# Tennessee Valley Pediatric Surgery

James C. Gilbert, MD, FACS, FAAP
Zaria Murrell, MD, FACS
Evans Valerie, MD
Stephanie Drieling, CRNP
Paul Edwards, CRNP

Dear Families,

Welcome to Tennessee Valley Pediatric Surgery at Huntsville Hospital for Women & Children. We understand that "your child needs surgery" are some of the most frightening words any parent ever hears. Faced with the prospect of your child's surgery, you need information and you want an experienced surgeon. You also want to know that your child is receiving compassionate care and that the healthcare providers are working as a team.

Our office works closely with other programs and services throughout the Hospital – including Pediatrics, Anesthesiology, Critical Care Medicine, Radiology, Gastroenterology, Neonatology and Surgery to provide integrated care for your child.

Our staff knows that while they see many patients each year, this may be the first time your child has needed surgery. We will reassure and provide you and your child all the resources needed to successfully navigate your experience.

Enclosed are the patient registration information forms and an appointment card for your child's initial consultation appointment. **Please complete** the patient registrations forms and bring them with you to your appointment. You will also need to bring **a parent or guardian photo ID, your insurance card, list of all medications that your child is currently taking, and legal guardian documentation if applicable and your insurance co-payment**. If no insurance card is provided we will have to list you as a "self pay" patient until the card is presented to us and payment will be due at time of service.

**Please be advised a parent(s) or legal guardian MUST be present for the initial consultation appointment**. Otherwise, we will not be able to appropriately discuss the potential risks, benefits and/or alternatives to the recommended treatment plan.

If you are unable to keep your appointment or accompany your child please call us as soon as possible to reschedule, before your scheduled appointment time, to ensure you will not be charged **$25 for not keeping your appointment**.

Thank you for trusting us with your child's care. Please let us know what we can do to help make this time less difficult for you.

Sincerely,

James Gilbert, MD, FACS, FAAP
Zaria Murrell, MD, FACS
Evans Valerie, MD

**Please call our office to confirm your appointment upon receiving this paperwork.**

*910 Adams Street,*
*Ste. 220*
*Huntsville, AL 35801*
*o: (256) 265-1800*
*f: (256) 265-1801*

Patient name | DOB | Chart # | Date

Tennessee Valley Pediatric Surgery

*910 Adams Street, Ste. 220 · Huntsville, AL 35801*
*o: (256) 265-1800 · f: (256) 265-1801*

James C. Gilbert, MD, FACS, FAAP · Zaria Murrell, MD, FACS
Evans Valerie, MD · Stephanie Drieling, CRNP · Paul Edwards, CRNP

# REVIEW OF SYSTEMS HEALTH QUESTIONNAIRE

By answering these questions, you will provide for us a more complete medical history of your child. These pages are considered part of his/her permanent medical record. Please answer as completely and honestly as possible.

Was he/she born on time? Yes / No Weight: _____lbs _____oz

Were there any complications with his/her birth? Yes / No Natural? Yes / No C-section? Yes / No

Were there any complications with the mother's pregancy? Yes / No

Were there any problems with his/her nursery stay? Yes / No

Are his/her shots up-to-date? Yes / No

Has your child ever had a bad reaction to medicine or food? Yes / No

## HAS YOUR CHILD HAD ANY RECENT PROBLEMS WITH ANY OF THE FOLLOWING?

**Cardiovascular**
- ☐ Chest pain and/or pressure
- ☐ Awoke breathless at night
- ☐ Accelerated heartbeat
- ☐ Cold and/or blue hands/feet

**Pulmonary**
- ☐ Cough with sputum and/or blood
- ☐ Shortness of breath
- ☐ Sleep apnea and/or loud snoring
- ☐ Asthma
- ☐ Frequent colds

**ENMT**
- ☐ Sore throats
- ☐ Earaches
- ☐ Dizziness
- ☐ Ear infections
- ☐ Nose bleeds
- ☐ Difficulty swallowing

**Constitution**
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fever
- ☐ Night sweats

**Nervous**
- ☐ Headaches
- ☐ Faints/blackouts
- ☐ Seizures
- ☐ Limp
- ☐ Tremors
- ☐ Paralysis
- ☐ Poor vision

**Alimentary**
- ☐ Abdominal pain and/or discomfort
- ☐ Bloating/distention
- ☐ Nausea/vomiting
- ☐ Incontinence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gastric reflux

**Psychiatric**
- ☐ Attention deficit
- ☐ Hyperactivity disorder
- ☐ Learning disability
- ☐ Sleepwalking
- ☐ Difficulty sleeping

**Genitourinary**
- ☐ Bed wetting
- ☐ Blood in urine
- ☐ Genital rash, lumps

**Endocrine**
- ☐ Sweating
- ☐ Fatigue
- ☐ Hand trembling
- ☐ Neck swelling
- ☐ Skin, hair, voice changes
- ☐ Thirst

**Integumentary**
- ☐ Itchy skin
- ☐ Rashes

**Hematological**
- ☐ Excessive bleeding
- ☐ Lumps under arms, neck, loin
- ☐ Clots in legs, lungs
- ☐ Easy bruising
- ☐ Anemia

**Rheumatiod/ Musculoskeletal**
- ☐ Joints: pain, stiffness, swollen
- ☐ Variation in joint pain during the day
- ☐ Fingers painful/blue in cold

☐ **Other**: _____
_____
_____

**Female patients only:**

Experienced menses?
Yes / No
Age of first menses _____
Date of LMP _____

Is the patient a smoker? Yes / No Drug use? Yes / No Alcohol use? Yes / No

Does anyone in your home use tobacco products? Yes / No

Who lives in your home (i.e. mom, grandmother, 2 yr old brother) _____

_____

_____

Are his/her parents in good health? Yes / No Are his/her siblings in good health? Yes / No

## Family History

Please complete this information about your child's family history dating back to your child's grandparents.

| | Relationship | | Relationship |
|---|---|---|---|
| ☐ Severe reactions to anesthesia | | ☐ Diabetes | |
| ☐ Heart disease before age 60 | | ☐ Cancer | |
| ☐ Malignant hyperthermia | | ☐ Sudden Infant Death Syndrome (SIDS) | |
| ☐ Anemia or bleeding disorders | | ☐ Asthma | |
| ☐ Kidney disease | | ☐ Seizures | |
| ☐ High cholesterol | | ☐ Bowel disease | |
| ☐ High blood pressure | | ☐ Hereditary disease | |

## Current Medications

| Name | Dosage | Frequency | Prescribing physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Form completed by _____ Relationship to patient _____ Date / Time _____

Reviewed by _____ Date / Time _____

Tennessee Valley Pediatric Surgery

910 Adams Street, Ste. 220 · Huntsville, AL 35801
o: (256) 265-1800 · f: (256) 265-1801

James C. Gilbert, MD, FACS, FAAP · Zaria Murrell, MD, FACS
Evans Valerie, MD · Stephanie Drieling, CRNP · Paul Edwards, CRNP

*PLEASE PRINT*

# PATIENT INFORMATION

Date _____

Patient's name _____ D.O.B. ____/____/____
Last First MI

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

SSN ____-____-____ Sex M F

## Parent information

Mother's name _____ D.O.B. ____/____/____ SSN ____-____-____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Employeer _____ Employer address _____

Father's name _____ D.O.B. ____/____/____ SSN ____-____-____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Employeer _____ Employer address _____

## Pediatrician / primary care physician information

Physician name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referring physician (if different) _____ Phone _____

Address _____ City _____ State _____ Zip _____

## Emergency contact information

In case of emergency, notify _____ Relationship _____

City _____ State _____ Phone _____

## If patient is a minor: list persons, other than responsible party on previous page, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

## Foster child information

Case worker _____ Phone _____

Date of child's placement in your care _____

Circumstances of child's placement into foster care _____

_____

_____

If birth parents call, may we give out information? ☐ Yes ☐ No, refer them to _____

## Primary insurance to file

Policy # _____ Group # _____

Insured's name _____ Relationship to patient _____

Insured's social security or I.D. # _____ Insured's date of birth _____

Insurance Company Name _____

## Secondary insurance to file

Policy # _____ Group # _____

Insured's name _____ Relationship to patient _____

Insured's social security or I.D. # _____ Insured's date of birth _____

Insurance Company Name _____

---

Person responsible for this account _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Tennessee Valley Pediatric Surgery to release information to insurance carriers and for insurance carriers to release information to Tennessee Valley Pediatric Surgery concerning my illness, treatment and payments. I hereby assign to the physicians all payments for medical services rendered to myself or my dependaents if assignment applies.

Signature _____ Date _____ Time _____

Relationship to patient _____

Health System

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ SSN (opt):_____

Date of Birth: _____ Address:_____

Phone: _____ Date of Service: _____

Chart #: _____

Provider: _____

***I authorize the use or disclosure of the above named individual's health information as described below:***

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
  - ☐ All/entire record
  - ☐ Visit/encounter notes
  - ☐ Laboratory results
  - ☐ X-ray and imaging reports
  - ☐ Problem list
  - ☐ Medication list
  - ☐ Allergies list
  - ☐ EKG report
  - ☐ Pathology report
  - ☐ Consultation report
  - ☐ Operative report
  - ☐ Immunization record
  - ☐ Drug and alcohol treatment
  - ☐ HIV/AIDS/STD treatment
  - ☐ Registration record
  - ☐ Other: _____

  **Records release format:**
  (choose one)
  - ☐ e-delivery (HealthPort connect)
  - ☐ CD
  - ☐ Paper
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:

  Name: _____ Address: _____

  for the purpose of: _____
- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

  _____

  If left blank, this authorization will expire six months from the date of signing.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

_____ _____ _____
Signature Date Time

_____
Relationship to patient (if signed by legal representative)

_____ _____ _____
Signature of witness Date Time

OFFICE USE ONLY: Any portion of the record request found in paper chart? ☐ Yes ☐ No

**HH System Clinics Registration Update Sheet**

Patient: _____ Date of Birth: _____ Fin #_____

**----------AUTHORIZATION TO CALL---------**

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

_____ Reminder appointments calls

_____ Lab and/or Test results

**----------HH SYSTEM CLINICS ADVANCE DIRECTIVE POLICY---------**

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

**----------FINANCIAL FEES AND ASSISTANCE---------**

FINANCIAL FEES: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

FINANCIAL ASSISTANCE: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at 256-265-9438.

**----------AUTHORIZATION OF TREATMENT---------**

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

**----------ASSIGNMENT OF BENEFITS, AGREEMENT AND GUARANTY ----------**

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

**----------HH HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT----------**

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

**----------EXPRESS PERMISSION TO CONTACT PATIENT BY CELL PHONE----------**

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages

Patient: _____ Date of Birth: _____ Fin #_____

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

**----------PHOTOGRAPHY CONSENT----------**

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

**----------FOR USE BY HEALTH SYSTEM PERSONNEL ONLY ----------**

**--------(Complete if patient Acknowledgment is not obtained) ----------**

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____

Witness/Employee Signature: _____ Employee ID: _____

Date _____ Time _____