Premier Health
Premier Physician Network

Welcome to The Pediatric Group!

Appointment/Procedure Preparation

To schedule an appointment with The Pediatric Group, please call **(937) 440-8687** and we will be happy to assist you. Currently we are accepting new patients.

We make every effort to see acutely ill patients within 24 hours. For a same day appointment, please try to call as early in the morning as possible.

Hours:

- 7:30 a.m. to 6 p.m., Monday
- 7:30 a.m. to 5 p.m., Tuesday to Friday
- Troy Location and by appointment only on Saturday

Walk-ins for acute problems such as ear pain, sore throats, cough and cold symptoms or rashes at our Piqua location only

To change or cancel an appointment, kindly let us know 24 hours in advance.

Please be aware that on occasion, our pediatricians may be called out of the office for an emergency. This may require rescheduling your child's appointment. We ask for your understanding if this situation occurs. We will make every attempt to accommodate your schedule as soon as possible.

What to Expect

In order for a child under the age of 18 to receive care by The Pediatric Group, a parent or a legal guardian must accompany their child to an appointment. When a parent is unable to come with their child to the scheduled appointment, written permission, signed by the parent or legal guardian, must be presented before the child can be treated.

Each time you visit our office, please bring a photo ID and your health insurance card along with any co-payment if required by your insurance carrier. Before your appointment, please review your insurance plan details because co-payments, deductibles and reimbursements may vary in amount according to the type of visit scheduled. The Pediatric Group accepts all private insurance plans and participates in many HMOs and PPOs.

We ask that you arrive 15 minutes prior to your scheduled appointment time to complete all necessary paperwork if not completed prior to your visit.

Prescription Refills

If your child needs a prescription refill, please call **(937) 773-8077** or **send us a message using My Chart**. Please allow 72 hours (not including weekends for holidays) for us to process the request. There are special circumstances under which our physicians may want to see your child before approving a refill request.

P-W-MKT04358-10/2020

Medical Forms

We receive many requests for various forms for your children for schools, daycare, camps and athletics. We are happy to help with these forms. Fax, mail or drop off the necessary forms after filling out your required sections of the document. Please allow 3-4 days for us to sign and complete the paperwork. Please note that a current physical (within the previous 6-9 months) is required before a sports participation document will be completed. We reserve the right to charge for any documentation assistance.

Nights and Weekends

Please call (**937) 440-4000**, if there is an urgent problem that cannot wait until the next business day. One of our practitioners is available by phone nights and weekends for emergency calls.

Urgent situations include:

- Difficulty breathing
- Persistent diarrhea
- Persistent vomiting
- Repeated spiking of a high fever

Urgent situations **do not** include:

- Medication refills
- Over-the-counter dosage questions
- Routine questions

In Case Of Emergency

If your child is in need of immediate medical attention, please call **911** or go to the nearest emergency facility right away.

Locations

280 Looney Rd.
Suite 203
Piqua, Ohio 45356

3130 N. County Rd. 25A
Suite 201
Troy, Ohio 45373

450 N. Hyatt St.
Suite 204
Tipp City, Ohio 45371

The Pediatric Group
Outpatient Care Center
North 280 Looney Rd.
Ste. 203
Piqua, Ohio 45365

(937) 440-8687 Office
(937) 773- 8058 Fax

Paul Weber, MD   Becky Blackton, RN, CPNP
Tammy Taylor, DO   Allyson Woerndle, RN, CPNP
Meredith Prenger, MD   Tammy Kaiser, RN, CPNP
Shelsea Johnson, MD   Lindsey Jones, RN, CPNP

Patient/Parent Code of Conduct

Thank you for trusting our practice, The Pediatric Group, to care for and provide medical treatment for your child(ren). We are committed to providing the best possible care in a timely fashion. It is our commitment to always be respectful and courteous when you interact with our office; whether you are calling for medical advice, scheduling an appointment, or have a question about billing or insurance. Or, when you are in the office with your child interacting with our clerical or nursing staff or with one of the physicians or nurse practitioners. Please let our office manager know if we do not succeed in this goal.
It is our expectation that our families and parents also treat our staff and providers with dignity and respect. When a problem or concern arises that affects you or your child, we will work through that issue in a professional manner to resolve the situation. Our staff and providers will not be asked to tolerate inappropriate language or actions by our patients or parents. Such inappropriate behaviors include:

- Yelling at or swearing at staff/providers
- Threatening staff in any way
- Any behavior that is offensive or threatening to our staff, providers or other patients who may be present in the office.
- Inappropriate clothing or hygiene

If such a situation arises, we will refer the situation to our office manager. If a resolution cannot be reached, we reserve the right to dismiss your family from our practice.

I have read the above and am in understanding of this policy.

____
Parent/Legal Guardian Signature

List all Children that are patients at The Pediatric Group

NAME	DOB	NAME	DOB

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THE PEDIATRIC GROUP

Child's Name:_______________________________________ DOB:_________________

List any brothers or sisters:

NAME	DATE OF BIRTH

Patient lives with:

Name	DOB	Relationship to child	Occupation	Smoker
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

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PERMISSION FOR VERBAL COMMUNICATIONS

Patient's Full Name	Last 4 Digits of Social Security Number	Date of Birth

Patient's Address	City	State	Zip Code

I HEREBY AUTHORIZE THE FOLLOWING HEALTH CARE ENTITIES, THEIR PROVIDERS, NURSES, AND OTHER PERSONNEL TO DISCUSS MY DESIGNATED HEALTH INFORMATION, IN PERSON OR BY TELEPHONE, WITH ALL OR ANY OF THE INDIVIDUALS INVOLVED IN MY CARE AND IDENTIFIED BELOW:

Health Care Providers:

- ☐ ALL PREMIER PHYSICIAN NETWORK ENTITIES AND PROVIDERS (PPN)
- ☐ Other (specify entity or provider) ______________________
- ☐ Other (specify entity or provider) ______________________
- ☐ Other (specify entity or provider) ______________________

Designated Health Information:

- ☐ Facesheet
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Consultation
- ☐ Emergency Room Treatment
- ☐ Physician Orders
- ☐ Mental Health Treatment
- ☐ Laboratory Reports
- ☐ Radiological Reports
- ☐ Operative Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Prescribed Medications
- ☐ Treatment Plan
- ☐ Other (specify) - ______________________

Part 2 Designated Health Information:

- ☐ Drug/Alcohol Abuse Treatment

State Designated Health Information:

- ☐ Psychotherapy Treatment Notes
- ☐ HIV/AIDS Related Diagnosis and Treatment

Self/Patient

Patient Name	Preferred Phone Number	Alternate Phone Number	May Leave A Voicemail
			☐

Individuals Involved in My Care:

Full Name	Relationship	Phone Number	May Leave A Voicemail
			☐
			☐
			☐

I understand that the information Individuals Involved in My Care receive may be redisclosed and no longer protected by federal or state privacy regulations. I also understand that my Designated Health Information may contain information related to treatment for drug and/or alcohol abuse treatment, psychotherapy treatment, or HIV and/or AIDS related diagnosis and treatment. If applicable, by checking those respective boxes above, I acknowledge and expressly permit the inclusion of such information in verbal communications permitted by this authorization. I understand that this authorization is voluntary and that I may refuse to sign it. My refusal to sign will not affect my ability to obtain treatment. **If, at any time, I do not want my Health Care Providers to have verbal discussions with myself or any of the Individuals Involved in My Care, I must notify my Health Care Provider in writing. No Health Care Provider will be liable for communications that were permitted by this authorization and made prior to its revocation.**

I understand that this authorization expires two years from the date it is signed unless I specify a different date or time period in this space _____________. I am aware that this authorization may be copied and said copy will be considered valid.

______________________________ ______________
Patient/Legal Representative Signature **Date**

If the above signature is not that of the patient, explanation must be provided below and documentary evidence of appropriate designation is required to accompany this authorization ______________________________

____

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THE PEDIATRIC GROUP

MEDICAL CONSENT FORM

Authorization by parents for consent to medical treatment during absence of parents/guardians.

Child's Name: ____________________________

Date of Birth: ____________________________

Allergies: _______________________________

I/We hereby appoint:

____

Name Phone Relationship

____

Name Phone Relationship

____

Name Phone Relationship

____

Name Phone Relationship

As the person who during my/our absence from the office visit should be authorized to consent for all medical and/or surgical treatment and/or special procedures which may be required during my/our absence. The provider(s) consulted for these circumstances would be Paul Weber M.D., Tammy Taylor D.O., Meredith Prenger M.D., Shelsea Johnson, MD, Becky Blackton RN, CPNP, Allyson Woerndle RN, CPNP, Tammy Kaiser RN, CPNP, Lindsey Jones RN, CPNP whose offices are located at 280 Looney Rd. Suite 203, Piqua, Ohio 45356, 3130 N. Dixie Hwy. Ste. 201, Troy, Ohio 45373, and 450 N. Hyatt St. Suite 204, Tipp City, Ohio 45371. The telephone number is 937-440-8687.

The consent and authorization shall include and extend to all matter for which consent or authorization is required under the policies of the office. This authorization shall be effective until ________________ or until revoked in writing.

______________________________ ________________________________

Mother/Guardian Date Father/ Guardian Date

In the even that this form is executed only by one parent/guardian, please state below the reason why the signature of the other parent cannot be obtained____

____.

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MyChart Child Proxy Form

To sign up for access to your child's MyChart record (or other child for which you have legal guardianship), please complete all pages of this **Child Proxy Form** and return it to your physician's office.

Please note that your child's chart will be accessed through your MyChart record.

Parent/Guardian Information (All sections required, please print clearly)

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Address		
City	State	Zip
Email address:		
Do you currently have a My Chart Account? If so, at which office/clinic?		
If you are a guardian, please provide paper work to document this.		

Please note the following age range limitations for MyChart. These age range limitations do not affect any legal right you have to access your child's record by other means. To request a paper copy of your child's record, contact your child's primary care office/clinic.

- If your child is **age 0-11:** You will be granted full access to your child's MyChart record.
- Once your child reaches **age 12,** you will no longer have access to your child's MyChart record. Patients over the age of 12 may view their own health information independently.
  - If the patient over the age of 12 is disabled, please consult with your physician or office manager on special Proxy access in this case.

Please provide the following information for each child: (All fields are required.) If you have more than four children for whom you would like proxy access, please request another form.

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Primary Office/Clinic where Proxy will be activated		

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Primary Office/Clinic where Proxy will be activated		

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Primary Office/Clinic where Proxy will be activated		

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Primary Office/Clinic where Proxy will be activated		

Last Name	First Name	Middle Name
Date of Birth	Last 4 digits of Social Security	Phone Number:
Primary Office/Clinic where Proxy will be activated		

MyChart Terms and Agreement:

- I understand that MyChart is intended as a secure online source of confidential medical information. If I share my MyChart ID and password with another person, that person may be able to view my or my child's health information and health information about someone who has authorized me as a MyChart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that MyChart contains selected, limited medical information from a patient's medical record and that MyChart does not reflect the complete contents of the medical record. I also understand that a paper copy of a patient's medical record may be requested from the patient's clinic.
- I understand that my activities within MyChart may be tracked by computer audit and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided by Premier Health Partners as a convenience to its patients and that PHP has the right to deactivate access to MyChart at any time for any reason. I understand that use of MyChart is voluntary and I am not required to use MyChart or to authorize a MyChart proxy.
- By signing below, I acknowledge that I have read and understand this MyChart Sign-Up Form and I agree to its terms.

►__________________________________/____________________________/___________

Signature of Parent/Guardian Relationship to Patient Date

(Required)

►____/___________

Witness Date

(Required)

Office Staff:

1. Scan completed form to Media Manager
2. Scan needed guardianship information to Media Manager