

3312 Henry Road
Anniston, AL 36207

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



Chase E. Thomas, CRNP
Elizabeth Patrenos, MD, FAAP
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John Loper, CRNP
Blair Smith, CRNP
Tiffany Waugh, 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 health and happy adult.

At the age of 16, 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, heigh, weight, blood pressure, temperature, heart rate.
- Your child will perform a vision and hearing screening and also 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 | • Contraception |
| • Mental Health | • Nutrition |
| • Smoking | • Exercise |
| • Alcohol and Drug Use | • Sports |
| • Sexuality | • Making Good Choices |
| • Sexually Transmitted Diseases | • 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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Pediatrics Plus Adolescent Confidentiality Policy

At Pediatrics Plus, we recognized 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 following:

- **Beginning at age 16, 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.

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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

Patient Contact Number: ()

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Parent / Guardian

Physician / Provider

Patient

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responsibility of being honest and will follow the health care recommendations my physician / provider and I
establish.

Patient

Physician / Provider

Patient Contact Number: (____) _____

PEDIATRICS PLUS, P.C.
3312 HENRY RD.
ANNISTON, AL 36207
Phone (256) 241-2671
Fax (256) 241-2676/(256) 770-4832

Medical Records Release Form
Minors Age 16 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 16 or older)

Witness

Date

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Adolescent Confidentiality Refusal:

Parent

I, _____ (parent of guardian), **do not** allow my
son/daughter

(patient), to enter a confidential patient-
physician/provider relationship.

Parent / Guardian

Physician / Provider

Patient

I, _____ (patient), **do not** wish to enter a confidential
physician/provider-patient relationship with _____ (physician /
provider).

Patient

Physician / Provider