3312 Henry Road
Anniston, AL 36207

P: 256-241-2671
F: 256-241-2676 or 256-770-4832

Pediatrics Plus

Chase E. Thomas, CRNP
Elizabeth Patrenos, MD, FAAP
Holly F. Mays, CRNP
Katie C. Smith, CRNP
John Loper, CRNP

Your growing Adolescent....

Thank you for giving us the opportunity to care for your adolescent; we appreciate the trust you place upon us and will never take that responsibility lightly. Our most important job is to help you in the medical and psychological development of your child so that he or she grows into a mature, well rounded, physically healthy and happy adult.

At the age of 14, we encourage our adolescent patients to begin their visit with their healthcare provider on their own. During the time you are separated from your child the following will take place:

- Vital signs will be taken. This includes, height, weight, blood pressure, temperature, heart rate.
- Your child will perform a vision and hearing screening and also a urinalysis.
- At certain ages we also require Anxiety and Depression Screening be filled out by the adolescent themselves.

Along with the above tests, below is a list of topics that could be discussed with your adolescent.

Topics that will be discussed include:

- Personal Safety
- Mental Health
- Smoking
- Alcohol and Drug Use
- Sexuality
- Sexually Transmitted Diseases
- Contraception
- Nutrition
- Exercise
- Sports
- Making Good Choices
- Social Issues

Before we do a physical exam, you will be asked to rejoin your child. Also, if, at any point that your child wishes to have you present in the room, we will immediately retrieve you.

We know that you share our goal of providing the best and most complete healthcare possible to your adolescent. This is another reason we use this time to discuss important and personal issues with your adolescent and assurance of confidentiality is crucial to the success of the discussion and to your adolescent personally.

Your Pediatrics Plus Providers

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Adolescent Confidentiality Agreement:

Parent

I, _____(parent of guardian), allow my son/daughter _____(patient), to enter a confidential patient-physician/provider relationship. I understand that my son/daughter can make independent health care decisions, but that my input and involvement will be encouraged.

My son/daughter has permission to receive confidential reports from Pediatrics Plus. I further understand that various laboratory test may be necessary in medical protocols and accept responsibility for physician charges and laboratory fees.

_____ _____

Parent / Guardian Physician / Provider

Patient

I, _____ (patient), am entering a confidential physician/provider-patient relationship with _____ (physician / provider). I will make an effort to communicate with my parent(s) about issues concerning my health. I accept the personal responsibility of being honest and will follow the health care recommendations my physician / provider and I establish.

_____ _____

Patient Physician / Provider

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Pediatrics Plus Adolescent Confidentiality Policy

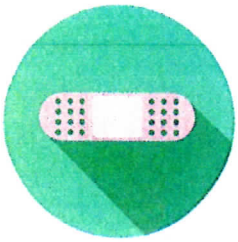
At Pediatrics Plus, we recognize that adolescence is an important time of transition toward adulthood. During this transition period, we are committed to empowering our adolescent patients to assume more responsibility for their own healthcare. In an effort to provide the best quality of care for our adolescent patients please be aware of the following:

- **Beginning at age 14, each patient will be encouraged to meet with a Provider for a portion of his/her visit without a parent present.** We believe that this private time provides an opportunity to discuss sensitive topics that an adolescent may not feel comfortable addressing otherwise. During this time a teenager will always have the option of requesting a nurse to be present in the room as a "chaperone" if they desire.
- **The information discussed by an adolescent and the Provider is considered private and confidential.** This simply means that it will not be shared with anyone without permission/consent of the adolescent. While this information is considered confidential, we always encourage our adolescent patients to be open and honest with their parents/guardians and can often help facilitate the process of sharing sensitive information.
- **The only time that we would break confidentiality is in the rare circumstance that we think a patient poses a severe risk to him/herself or another person, or if there is concern for immediate risk of life or limb.**

This policy is consistent with Alabama state law surrounding adolescent confidentiality as well as the policies of the American Academy of Pediatrics and the Society for Adolescent Medicine. If you have specific questions or concerns about this policy, please share them with your Provider.

TEEN WELL VISITS

The pre-teen and teen years are times of change, growth and social pressures that make going to the doctor every year more important than ever!



WHAT?

A "well visit" is a scheduled appointment when your teen is not sick. This visit helps to PREVENT health problems and is a perfect chance for teens to talk to the doctor about any concerns. Well visits are also referred to as "checkups" or "yearly physicals." All teens and preteens 11-17 years old should have a well visit at least once a year.

WHAT DOES A WELL VISIT INCLUDE?

Blood Pressure Check • Weight Check • Physical Examination • Vision and Hearing Screen
Vaccinations • Mental Health Screen • Infection Screen • Alcohol and Drug Risk Screen

WHY YEARLY WELL VISITS? Teens Develop Relationships with Providers

Doctors start to talk with their adolescent patients around age 13 without the presence of a parent.
Well visits are a perfect chance to develop trust between themselves and their health care providers.

TEENS TAKE CHARGE OF THEIR HEALTH

Teens should start paying closer attention to their bodies and their health care needs.
Developing a relationship with their doctor is a sure sign of taking ownership of one's health.

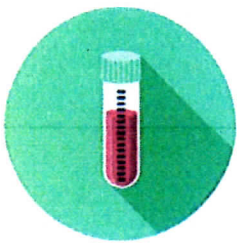
TEENS COMMUNICATE WITH THEIR FAMILIES

Parents should encourage check-ups and help their teen take charge of their health by being open to conversations about various health concerns. Parents can let them schedule the appointment.

STAY ON TOP OF EMERGING PROBLEMS

Social pressures and daily stressors are ever present during the teen years. Doctors and health care providers can help identify signs of depression and other issues in order to help teens and parents navigate these years in the best way possible.

Contact your doctor or clinic today!
Don't have one? Visit www.healthychildren.org



ALABAMA ACADEMY OF FAMILY PHYSICIANS

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Alabama Chapter

#StayWell

ALABAMA PUBLIC HEALTH

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3312 HENRY RD.
ANNISTON, AL 36207
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Medical Records Release Form
Minors Age 14 or Older

By signing this form, I authorize **PEDIATRICS PLUS, PC** to release confidential health information of my medical records or a summary or narrative of my protected health information, by copying of or by verbal communication to the person and/or persons listed below.

Patient Name:_____ Date of Birth:_____

The information you may release subject to this signed release form is as follows:

_____ Complete Records	_____ History & Physical	_____ Progress Notes
_____ Lab Reports	_____ Radiology Reports	_____ Pathology Reports
_____ Treatment Record	_____ Operative Reports	_____ Hospital Reports
_____ Medication Record	_____ Immunization Record	_____ Other (please specify below)

_____

Release my protected health information to the following person/persons:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Information that is being released may be (check all that apply):
FAXED_____ MAILED_____ VERBAL _____PICKED UP BY (NAME)_____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person and/or persons receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, pregnancy, venereal disease, drug dependency and/or alcohol toxicity including substance abuse diagnosis and treatment information may also be disclosed.
- This authorization expires on ___/___/____. If left blank, this authorization will remain in effect until written notice of cancellation.

Signature:

_____ _____
Printed Name of Patient Signature of Patient (Age 14 or older)

_____ _____
Witness Date