Patient CONSENT to the Use and Disclosure of Health Information for Treatment, Payment, & Healthcare Operations

To be filled out by a parent or legal guardian ONLY! *Please Print*

Today's Date: ______________________

PATIENT NAME: ____ DATE OF BIRTH: ______________

I hereby assign all **Medical Insurance benefits** directly to **Crimson Pediatrics** for services rendered. I understand that I am financially responsible for all charges whether or not paid by my (or patient's) insurance. I understand that I am responsible for all charges even if/when another authorized guardian brings the child to the doctor in my stead. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature (below) on all of my insurance submissions.

I understand that as part of my healthcare, Crimson Pediatrics originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, medication history, and any plans for future care or treatment. I understand that this information serves as:

(1) A basis for planning my care and treatment, (2) A means of communication among the many health professionals who contribute to my care, (3) A source of information for applying my diagnosis information to my bill, (4) A means by which third-party payers verify that services billed were actually provided, and (5) A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided a *Notice of Privacy Policy* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

(1) The right to review the notice prior to signing this consent, (2) The right to object to the use of my health information for directory purposes, and (3) The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Crimson Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that if I refuse this consent, this organization may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Crimson Pediatrics reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Crimson Pediatrics change their notice, they will send a copy of any revised notice to the address that I have provided.

RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION

TO BRING PATIENT TO CLINIC & FOR HEALTH INFORMATION

- I authorize the people listed below to BRING my child (the Patient) to the doctor ONLY when I am unable to do so. For the occasions when I may be unable to accompany my child, I consent to and give Crimson Pediatrics my authorization in advance to provide any medical treatment that Crimson Pediatrics deems necessary for the continuing healthcare of my child. If my child is brought in by someone not listed, I understand that the doctor will **NOT** be able to treat my child.
- I also authorize Crimson Pediatrics to discuss and/or release health information and/or medical records to the people that I have listed.

Print Names				
Relationship to Patient				

I understand that as part of this Organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Print your name and Relationship to Patient ____________ Date Signed ____________

SIGN (**Parent / Legal Guardian** if Patient is under 18 years old) ____________

We can only treat the patient in the company of an adult listed on a current Consent Form.
This Consent Form is valid for ONE year from the signed date.
Form must be renewed yearly.

SOUTHERN SURGICAL ASSOCIATES, LLC / DBA **CRIMSON PEDIATRICS**

Demographics Update

Date: ____________________

Patient's Name: ____

Patient's DOB: ______________ Gender: __________ Age: ______ SSN#: ________________

Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. To get a better idea of health risks you may have and better meet your health needs, we are collecting race and ethnicity information from **all** of our patients. Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record. It is perfectly alright if you do not want to answer the questions, however, this information **does** help us provide better care.

1. Race: ______________________ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

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Home Address: ______________________________ Apt/Suite/Lot#: __________

City: ______________________ State: __________ Zip: __________

Primary Cell Phone# ______________________ **Cell Phone Carrier:** ______________
(Example: AT&T, T-Mobile, Verizon, Cricket, Metro, etc.)

Secondary Phone# ______________________

Email Address (please write **clearly**): ______________________________

Mother's Name: ______________________ DOB: __________ SS# __________

Father's Name: ______________________ DOB: __________ SS# __________

Legal Guardian's Name: ______________________ DOB: __________ SS# __________
(if applicable) *(For Legal Guardian, we will need legal documents to prove guardianship.)*

Please list all siblings that are currently patients here at Crimson Pediatrics so that we may update their accounts.

Sibling's **Name**: ____

Sibling's DOB: ______________ Sex: __________ Age: ______ SSN#: ________________

1. Race: ______________________ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

---

Sibling's **Name**: ____

Sibling's DOB: ______________ Sex: __________ Age: ______ SSN#: ________________

1. Race: ______________________ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

---

Sibling's **Name**: ____

Sibling's DOB: ______________ Sex: __________ Age: ______ SSN#: ________________

1. Race: ______________________ **2.** Ethnicity (circle one): Caucasian Hispanic Not Hispanic

---

(If there are more siblings to list, please use the back of this sheet.)

1st Insurance Co.: ______________ Insurance Policy# ______________ Group# __________

Name of Subscriber (name on card): ______________________ DOB of Subscriber: __________

2nd Insurance Co.: ______________ Insurance Policy# ______________ Group# __________

Name of Subscriber (name on card): ______________________ DOB of Subscriber: __________

Pharmacy of Choice: ______________________ Phone# ______________

Pharmacy Address, City, State, Zip: ____
(There are multiple Walgreens, CVS, Rite Aids, etc... in town and some are also on the same street!!! Please be specific.)

____
Print: (Parent/Guarantor Name)

____
Date:

____
Sign: (Parent/Guarantor Name)

VACCINE POLICY

TO ALL OUR VALUED FAMILIES:

We at Crimson Pediatrics care deeply about the health and safety of the children in our care. One of the most vital steps in keeping them healthy is to be current with their childhood vaccines. Our clinic follows the recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) by encouraging our patients to be immunized according to their published schedule.

Unvaccinated children are at higher risk for becoming ill with a host of preventable diseases that can have very serious and sometimes devastating consequences. In addition, unvaccinated children can potentially spread a preventable disease to another child who may be too young to be vaccinated or whose medical condition prevents them from receiving immunizations. The vaccines our children receive have each been thoroughly tested for safety and effectiveness.

With those important issues in mind, and for the safety of all the children in our care, we are providing our families with The Crimson Pediatrics **VACCINE POLICY**.

EFFECTIVE IMMEDIATELY:

- Crimson Pediatrics does not accept new patients who choose to remain unvaccinated or who are on an alternative vaccine schedule.
- Parents of unvaccinated children ALREADY IN OUR CARE, will be given a 30 day notice in which to enroll with a different primary care physician.
- We will not administer an alternative vaccine schedule for our current patients. Parents of current patients who choose to use an alternative schedule will be asked to find another primary care provider.
- Parents of under-immunized children who would like to start following the AAP and the CDC guidelines for immunizations are encouraged to discuss catch-up immunizations for their child.

We at Crimson Pediatrics look forward to providing your children with the best possible medical care and guidance, and we value your trust and confidence.

PLEASE NOTE

Crimson Pediatrics will continue to see children in our care who have medical conditions, severe documented reactions, or treatments that preclude them from receiving vaccines. These children will be exempt from this policy until they are medically eligible to obtain vaccines.

I have read this Vaccine Policy. I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC Immunization Schedule. My consent also includes visits during which my child is accompanied by an adult that I have listed on the consent form. I understand that should I decide to decline vaccines at any time, I will have 30 days in which to enroll with a different primary care provider.

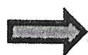
PRINT: ______________________________ **DATE:** ______________

PATIENT Full Name

PRINT: ______________________ **SIGN:** ______________________

Parent / Legal Guardian **Parent** / Legal Guardian

Revised 6/26/2019



INSTRUCTIONS: Please read carefully.

(We will not accept incomplete Registration Forms.)

Please **COMPLETE ALL QUESTIONS** on this form. If a question does not apply to you or your child, please answer NO or write N/A.

Do **NOT** leave any blanks. Please **PRINT** clearly. Use **ONLY** black or blue ink.

When returning this form, please bring the patient's insurance card and a valid driver's license, as these will be requested at each visit; your child will not be seen without their insurance card. (For Medicaid patients, an insurance verification letter is acceptable if you haven't received the insurance card yet.)

We do **NOT** accept faxed or mailed forms. The forms must be returned in person.

Only a Parent or a Legal Guardian can sign these forms (If you are the legal guardian, please be sure to bring legal documents proving your guardianship of this patient).

FOR NEWBORNS: Please be sure to bring your discharge instructions when you turn in these forms. Also list the name of the birth hospital on the attached "AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION" form so that we can request all additional records that may be needed prior to your first visit.

FOR CHILDREN TRANSFERRING HERE FROM ANOTHER DOCTOR: For continuity of care, we must have your complete medical records. You can either bring the records to our office along with these completed forms (which will make the registration process quicker), or you can fill out the attached "AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION" form which we will then fax to the doctor that you listed on that form. It is your responsibility to contact your previous doctor's office to get the fax number. We will NOT do this for you. All previous medical records must be received before an application is considered for approval. If approved, we will call you to schedule an appointment. (Turning in an application does not guarantee acceptance into our practice.) If your child has seen multiple doctors in the past, please list all of those doctors on the AUTHORIZATION form. We will need ALL of those records.

PARENTS/LEGAL GUARDIANS: We do understand that it is not always possible for working parents to bring their child/children to the doctor for all appointments, however, you are REQUIRED to accompany your child to the first appointment. The appointment **will be** rescheduled if your child is brought in by anyone else. After the first appointment, an authorized adult (an adult you have listed on the attached Consent Form) may accompany the child, but this adult must be knowledgeable about your child's health (and/or illness, if any).
We **do** ask that a parent/legal guardian (or an authorized adult regularly caring for your child) be present for all routine physicals / well-child-visits.

Please be advised that **ONLY 3 people** (including the patient) are allowed in the exam rooms. All additional persons must remain in the waiting room. It is best to leave any additional children (those who do not have an appointment) at home. If you do bring additional children, you must bring an adult to watch them in the waiting room while you are in the back with the child being seen. Our office is not responsible for unaccompanied minors at any time. If the additional children do not have a person to watch them in the waiting room, your appointment will be rescheduled.

NO-SHOW POLICY: We are enforcing a strict No-Show Policy. A No-Show to a New Patient appointment means automatic dismissal of the family from our practice. Repetitive No-Shows to appointments will also result in dismissal from this practice. No-Shows are counted per entire family per year (not just per patient). Calling the same day of an appointment to reschedule it is also considered a No-Show.

BEHAVIOR: Inappropriate language or behavior towards staff or other patients is not tolerated at Crimson Pediatrics and will result in immediate dismissal from our practice.

APPOINTMENTS: Please arrive at least 15 minutes before your scheduled appointment. This allows time for us to update any necessary paperwork that may be needed and verify insurance eligibility in a timely manner. Late arrivals may be asked to reschedule the appointment.

CRIMSON PEDIATRICS

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Crimson Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to give you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

CRIMSON PEDIATRICS Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may request a copy of the protected health information that we maintain. As permitted by federal regulation, we require that requests for a copy of your protected health information be submitted in writing. You may obtain a medical release form to request a copy of your records by contacting the front desk. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. There is a fee charged for the copying of records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
CRIMSON PEDIATRICS
535 Jack Warner Pkwy NE
Suite K
Tuscaloosa, AL 35404

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The person you can contact for further information concerning our privacy practices is:

[Same as Above]

Effective Date

This notice is effective on or after 01/01/2016.

DATE: ________________ **USE BLACK INK.** **PLEASE PRINT CLEARLY.**

Lena Bedri, MD **CRIMSON PEDIATRICS** ***Brandi Hubbard, CRNP***

535 Jack Warner Pkwy NE, Suite K, Tuscaloosa, AL 35404 Phone (205) 758-6471

INSTRUCTIONS: Please read carefully. **(Only "3" people TOTAL are allowed in the exam room.)**

Please **COMPLETE ALL QUESTIONS** on this form. If a question does not apply to you or your child, please answer **NO** or write **N/A**. Do **NOT** leave any blanks. When returning this form, please bring the insurance card and a driver's license, as these will be asked for at each clinic visit; your child will not be seen without their insurance card. We do **NOT** accept faxed or mailed forms. The forms must be returned in person.
(We cannot schedule an appointment if the form is not filled out in its entirety.)

PATIENT'S Full Name ______________________________
(First) (Middle) (Last)

Patient's: DOB ____________ **Gender** ________ **Age** ______ **SS#** ____________

Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. To get a better idea of health risks you may have and to better meet your health needs, we are collecting race and ethnicity information from ALL of our patients. Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record. It is perfectly alright if you do not want to answer the questions, however, this information **does** help us provide better care.

Race: ____________________ Ethnicity (circle one): Caucasian Hispanic Not Hispanic

Home Address ______________________________

(circle one) APT / UNIT / LOT #__________ City ____________________ State________Zip__________

Main Cell Phone#______________ **Name of Cell Phone Company:** ______________ **Main # belongs to:**__________

Alternate Phone#______________ (Circle one) HOME or CELL Alternate # belongs to:__________

Email Address (please write this CLEARLY): ______________________________

For **NEWBORNS:** Name of the Hospital where born ______________________________
Did the hospital instruct you to have your baby seen by a pediatrician sooner than the regular 2-week check-up? If YES, how soon and why?
____

BROTHERS & SISTERS OF THE PATIENT.
Name:____________________DOB:__________ Sex: ______ Current Doctor:__________
Name:____________________DOB:__________ Sex: ______ Current Doctor:__________
Name:____________________DOB:__________ Sex: ______ Current Doctor:__________

Mother Name ____________________ DOB: __________ SS# __________

Father Name ____________________ DOB: __________ SS# __________

Legal Guardian Name (if applicable) ____________________ DOB: __________ SS# __________

Primary Insurance ______________ Policy/Member/ID# ______________ Group# __________

Name of Subscriber ______________ DOB of Subscriber__________ Relationship to Patient __________

Secondary Insurance______________ Policy/Member/ID# ______________ Group# __________

Name of Subscriber ______________ DOB of Subscriber__________ Relationship to Patient __________

Crimson Pediatrics follows the vaccine schedule recommended by the American Academy of Pediatrics (AAP) and the CDC.

Do you plan to have your child vaccinated? __________ Are your child's immunizations up to date? __________

List any chronic illness your child may have such as ADHD, Asthma, Diabetes, etc.:______________________________

Pharmacy of Choice______________________________Phone#______________

Pharmacy Address: ______________________________
(There are multiple Walgreens, CVS, Rite Aids, Walmart Pharmacies etc... in town & sometimes on the same street. Please write a specific address!)

Previous Dr.: ______________________________Phone #______________

Address: ______________________________

Reason for Changing Doctor: ______________________________

Date: ____________________

CRIMSON PEDIATRICS

Patient History Intake Sheet

Patient's Name: ______________________________ Date of Birth: __________________ Age: ______

Name of Person Completing this Form (Must be Parent or Legal Guardian): ______________________________

Relationship to Patient: ______________________________

Patient's Birth History:

Birth Weight: ______________ Delivery Hospital: ______________________________

Due Date: ______________ Doctor: ______________________________

Length of Pregnancy: ________ weeks Early (<38 wks) Term (38-42 wks) Late (>42 wks)

Type of Delivery: ☐ Vaginal ☐ C-Section If C-Section, Give Reason: ______________________________

Complications of Pregnancy, Labor, or Delivery: ☐ No ☐ Yes: List ______________________________

Baby went to: ☐ Well Baby Nursery ☐ NICU.....Length of Stay ______________________________

APGAR Scores: 1 Minute __________ 5 Minutes __________

Problems in Nursery? ☐ No ☐ Yes: List ______________________________

Mother's Age at Delivery: ______________________________

Previous Pregnancies: Full Term ________ Premature ________ Miscarriages/Abortions: ______

Child's Family History:

Relationship	Age	Medical Problems No	Medical Problems Yes	Describe
Mother	______	☐	☐	______________________
Father	______	☐	☐	______________________
Sister(s)	______	☐	☐	______________________
Brother(s)	______	☐	☐	______________________

Patient's Past Medical History:

	No	Yes	Reason	Date/Hospital/Doctor
Hospitalizations:	☐	☐	______________	______________
			______________	______________
Surgeries:	☐	☐	______________	______________
			______________	______________

Allergies:

	No	Yes	Type	Describe Reaction
Medication	☐	☐	______________	______________
			______________	______________
Food	☐	☐	______________	______________
			______________	______________
Other	☐	☐	______________	______________

Patient's Name: ______________________________

Has Your Child Ever Had:

	No	Yes		No	Yes		No	Yes
Asthma/Wheezing	☐	☐	Ear Infections	☐	☐	Seizures	☐	☐
Breathing Problems	☐	☐	Fractures/Injuries	☐	☐	Skin Problems	☐	☐
Bronchiolitis	☐	☐	Heart Problems/Murmur	☐	☐	Slow Development	☐	☐
Bronchitis	☐	☐	Joint Problems/Arthritis	☐	☐	Tonsillitis	☐	☐
Chicken Pox	☐	☐	Kidney Problems/Infections	☐	☐	Vision/Eye Problem	☐	☐
Difficulty Talking	☐	☐	Pneumonia	☐	☐	Other: ______________		

Has a Relative of Your Child Ever Had:

(Indicate Child's: **M**-mother, **F**-father, **S**-sister, **B**-brother, **MGM**-maternal grandmother, **MGF**-maternal grandfather, **PGM**-paternal grandmother, **PGF**–paternal grandfather. Also include maternal and paternal aunts, uncles, or cousins.)

	No	Yes	Relationship		No	Yes	Relationship
ADHD	☐	☐	______	Epilepsy	☐	☐	______
Alcohol Abuse	☐	☐	______	Family History of Allergies	☐	☐	______
Arthritis	☐	☐	______	Genetic Defects	☐	☐	______
Asperger's Disorder	☐	☐	______	Hearing Disorder	☐	☐	______
Asthma	☐	☐	______	Kidney Disease	☐	☐	______
Autism	☐	☐	______	MI/Heart Attack	☐	☐	______
Blood Disorder	☐	☐	______	Mental Retardation	☐	☐	______
Cancer	☐	☐	______	Muscular Dystrophy	☐	☐	______
Celiac Disease	☐	☐	______	Seizures	☐	☐	______
Cystic Fibrosis	☐	☐	______	Sickle Cell Trait	☐	☐	______
Diabetes	☐	☐	______	Skin Disease	☐	☐	______
Digestive System Disorder	☐	☐	______	Substance Abuse	☐	☐	______
Down's Syndrome	☐	☐	______	Thyroid Disease	☐	☐	______
Eczema	☐	☐	______	Tuberculosis	☐	☐	______
Elevated Cholesterol	☐	☐	______	Vision Disorder	☐	☐	______

Other: ______________________________

Child's Social History:

City or Area Where Child Lives: ______________________________

Type of Home: ☐ House ☐ Mobile Home ☐ Apartment

City Water? ☐ Yes ☐ No   Well Water? ☐ Yes ☐ No

Do you have access to the Internet? ☐ Yes ☐ No

Child Lives With: ☐ Mom & Dad ☐ Mom Only ☐ Dad Only ☐ Other: ______________

Parents are: ☐ Married ☐ Divorced ☐ Single

Number of People in Household: ______ Relation to Child: ______________

Father's Occupation: ______________ Mother's Occupation: ______________

Do Household Members Smoke? ☐ Yes ☐ No

Pets? ☐ Yes ☐ No Type: ______________ Inside the Home? ☐ Yes ☐ No

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- I also authorize Crimson Pediatrics to discuss and/or release health information and/or medical records to the people that I have listed.

Print Names				
Relationship to Patient				

List additional people on separate page if needed.

I understand that as part of this Organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

______________________________________ ____________________

Print **your name** and Relationship to Patient Date Signed

____

SIGN **(Parent / Legal Guardian** if Patient is under 18 years old)

CRIMSON PEDIATRICS

APPOINTMENT REMINDER CONSENT FORM

(It is understood that the parent or guardian will fill out this form if the patient is under 18 years of age.)

PLEASE PRINT LEGIBLY SO THAT THE INFORMATION
IS KEYED CORRECTLY INTO YOUR CHART

Crimson Pediatrics can send appointment reminders to your email address and to your cell phone (via text message). Reminder is sent at the time the appointment is made and also **1 day** prior to your scheduled appointment.

PATIENT'S NAME: ____
(PRINT)

PATIENT'S DATE OF BIRTH: ____________________

PARENT/LEGAL GUARDIAN if Patient is under 18: ____________________________
(PRINT)

- The **EMAIL** that I authorize to receive messages for appointment reminders
  is ___________________________________@________________
  (PLEASE PRINT CLEARLY)

AND

- The **CELL PHONE NUMBER** that I authorize to receive TEXT reminders
  is (_______) _______ -____________

(I am aware that my cell service provider may charge me additional fees if I do not have a text messaging feature on my phone plan.)

My CELL PHONE CARRIER (circle one or write the name of carrier if not listed here):

AT&T	Verizon	T-Mobile	Sprint PCS	Virgin Mobile
US Cellular	Metro	Boost	Alltel	Other: ______________ (PLEASE SPECIFY WHICH CARRIER)

I *(the patient, or the parent/guardian of the patient)* consent to receive emails and text messages to my cell phone *(and any number forwarded or transferred to that number)* from Crimson Pediatrics for appointment reminders. I understand that this request to receive messages will apply to all future appointment reminders unless I request a change in writing.

I *(the patient, or the parent/guardian of the patient)* am aware that Crimson Pediatrics will NOT respond to any text messages or emails that I might send in response. The service is only provided to inform me of upcoming appointments. The text service and email service is not a method of further communication. If I have any questions, I will call the Crimson Pediatrics main number during business hours.

____ ______________

SIGNATURE *(PARENT / LEGAL GUARDIAN OF THE PATIENT)* **DATE**

* Please note that it is the patient's, parent's, or guardian's responsibility to notify our office immediately if there is any change in the email or cell phone number provided, or if they want to stop any or all forms of appointment reminders. *

FOR OFFICE USE ONLY – **The section BELOW is only for CANCELING the reminders.** – FOR OFFICE USE ONLY

REVOCATION **(choose one or both)** **Revocation Date:**__________ **SIGNED:**______________

☐ I hereby revoke my request to receive any future appointment reminders via email.
☐ I hereby revoke my request to receive any future appointment reminders via text.

SOUTHERN SURGICAL ASSOCIATES, LLC / DBA **CRIMSON PEDIATRICS**

535 Jack Warner Pkwy NE, Suite K, Tuscaloosa, AL 35404

Phone (205) 758-6471 Fax (205) 758-6472

Lena Bedri, M.D.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize to *Southern Surgical Associates, LLC / DBA* ***Crimson Pediatrics*** the use or disclosure of the following information from the health records of:

Patient Name ____________________ Date of Birth ____________

Address ______________________________

Phone# ______________________________

Information to be Disclosed:

- Complete health record(s)
- Other (Please specify): ______________________________

FROM: (the doctor/facility that currently has your records)

(required) → Name ____________________

Please Print

Address ____________________

____

Phone# ____________________

(required) → **Fax#** ____________________

TO: (the doctor/facility requesting your records)

Name: Crimson Pediatrics – Dr. Lena Bedri

Address 535 Jack Warner Pkwy NE, Ste K

Tuscaloosa, AL 35404

Phone# 205-758-6471

***Fax#** 205-758-6472

I understand that this will include information relating to:

- Behavioral health service/Psychiatric care
- Treatment for alcohol and/or drug abuse
- Acquired Immunodeficiency Syndrome (AIDS)
- Human Immunodeficiency Virus infection (HIV)

I understand this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date below.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____________________ ____________

Print Name (Patient / Guarantor if Patient is under 18) Date:

____________________ ____________

Signature (Patient / Guarantor if Patient is under 18) Date: