Welcome to Elemental Pediatrics!

Enclosed is our New Patient packet. For families with multiple children, we recommend completing the common sections of the documents (essentially everything except the names and dates of birth) and making copies to streamline the process and avoid needing to write the same information multiple times.

The Authorization for Alternate form is necessary only if you need to grant permission for someone other than a parent or legal guardian to bring your child in—such as a grandparent, aunt, or babysitter.

For the medical records transfer, we have provided an auto-populated version for Priority Care Pediatrics and a blank form. If your child has been seen only at Priority Care Pediatrics, please sign the pre-printed form. For records from other locations, kindly include the name of the office and fax number on the form. If your child has received routine care at multiple offices in the past 2-3 years, please submit a separate form for each location.

While you are welcome to bring the completed forms to your first visit, returning them in advance will help us expedite the process. You may fax, mail, or drop off the forms at our office, or send them securely via email to info@elementalpediatrics.com.

We highly encourage you to sign up for our Patient Portal as soon as you receive your invitation which will be sent immediately after your information is entered into our system. The portal offers a range of useful features, including the ability to schedule visits, review past appointments, access growth charts, request medication refills, and complete screening forms before your visit. Additionally, you can contact us with questions through the portal at any time, attaching pictures and necessary documents. We monitor messages frequently while in the office and check them a few times each evening and on weekends.

Regarding availability, while our office is officially open Monday through Thursday from 9 AM to 5 PM, we strive to be accessible whenever you need us. Your calls and messages are always appreciated, and it is our privilege to assist you. We offer convenient telehealth visits, including evenings and weekends. Most appointment types can begin as telehealth consultations, and if a same-day in-office follow-up is necessary (such as for an ear examination or a Strep test), it will all be considered part of the same visit. To request a telehealth appointment, please call us or send a message through the Portal, even after hours. We can also arrange in-person visits during evenings, Fridays, and weekends as needed.

For phone inquiries, we utilize a simple two-option menu. When you call during office hours, you will be prompted to select 1 for medical questions or 2 for other inquiries—it's that easy. No complicated phone trees or extended hold times; your call will be promptly answered by our team. If you do call after hours or if we are momentarily unavailable, please leave a message. Your message will be immediately delivered to our mobile phones, and we will respond as soon as possible.

We look forward to the privilege of seeing you!

Best of Health,
Elemental Pediatrics LLC

Phone: (816) 704-5800
Fax: (816) 704-5793
116 N. Main St.
Plattsburg, MO 64477
www.ElementalPediatrics.com

Consent to Treat

By signing, you consent to treatment in our office at today's visit. This includes any examinations, tests, immunizations, or other procedures which may be deemed advisable or necessary. You will be notified of any such testing or procedures and you have the right to an explanation of any procedures and their risks, benefits, alternatives before they occur. We can provide our billed charge for such procedures, but the amount covered (if any) is strictly determined by your insurance and their decisions are final in regard to your cost for such. Your signature here consents to these procedures; it is your responsibility to inquire about and/or decline any such procedures if you do not wish them to occur. The occurrence of a procedure indicates that you understand the risks and benefits and are satisfied with the explanations provided and/or have asked any questions and are satisfied with the response given. If you are not the parent or guardian, you affirm that you have the authority of the parent or legal guardian to sign on their behalf today.

_____	_____
Signature of Patient or Legal Guardian	Relationship to Patient
_____	_____
Patient's Name	Patient's Date of Birth
_____	_____
Print Name of Person Signing Above	Today's Date

Phone: (816) 704-5800
Fax: (816) 704-5793

116 N. Main St.
Plattsburg, MO 64477

www.ElementalPediatrics.com

Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices for Elemental Pediatrics LLC and have been offered a printed or electronic copy if desired.

Signature of Patient or Legal Guardian	Relationship to Patient
Patient's Name	Patient's Date of Birth
Print Name of Patient or Legal Guardian Signing Above	Today's Date

Phone: (816) 704-5800
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New Patient Registration

Patient Full Name:_____

Patient Date of Birth:_____

Sex: M F Other_____

Parent/Guardian where patient lives Name:_____

Address where patient lives:_____

_____

Mobile Phone:_____ Work Phone:_____

Emergency Phone:_____ Preferred? Mobile Other:

Email:_____

Race:_____ Ethnicity: Hispanic or Non

Preferred Language:_____

Login for Portal Account sent to: Mobile Email Other:_____

Insurance Policy Company:_____

Policy Holder Name:_____

Policy Holder Date of Birth:_____ and SSN:_____

Insurance Policy ID/Account #:_____

Insurance Policy Group Number:_____

Please bring to the visit:

___ This form

___ Insurance Card

___ Parent/Guardian's ID

We look forward to seeing you!

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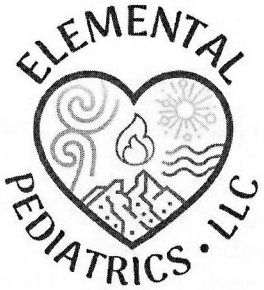
Universal Authorization Waiver

For this document, "we," "us," "our," and "I" refer to the patient, parent(s), guardian(s) (in singular and in plural as applicable) and "office" refers to Elemental Pediatrics LLC and its doctors, providers, employees, and authorized agents. With our signature, we grant consent to the office for the following permissions. We may revoke consent for any or all permissions in writing in a separate document, although revocation of some permissions may result in the office being unable to provide care/services to us. These permissions shall remain in effect until revoked by either party.

Permission to Contact: We give consent for the office to contact us by any method for which we have given our contact information and/or which the office discovers by other legal methods such as from insurance companies, healthcare providers, other individuals, etc. Examples include email, text/SMS message, portal message, postal mail, fax, and phone. We understand that it is our responsibility to keep the office informed of changes to our contact information. The office HIGHLY recommends that we use the portal to allow all communications to be recorded in the patient chart. All such contact by the office will follow the privacy policy and Notice of Privacy Practices. The office will use our preferred method of contact whenever possible but may use other methods if necessary. Appointment reminders sent to us by any of the methods are strictly a courtesy and failure of such notices does not relieve us of our responsibility to attend the appointment on time. Specifically related to SMS messaging, replying STOP will end that form of communication. Why? It is important for the office to be able to reach us.

Permission to submit insurance: If the patient is covered by an insurance plan with which the office has a contract, the office must adhere to the terms of that contract. The insurance company information may be provided by us or may be discovered by the office from other sources such as insurance registries, hospitals, etc. As a courtesy, the office will file the insurance claim for us for contracted plans and we grant consent for all required information to be provided for claim processing. It is our responsibility to provide the insurance company with any requested information, including following any procedures for authorization. We assign all benefits and payments from the insurance company to be paid to the office. We accept all responsibility for any services not covered by the insurance which are legally billable to us or when insurance in inactive or invalid. We agree to make prompt payment for any amounts due, generally understood to be within 30 days of being billed. Payment delays may incur additional charges, and we accept all responsibility for any fees related to collection efforts. In the event of financial hardship, we will contact the office to discuss payment terms. We give permission for the office to file an appeal on our behalf if needed and accept responsibility for appeals when our participation in such is necessary. Why? Our insurance company requires the office to do this.



Permission to share clinical information: The office participates in Clinical Document Exchange. This means that our records will be shared automatically ONLY for treatment purposes to and from legally certified agencies which request them or from which the office requests them. This includes vaccine information shared to and from the ShowMeVax state immunization registry and prescription information shared to and from SureScripts and the Missouri Prescription Drug Monitoring program. Why? It is important for the office and other healthcare providers to have full medical information available to provide the best care.

Permission for AI assistance: The office may use Artificial Intelligence solutions to collect information during a visit, on phone calls or other interactions, and in compiling medical history and plans. The office will never use it without human interaction and guidance and will only use it in ways which protect our privacy. Why? This technology allows visit information capture and other assistance to facilitate our care.

Permission to share anonymous data for research: The office participates in research with agencies such as the American Academy of Pediatrics and others. Data regarding health trends such as blood pressure, medication side effects, etc. can be searched from our records but IN NO WAY will that be linked to us. Any research that could be linked to us will require informed consent separate from this document. Why? It is important to gather large amounts of data to find health trends and risks across the population.

Permission for pictures: We grant permission for digital pictures for patient care (for example, of a rash or lesion) to be stored in the patient chart for medical documentation and to be considered a part of the medical record. If we provide a picture to the office (such as a school picture, holiday card, or one drawn/created by us), we grant permission for it to be displayed in the office or online (website or social media), even if it includes a name or other information that would ordinarily be considered protected health information. The office will not and may not add any such protected health information to our picture. Why? Pictures for patient care are very helpful and other pictures are appreciated.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Patient's Name | Patient's Date of Birth

_____ _____

Print Name of Patient or Legal Guardian Signing Above | Today's Date

Phone: (816) 704-5800
Fax: (816) 704-5793

116 N. Main St.
Plattsburg, MO 64477

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Authorization for Alternate

Patients typically must be accompanied by a parent or legal guardian if under the age of 18. Parents and guardians may authorize others (grandparents, babysitters, etc.) to accompany a patient for care and may authorize older adolescents to be seen without an accompanying adult. This form grants permission for those situations, allows the office to share health information with the individual(s) listed, and authorizes the accompanying adult or unaccompanied patient to consent for any needed and legally permitted care, including vaccines. The parent or guardian also accepts full financial responsibility for the care provided.

Expiration: ❑ None ❑ Other:_____

❑ I authorize the adolescent minor (age 14 or higher) listed below to present for medical care without my presence.

❑ I authorize the following individual(s) to accompany the patient listed below and serve as my surrogate for medical care decisions:

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient

Signature of Patient or Legal Guardian	Relationship to Patient
Patient's Name	Patient's Date of Birth
Print Name of Parent/Legal Guardian Signing Above	Today's Date

Phone: (816) 704-5800
Fax: (816) 704-5793

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Plattsburg, MO 64477

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AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

This authorization permits receipt and/or disclosure of the following individually identifiable health information about me or my child:

To Elemental Pediatrics LLC
116 N. Main St.
Plattsburg, MO 64477-1236
Phone: (816) 704-5800 Fax: (816) 704-5793 Secure email: info@elementalpediatrics.com

These records should be released:

From: _____

_____

_____

Fax: _____

Records to be released: ☐ Immunization Record ☐ Growth Chart ☐ Laboratory/X-ray reports
☐ Complete Medical Record including immunization data and other physician reports
☐ Consultant / Other Physician Reports ☐ Mental Health Information ☐ HIV/AIDS test results
☐ NOTE: MUST INCLUDE C-CDA or CCD if from an electronic health record
Dates: ☐ All ☐ ___/___/___ to ___/___/___ Authorization Exp. Date (1yr unless noted):___/___/___

The information released will be used for the following purpose: ☐ Medical Care
☐ At the patient/guardian's request ☐ Other:_____

Note that signing this form is not required to receive treatment from Elemental Pediatrics LLC (EP). In addition, EP may send, receive, and/or use personal health information as legally allowed with or without this form being signed. This authorization may be revoked at any time by submitting written instructions for such to EP except to the extent that EP may have already acted in reliance on this authorization.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date of Birth

_____ _____
Print Name of Patient or Legal Guardian Signing Above Today's Date

AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

This authorization permits receipt and/or disclosure of the following individually identifiable health information about me or my child:

To / From: Elemental Pediatrics LLC
116 N. Main St.
Plattsburg, MO 64477-1236
Phone: (816) 704-5800 Fax: (816) 704-5793 Secure email: info@elementalpediatrics.com

These records should be released:

To / From: ____Priority Care Pediatrics_____
____9405 N. Oak Trfwy_____
____Kansas City, MO 64155_____
Fax: ____816-412-2915_____

Records to be released: ☐ Immunization Record ☐ Growth Chart ☐ Laboratory/X-ray reports
☒ Complete Medical Record including immunization data and other physician reports
☐ Consultant / Other Physician Reports ☐ Mental Health Information ☐ HIV/AIDS test results
Dates: ☒ All ☐ ___/___/___ to ___/___/___ Authorization Exp. Date (1yr unless noted):___/___/___

The information released will be used for the following purpose: ☒ Medical Care
☐ At the patient/guardian's request ☐ Other:_____

Note that signing this form is not required to receive treatment from Elemental Pediatrics LLC (EP). In addition, EP may send, receive, and/or use personal health information as legally allowed with or without this form being signed. This authorization may be revoked at any time by submitting written instructions for such to EP except to the extent that EP may have already acted in reliance on this authorization.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name Date of Birth

_____ _____
Print Name of Patient or Legal Guardian Signing Above Today's Date