relationship

_____ ☐Schedule/Cancel Appt ☐Change Record
Name Phone # Relationship

_____ ☐Schedule/Cancel Appt ☐Change Record
Name Phone # Relationship

_____ ☐Schedule/Cancel Appt ☐Change Record
Name Phone # Relationship

_____ _____
Parent/Guardian Signature **Date**

_____
Relationship to patient