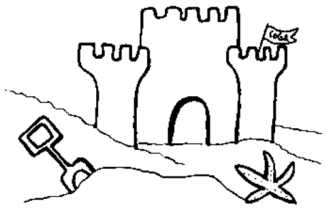


COASTAL GEORGIA CHILD NEUROLOGY

Dr. Sharlisa W. Hutson

106 Anderson Way
Brunswick, Ga 31520

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my health care, this medical practice originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool a routine healthcare operations such as assessing quality of care

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information used and disclosures. I understand that I have the right to review the notice prior signing this consent. I understand that the practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to healthcare operations and that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I fully understand and accept the terms of this contract.

_____

Signature of Patient or Legal Representative

_____

Date

I Request the following restrictions to the use or disclosure of my health information

_____

_____

_____

FOR OFFICE USE ONLY

Consent received by: _____ on_____

Consent refused by patient, and treatment refused as permitted.

Consent added to patient's medical records on _____

COASTAL GEORGIA CHILD NEUROLOGY

Dr. Sharlisa W. Hutson

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will used to:

- Provided and coordinates my treatment among a number of health care providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payer(s) for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

For Office Use Only:

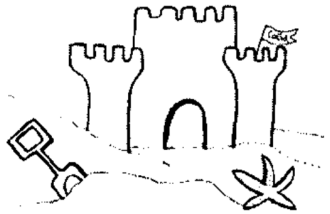
We were able to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to following reason:

□ The patient refused to sign
□ communication barriers
□ Emergency situation
□ Other

Revised 1/10/2020

106 Anderson Way Brunswick, GA 31520 (912) 342-0996
fax 912-342-4977 info@cogahealth.com

COASTAL GEORGIA



Child Neurology

Sharlisa Hutson MD
106 Anderson Way
Brunswick, Ga 31520

p (912) 342-0996
f (912) 342-4977

info@cogahealth.com

Patient Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

Today's Date: _____ Age: _____ Sex: _____

Child's Legal Guardian: Mother_____Father_____Other: (specify)_____

Mother's Name: _____

Mother's Cell Phone: (_____) _____

Mother's Email Address: _____

Father's Name:_____

Father's Cell Phone: (_____) _____

Father's Email Address: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Alternate Home Address:_____

City: _____ State: _____ Zip Code: _____

Child's Primary Care Physician: _____

Physician's Phone Number: (_____) _____

Physician's Fax Number: (_____) _____

Pharmacy Name: _____

Pharmacy Phone Number: (_____) _____

Pharmacy Fax Number: (_____) _____

Who has referred this child: _____

Coastal Georgia Child Neurology Practice Policy

Coastal Georgia Child Neurology would like to welcome you to our practice. We look forward to our relationship with you in partnering to ensure the most success possible. We want to provide the care you need in a timely manner with up-to-date treatment and compassion. We want you to know that we are dedicated to you and our community. We hope this information will enable you to get the most from your care here at Coga CN. Please refer back to this before calling our office, except in the case of an emergency and you should call 911 at that time. We look forward to meeting you.

Office hours:

Tuesday, Wednesday, Thursday 9:00 am- 5:00 pm

Some other appointment times as offered.

After hours:

For ALL LIFE-THREATENING EMERGENCIES, Dial 911.
If you are in need of medical advice after hours, please call your primary care provider/pediatrician.
If your child needs to be seen by a medical provider outside of normal office hours, go to the nearest Emergency department or urgent care facility.

Prepare for your appointment:

*Please complete the enclosed forms to the best of your ability and bring them to your appointment
*Bring bottles of any current medications including over the counter and vitamins/supplements.
*Bring any medical records pertaining to the current problem including CDs with imaging or videos of the symptom being addressed.
*Bring your insurance card and picture ID.
*For patients being seen for spells and seizure like activity it is important to bring an eye witness to the appointment.
*We are located at 106 Anderson Way, Brunswick, GA 31520. The parent or legal guardian must accompany the child (including teenagers).
*If there are young, active, and vocal siblings it may best to leave them with a babysitter so that the parents can dedicate their attention to the child being seen.

When you arrive:

*Please check-in with the front desk at each visit. Sitting in the lobby without checking in may delay your appointment.
*New patients are asked to arrive 40 minutes early if the enclosed paperwork is not completed, or 20 minutes early if paperwork is complete.

*Established patients are asked to arrive 5-10 minutes prior to their scheduled appointments. This provides adequate time for check-in to the clinic, verification of demographics and health insurance, and completion of all paperwork necessary for a valuable visit.
*Upon checking-in, please notify the front desk if you have had any changes since your last appointment (i.e. address, phone, and insurance).
*Dr. Hutson and staff do all we can to stay on schedule and respect your time. If you are waiting for more than 15 minutes after checking-in, please notify the receptionist about this. Filling out all appropriate paperwork ahead of time and arriving on time for your scheduled appointment helps us to see you, as well as every patient following you, at the time of the scheduled appointment. Unfortunately, there are times a patient is scheduled for a routine appointment and may have developed a complication that requires additional time than their appointment allowed. We ask for your patience if this happens, as we know that you would want us to spend the necessary time with you and your loved one if needed.
*Your evaluation by Dr. Hutson will take approximately 1-2 hours (new patient) or 20-40 minutes (follow up). It will consist of Dr. Hutson taking a medical history, assessing current medical problems, performing a neurological examination, discussing the details of her assessment and plan, answering your questions as well as providing appropriate education and counseling.

Appointments:

*To make or reschedule an appointment please call the clinic.

You may also go online on the website to schedule at WWW.coastalgeorgiachildneurology.com

*If you cannot keep your appointment, we ask that you call to cancel or reschedule at least 48 hours (2 business days) prior to your appointment. If we do not receive confirmation your appointment will be given to another patient. If you cancel within the 48 hr window there is a reschedule fee.

No-show and late arrival policy:

*No-shows create barriers to accessing pediatric neurology care, which is very limited in Brunswick and the surrounding areas. It is unfair to the patients in need.
*<u>For New patients</u>

You will not be rescheduled without paying a fee of 50% of what the visit would have been.
The only exception is if you can produce a document showing a real reason you missed the appointment.

*<u>For Established or follow up patients</u>

If you miss your appointment without canceling or rescheduling at least 2 business days prior, we will charge $50 for the patient to be scheduled again. After a second no show we will charge $100 to schedule the patient an appointment. A third no show will result in the patient no longer being seen in the practice.
*If you should be dismissed from the practice you will receive written notice and we will continue to care for your child for 30 days until you find another physician. We will transfer records for you as well.
Please carefully read the enclosed no-show/cancellation/late arrival policy for more information.

Prescription Refills:

*Refills will be processed Monday – Thursday 8:30 a.m. to 3:00 p.m.

*Dr. Hutson will provide refills at the time of your visit that will last until the next visit. Initially some medication changes or increases may occur more frequently, and you will have appointments more frequently during that period.
*Any requested changes to medications in between visits will be addressed with a fee of $25.
*Most refills will be sent to your pharmacy upon their request Monday through Thursday.
It is best not to wait until Friday, as we do not process refills on the weekends and we are not in the office on Friday.
The pharmacy will contact us with the information we will need to authorize your refill.
*If you require a paper prescription, please have the following information ready when calling our clinic: the patient's name, the name of the pharmacy, the name of the medication, and the instructions on the label.
*Please, allow 48-72 hours for prescription refills.
*Please note that it takes time for your pharmacy to contact our office and for us to call in or have a written prescription ready to pick up. We do not want anyone to go without their necessary medications, so please plan ahead and have your pharmacy request the refill before the weekend if it is going to run out.
*In addition, please be aware that we are closed for the following holidays: New Year's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve and Christmas Day. So, as with weekends, please plan accordingly.

Messages and questions for the doctor:

*We will return your call within 24 hours.
*If your call is urgent, please convey the urgency of your call to the receptionist or on your message.
*We try to answer questions during the visit.

No messages sent through Facebook or facebook messanger will be answered.
You may lealve a message with the front desk receptionist and it will be answered, please do not call and leave multiple messages.

Unplanned Visits:

*If you need to come in for an unplanned visit, please call us first. We do not see patients on a walk-in basis.

Meals in the Clinic:

*The clinic has no food/beverage policy. Exceptions may be made for bottles/snacks for babies and toddlers, and in case of medical necessity (e.g. diabetic patients).

Telephones:

*To allow our physician and staff to serve you better, please turn off your cell phone prior to entering the exam room. No recording is allowed during your visit.

Labs and Imaging Studies Results:

*It is our policy that you receive your results at your next scheduled visit
Please make sure that you have an appointment pending to discuss your results at least 1 week after the study was done. We do not discuss results over the phone.
We will have telemedicine appointments available. Please ask us more about this.
See fee schedules if telemedicine would be from home. Otherwise it will be charged as a regular visit through your insurance if done at school or pediatricians office.

Records Release and Forms:

*You may request a copy of your records by filling out an Authorization to Disclose Protected Health Information, available at the front desk, or by mailing/faxing us the form. Please allow 1 week for the copying of your records and filling out your paperwork. There is a fee for your request to be processed. See fee schedule.

Insurance and Co-pays:

*For your convenience, the clinic will bill your insurance company. We make every attempt to ensure prior authorizations and requirements are met prior to services being rendered. However, ultimately it is the patient/guarantor's responsibility to verify that referrals and authorizations have been requested from their PCP. Please advise us of all insurance changes immediately.
*Co-pays are expected at time of service.
*Patients with high deductible policies will be expected to pay toward their deductible up-front. Our policy is to collect $200 for new patient visits and $100 return visits unless the deductible has been met.

Revised 1/10/2020

I have read and understand the practice policy for Coastal Georgia Child Neurology as stated above.

_____ _____

Guarantor signature if under 18 ***Date***
Patient signature if 18 or older

Sharlisa W. Hutson M.D.
106 Anderson Way
Brunswick, Ga 31520
Office: (912) 342-0996
Fax: (912) 342-4977
Coastalgeorgiachildneurology.com
info@cogahealth.com

COASTAL GEORGIA
Child Neurology

Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Form Completed By: Mother ____ Father____ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?
When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).
Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No__ Yes If yes, specify:

Does your child have any allergies? No __ Yes If yes, specify:

Are your child's immunizations up to date? Yes No If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?

Patient Name:	Date of Birth:

Birth History

Was your child born two or more weeks before the "due date"? No_____Yes _____

If yes, how many weeks early was your child born?_____weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child _____ Biological Mother's age at birth of your child _____

Number of pregnancies prior to this child _____ Number of miscarriages prior to this child _____

Were there any problems during the pregnancy, labor/delivery or following the birth? No_____Yes _____

If yes, please specify:

Was your child born by C-Section? No_____Yes _____

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No_____Yes_____

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please *write in* age. Ages in *parenthesis* are *approximate normal limits.)*

Gross Motor:	***Fine Motor:***
Rolled over (4-5 mos) _____ Sat without support (6-7 mos) _____ Walked alone (12-16 months) _____ Runs (15-18 mos) _____ Catches a ball (3 years) _____ Hops on one foot 2-3 times (4 years) _____	Copies circle (3 years) _____ Copies Square (5 years) _____ Adaptive /Self help: Drinks from a cup (12 – 15 mos) _____ Uses a spoon (15-24 mos) _____ Undresses completely (3 years) _____ Dresses Completely (4 years) _____
Language Development:	***Social/Emotional Development***
Babbles (6 mos) _____ Understands "NO" (9-10 mos) _____ 3-5 word vocabulary (12 mos) _____ Follows 1 step command with gestures (12 mos) _____ Can point to several body parts (16-17 mos) _____ 2 word phrases (24 mos) _____ Follows 2 step command (24 mos) _____ 3 word sentences (3 years) _____	Temperament as a baby (e.g. easy, colicy): Shy with strangers (7-8 mos) _____ Plays cooperatively with peers (4 yrs) _____ Current temperament/mood (e.g. irritable, anxious, happy):

Are there any current problems or concerns with development not mentioned already?

Patient Name:	Date of Birth:

Family Medical History (other than patient)

Please include all pertinent **family history** for first and second-generation **family members**.

	Y	N	Relationship to child
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

Patient Name:	Date of Birth:

Social history

Child's School: _____ City: _____

Teacher Name: _____ Grade: _____

Type of Classroom: Regular____RSP____Special Day Class _____

IEP:_____

This child is currently living with:

__ Biological mother and biological father

__ Biological mother

__ Biological father

__ Adoptive parents. Is your child aware that he/she is adopted? _____

__ Foster parents

__ Other (specify) _____

The biological parents of this child are currently:

__ Married to each other (Years married:____)

__ Divorced from each other

__ Separated from each other

__ Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Date of Birth:

Review of Systems

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child