ANDERSON
FAMILY CARE

Dear Prospective Patient Parent,

Thank you for your interest in Anderson Family Care. We are pleased to announce that Dr. Madison Cannon is accepting new patients. She is a board-certified family medicine physician with training and experience in pediatric care, and is excited to meet you and care for you and your family.

About Your Packet

Please take time to read over all of the information enclosed, including:

- Our Mission, Vision, and Core Values
- New Patient Information Forms
- Our Vaccine Policy and Notice of Privacy Practices

Some pages are yours to keep, and others must be completed and returned to our office. **Your completed forms must be received before we will schedule your first appointment**, so please return them as soon as you are able.

Before Your First Visit

- **Arrive early.** Once your appointment is scheduled, please arrive at least 30 minutes before your appointment time.
- **Keep your appointment.** Failure to show for your first scheduled appointment will result in removal from our patient panel.
- **Bring identification and insurance.** Please bring your insurance card and your driver's license or other state-issued ID. Copies will be kept on file in our office.
- **Be prepared to pay.** If your insurance requires a copay, please be prepared to pay the correct amount before you are seen. If you are uninsured, please be prepared to pay $150 at the time of your appointment, which will go toward the balance of your visit.
- **Bring your medications.** Please bring all medications you are currently taking.

If you have any questions while completing your packet, please call our office at 334-654-5080. We look forward to welcoming you to Anderson Family Care.

Sincerely,

Sheila Morrissette
Practice Manager
Anderson Family Care

PHONE: 334-654-5080

ANDERSON FAMILY CARE

FAX: 334-654-5081

Patient Request for Health Information

Patient Information

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Phone _____

_____ **I request that the following organization provide my health information to Anderson Family Care:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

_____ **I request that Anderson Family Care provide my health information to:**

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Release records from the following dates: _____ to _____

Release the following records:

_____ Entire Record/All _____ Labs _____ Immunizations _____ Images _____ Office Notes

_____ Other (specify): _____

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Relationship to Patient: _____

A processing fee may be applied.

PEDIATRIC NEW PATIENT FORM

Please fill out completely.

Last Name _____ First Name _____ Middle Name _____

Preferred Name of Child _____

Date of Birth _____ Gender _____ SSN _____-_____-_____

Street Address _____ City _____ State _____ Zip _____

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race ☐Black or African American ☐White ☐Asian ☐Other _____

Parental Information

Circle One: Mother Stepmother Guardian

Name _____

Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address _____

Email Address _____

Employer _____

Occupation _____

Parental Information

Circle One: Father Stepfather Guardian

Name _____

Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address _____

Email Address _____

Employer _____

Occupation _____

Emergency Contact _____ Phone (____) _____ Relationship _____

Pharmacy: _____ Pharmacy City: _____

Primary Insurance

Company _____ ID/Policy # _____ Group # _____

Policy Holder _____ Relationship to Child _____ SSN _____

Employer _____ Phone (_____) _____

Secondary Insurance

Company _____ ID/Policy # _____ Group # _____

Policy Holder _____ Relationship to Child _____ SSN _____

Employer _____ Phone (_____) _____

Insured's Signature _____ Date _____

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Patient Health History

Depending on your child's age, all of these questions may not be relevant. Please complete this form as fully as possible.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Name of person completing this form: _____ Relationship to patient: _____

Name of child's previous physician: _____

Delivery and Birth History ____ Unknown Was your child adopted? Y / N Date of Adoption: _____

Place of birth: Name of Hospital _____ City and State: _____

Type of delivery: ____ Vaginal (If yes, breech/feet first? Y / N) ____ Caesarean (If yes, was it planned?: Y / N)

How old was the birth mother at time of delivery? _____ Was the child premature? Y / N days:_____ weeks:_____

Child's birth weight: _____ length: _____ head circumference: _____

Were there any significant medical problems during your pregnancy? Y / N

Were there any significant complications during labor? Y / N

Did the baby have a NICU stay after birth? Y/N

Were there any complications during the baby's newborn period? Y / N

If yes, to any of the above, please explain: _____

_____

Growth and Development

Have you or your child's previous physician ever had any concerns about your child's growth or development? Y / N
(speech/language, social skills, motor skills, etc.)

Please provide your child's age when they first:

Sat up without help _____ Crawled _____ Walked without help _____ Spoke their first words _____

Girls only: Age at first period: _____

List any developmental concerns or issues you would like to speak to Dr. Anderson about: _____

_____

Child's Medical History

Please indicate if your child has had any of the following conditions.

Been hospitalized overnight		Pneumonia		Eating Disorder/Anorexia or Bulimia	
Asthma/wheezing		Seizure/Epilepsy		Seasonal Allergies	
Used a nebulizer		Liver Disease/hepatitis		Learning Delay	
Surgery		Kidney Disease		Learning Disability	
Broken bones		Bladder infection		ADD/ADHD	
Frequent or severe sprains		Sexually Transmitted Infection		Lead Poisoning	
Mental or behavior challenges		Skin problems		Obesity/overweight	
Seen in the Emergency Room		Hearing problems		Emotional/Behavioral Challenges	

If yes to any of the conditions above, please describe: _____

_____

_____

Medications and Allergies

Please list current medications, vitamins, and supplements, even those used occasionally:

Medication	Dosage	Directions	Prescribed By:
Example: Cetirizine	**5mg**	**Once a day**	**Dr. Anderson**

Please list allergies or reactions to medications, vaccines or foods:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Please list all others living in the child's household:

Name	Age	Relationship

Does your child attend school? Y / N Homeschool: Y / N Daycare: Y / N

Do you have pets in the home? Y / N If yes, type and number of pets: _____

Do you have guns/firearms in the home? Y / N If yes, are they locked _____

Does anyone in the home smoke? Y / N If yes, who _____

Approximately how many hours a day does your child spend in front of a screen? _____

Does your child play organized sports? Y / N If yes, what and for how long: _____

Family History

Please indicate if any family members have had any of the following diseases. If so, please write in their relation: mother, father, sister, brother, maternal aunt/uncle/grandmother/grandfather, paternal aunt/uncle/grandmother/grandfather

Disease	Family Member
ADD/ADHD	
Alcohol/Drug dependency	
Anemia	
Anxiety or depression	
Arthritis or Lupus	
Asthma/ Lung Disease	
Blood Clots	
Blood Transfusions	
Breast Disease or Cancer	
Cancer (list type)	
Dementia	
Diabetes	
Genetic disease or Birth defects	

Heart problems	
Hepatitis	
High Blood Pressure	
HIV	
Kidney disease	
Liver disease	
Mental Health Disorder	
Migraines	
Neurological disease	
Seizures	
Stomach problems	
Stroke	
Thyroid disease	
Tuberculosis	

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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 Anderson Family Care to seek medical care.

Patient Name(s) _____ Birthdate _____

_____ _____

_____ _____

Name (First and Last)	Phone Number	Relationship to Child

I understand that care will be provided by the staff of Anderson Family Care, including the administration of any medications and/or vaccinations deemed necessary by the treating provider at the time. I will make a good effort to call Anderson Family Care with any questions I have about my child's care before, during, or following any visit where I am not present. I understand that unless and until I provide written notice to the practice of any changes to the designation of authorized adult representatives, Anderson Family Care may rely on the consent provided herein.

_____ _____

Signature of parent / guardian or assigned representative Relationship to child

_____ _____

Print Name Date

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PATIENT CONTACT RECORD

Patient Name: _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). A copy of Anderson Family Care, LLC's Notice of Privacy Practices is included in this packet.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT OF FORM

I, _____, have received a copy of Anderson Family Care, LLC's Notice of Privacy Practices.

Signature _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL HISTORY TO ANOTHER INDIVIDUAL

Please list the individual(s) you will allow Anderson Family Care, LLC to release or discuss your child's PHI with. Do not list other physicians.

Name	Relationship	Phone Number

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I, _____, hereby authorize Anderson Family Care, LLC to obtain/download my child's medication history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will remain in effect until revoked by me in writing.

AUTHORIZATION TO LEAVE RECORDED MESSAGES

I give Anderson Family Care permission to leave protected health information on an answering machine or voicemail.

(Circle Yes or No) YES NO

AUTHORIZATION OF ELECTRONIC CORRESPONDENCE

I give Anderson Family Care permission to communicate protected health information with me via email, text message and other electronic mechanisms. I understand the potential risks associated with electronic correspondence.

(Circle Yes or No) YES NO

Signature _____ Date _____

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Policy for Divorced or Separated Parents

Anderson Family Care staff are dedicated to our patients and providing quality medical care to your child(ren). Our focus is on your child's medical, emotional, psychological and physiological health. We are not party to or to be involved in any legal issues involving divorce, separation or custody agreements. Please, read and agree to the following so that we may provide care to your child(ren).

1. The physician(s), medical assistants, office and billing staff will not be put in the middle of domestic issues or disagreement over the phone or in the office.
2. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice.
3. Only in situations where there is a confirmed, documented **Court Order** will one of the parents be denied access to the minor child's health records or visits at the office. Anderson Family Care must have a copy of this Court Order on file in the minor child's electronic chart.
4. If there is NOT a court order on file with our office, either parent or legal guardian can sign a "Designation of Authorized Adult Representatives" form that authorizes any named individuals (like grandparents, nannies etc.) to bring your child to our practice, be present during the visit and consent to any treatment during that visit. We will not be involved in any disputes regarding named individuals on the consent forms unless instructed by the court. Either parent or legal guardian can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary.
5. It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the staff to communicate visit information to each custodial parent separately. Our providers will not call the non-attending parent following visits.
6. Additionally, we will not call the other parent for consent regarding appointments scheduled, restrict either parent's involvement in the patient's care unless authorized by law or tolerate appointment scheduling/cancelling patterns of behavior between parents.
7. Furthermore, payments including copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are **not** a party to your divorce agreement. We will collect payment from the parent who brings the child to their visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Any disputes about payment that end up in the collection process, will be due at the next time of service or the patient will not be seen.
8. If we feel any of the above points are becoming an issue at the office and/or compromising patient care, we have the right to discharge the family from the practice.

By signing this form, you agree to honor the above policy and understand that breaking this agreement may result in the discharge of your family from the practice.

Print- Parent/Legal Guardian	Sign- Parent/Legal Guardian	Date
Print – Parent/Legal Guardian	Sign – Parent/Legal Guardian	Date



ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Anderson Family Care, LLC for any equipment or services provided to me by its physicians or clinical staff.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Anderson Family Care, LLC, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Anderson Family Care, LLC.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient Signature _____ Date_____

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VACCINE POLICY

At Anderson Family Care, we are passionate about the need for vaccinating children, including your children and our own children.

We firmly believe:

- in the safety of vaccines.
- in the effectiveness of vaccines to prevent serious illness and to save lives.
- that all children and young adults should receive all recommended vaccines according to the schedule published by the American Academy of Pediatrics (AAP).
- based on all available literature, evidence, and current studies, that neither vaccines nor thimerosal, a preservative which has been removed from infant vaccines, cause autism or other developmental disabilities.

Furthermore, we believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers and that parents can offer their children.

The recommended vaccines and their immunization schedule are the results of years of scientific study and data gathered on millions of children. We recognize that there has always been and will likely always be controversy surrounding vaccination, and the subject may be emotional for some parents. Our job as healthcare providers is to strongly encourage you to vaccinate your children based on the current recommended schedule. However, in some cases, we may alter the schedule to accommodate concerns or reservations. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, which can put your child at risk for serious illness (or even death) and goes against our medical advice. We believe very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults, for everyone's safety.

Trust is a very important part of the physician-patient-parent relationship. Unfortunately, not trusting your physician about the effectiveness and safety of vaccinations may lead to lack of trust regarding other aspects of pediatric care. We do not wish to put you or ourselves in that position. If you decide to refuse to vaccinate your child despite our strong recommendation, we kindly ask you to find an alternate health care provider.

If you do not wish to refuse vaccination, but simply want more education about the vaccines (e.g., what they do, when they are given, how the schedule is determined, etc.), we would love to talk to you about vaccines. Please feel free to make an appointment and our staff can discuss this with you.

Child's Name	Guardian's Signature	Date

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CONSENT TO USE AI SCRIBE DURING CLINICAL VISITS

At Anderson Family Care, we are committed to providing the best possible care for our patients. As part of this commitment, we are continuously looking for innovate ways to enhance our services.

We would like to inform you about a new technology that we are using called AI Scribe. AI Scribe is an artificial intelligence (AI) tool that assits us during patient visits by generating clinical notes based on our conversations. This tool allows our providers to focus more on you during the visit and less on computer documentation. This tool will allow the entire staff to better serve patients in and outside of the clinic.

There is nothing that you or the provider will do differently during your visit. The AI Scribe does not interact with you directly, it simply listens to the conversation and creates a clinical summary. The clinical summary will be reviewed for accuracy and signed by the provider before it enters your clinical chart. There will be no video recording of your visit.

Be assured that your privacy is our priority. The AI tool adheres strictly to Health Information Portability and Accountability Act (HIPAA) compliance guidelines to ensure that your data is secure and protected. Only the healthcare professionals involved in your care will have access to your clinical notes.

Your participation is voluntary and your consent is required for this service to be using during your visits. If you agree to the use of the AI Scribe during your visits, please sign and date the form below. You may withdraw your consent at any time. If you have any questions, please feel free to discuss them with us before signing this document.

I, _____, consent to the use of AI Scribe during my clinical visits at Anderson Family Care.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under age 18): _____ Date: _____

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CLINIC POLICIES

Cancellations
If you are ever unable to keep your appointment, you must call our office at 334-654-5080 to reschedule within 24 hours of the visit. Promptly rescheduling will help our clinic flow and will help other patients who may need to schedule an appointment during the time that would be made available by your cancellation.

Late to Appointments
Efficient scheduling is important to us. If you are more than 15 minutes late to your scheduled appointment, you will not be seen. We will do our best to reschedule you to the next available appointment, which may not be that same day. If you know in advance that you will be late, please call our office and we will make arrangements that do not disrupt our clinic flow.

Missed Appointments
It is important that you show up for your scheduled appointments or cancel within 24 hours if you are not able to attend. Anderson Family Care reserves the right to charge a fee in the case of missed and late cancelled appointments that must be collected before the next appointment will be made. After continued missed appointments or late cancellations, you may be dismissed from the practice. In the case of children who repeatedly miss scheduled appointments (especially well-child/developmental/immunization appointments), Anderson Family Care reserves the right to request assistance from local agencies to ensure that any issues hindering the child from getting to clinic are addressed.

Calls During Business Hours
Please review our clinic hours. We will do our best to answer each phone call as it comes in to the office. We understand that there may be times when you will be given the option to leave a voicemail and we ask, if it is not urgent, that you leave a message. All voicemails left before 2pm on Monday-Thursday and before 12pm on Friday will be checked and returned before the end of that day. Voicemails left after these times will be checked and returned on the following clinic day. Weekend voicemails will be returned on the next clinic day.

After-Hours Calls
You may call our office after hours if there is an urgent matter requiring you to speak to a member of our staff. You will be routed to an answering service that can page Dr. Anderson for urgent matters. Please note that no refill requests will be filled after hours or on weekends; we ask that you keep track of your medication counts and make these requests during office hours. No appointments will be made after hours or on weekends; we ask that you schedule appointments during office hours. If you have an after-hours *emergency*, we ask that you go to the *emergency room*! Do not call our office as there will be a delay in our getting back to you—please seek medical attention right away! Please note that overuse of the after-hours line for non-urgent matters may result in a fee.

Medication Refills
All appropriate medication refill requests will be filled within 24 hours of the request. Controlled medications will not be refilled without a visit to the office. Medications will not be refilled if you have not been seen at Anderson Family Care within the past 6 months. If you request an appropriate refill, you can assume that it will be sent to your pharmacy; you do not need to call our office to confirm, and we will not call you to say that it has been sent. We ask that you check the status of the prescription with your pharmacy before re-calling our office.

Controlled Substances
We adhere to state and national regulatory guidelines regarding the writing of prescriptions for controlled substances. As a board-certified physician, Dr. Anderson reserves the right to refuse to prescribe any medication or combination of medications that can be harmful or are not medically necessary. Patients prescribed controlled medications will be asked to sign and adhere to a controlled substance policy which includes urine drug testing.

Notification of Test Results
An attempt will be made to notify you within 48 hours of our receipt of your test results. Please give us time to review your results and call you. If your preferred communication is by phone, please ensure that we have an accurate number on file for you and if this number changes, please let us know. If your results are normal and you have elected to receive voicemails from our office, this information will be left in a message. If results require discussion, you will be asked to call our office. After 3 attempts, we will send a letter to the address on file, and you are then responsible for contacting our office. If you do not have test results within one week of the test, please call our office.

Account Balances
If you have an outstanding balance, you will receive written notification by mail or you can view this information on the Patient Portal. It is important that you clear your balances in a timely manner. We accept cash, personal checks, and all major credit cards. If you are unable to pay your balance, please call our office so payment arrangements can be made. Payment arrangements that are not adhered to are subject to fines and past due accounts may be turned over to our collection agency.

Returned Checks
If our bank returns your check for insufficient funds, we will ask that you come in to our office to pay the amount of the check plus a $35 fee, and the total must be paid by cash or card. We will not re-deposit returned checks through the bank. Returned checks that are not resolved within 2 weeks will be turned over to our collection agency.

Insurance
If you are insured, please be prepared to present your card at each visit. Insurance co-pays are due at the time of your appointment. Please inform our office immediately if your insurance changes.

Forms/Special Letters
Forms and requests for special letters should be presented to the clinic in a timely fashion. Please do not bring forms to clinic on the day they are due. In order to efficiently serve all patients, we will not stop clinic to complete forms. Please allow 5 days for all forms to be completed.

Use of Phones in Office
We do kindly ask that you refrain from talking/interacting on your phone in the exam room during the clinic visit. Our staff will give you our full attention during the visit and we ask the same from our patients.

Use of Photography and Recording Devices
Recording of the clinical visit and taking photographs during the visit are not permitted, unless explicitly discussed and approved by a member of the staff beforehand.

Clinic Behavior
As much as we want Anderson Family Care to be a happy place, we understand that sometimes visits to the doctor can be stressful. We will always strive to be kind, courteous, and understanding, and we ask the same from you. Patients who disrupt our environment, either verbally or physically, will be promptly dismissed from our practice and local authorities may be called.

Received by: _____ _____ _____
(Print Name) (Signature) (Date)