Pediatric Partners, LLC

Patient's Last Name: _____

Family's Primary Contact Phone Number: _____

List Full Name of **All** Children That Are Patients Here:

_____ M or F Date of Birth: _____
_____ M or F Date of Birth: _____
_____ M or F Date of Birth: _____
_____ M or F Date of Birth: _____
_____ M or F Date of Birth: _____

Home Address: _____

City: _____ Zip Code: _____

Primary language spoken in the home: _____

Ethnicity: (Circle one) Hispanic or Non-Hispanic or Decline to Answer

Race: (Circle all that apply) American Indian/Asian / Black / Hawaiian Native / White

Parent/ Guardian Information:

Parent 1: Name: _____ Date of Birth: _____
Address: _____
(*If different from patient) City: _____ Zip Code: _____
Work Phone: _____ Cell #: _____
E-mail: _____
Employer: _____
Relationship to Patient: _____

Parent 2: Name: _____ Date of Birth: _____
Address: _____
(*If different from patient) City: _____ Zip Code: _____
Work Phone: _____ Cell #: _____
E-mail: _____
Employer: _____
Relationship to Patient: _____

Emergency Contact (<u>Other than parents</u>):

Name: _____ Phone #: _____

Alternate Phone #: _____ Relationship: _____

Insurance:

Primary Insurance: _____

Policy Holder's Last Name: _____ Employer: _____

First Name: _____ Relationship to Child: _____

Policy Holder's Birth Date: _____ SSN: _____

ID#: _____ Group #: _____

***Please note, all state medical assistance insurance plans are <u>always</u> secondary to any private health insurance plan.**

Secondary Insurance: _____

Policy Holder's Last Name: _____ Employer: _____

First Name: _____ Relationship to Child: _____

Policy Holder's Birth Date: _____ SSN: _____

ID#: _____ Group #: _____

Billing statements should be sent to (If different from above):

Name: _____

Relationship to patient: _____

Address: _____

Primary Phone: _____ Cell #: _____

Privacy Constraints (Check one)**:**

----- No restrictions. Okay to leave message / send mail / send email

----- Restrictions: Person to person with patient / guardian only

----- Restrictions: _____

How would you ideally prefer to be contacted regarding (Circle one)**:**

Medical issues: Home Phone / Work Phone / Cell Phone / E-mail

Appointment Reminders: Home Phone/ Cell Phone/ E-mail

Well Visit Recalls: Home Address / Home Phone / Work Phone / Cell Phone / E-mail

Billing Statements: Home Address / E-mail

General Notices: Home Address / Home Phone / Work Phone / Cell Phone / E-mail

Patient Portal: Cell Phone/ Home E-mail

*Preferred Lab: Lab Corp*_____ *Quest*_____

If parents are divorced or separated, who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? **Yes or No**

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

I authorize the release of any medical information necessary to process claims and payments for Pediatric Partners, LLC. I fully understand that I am financially responsible for all charges and balances remaining from claims, including charges not covered or denied by my insurance. I have been offered a copy of the Notice of Privacy Practice (HIPAA).

Signature: _____ **Date:** _____

FINANCIAL POLICY

Pediatric Partners, LLC is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy. For more details visit our web site: www.pediatricpartnersmd.net.

Insurances: We participate with several insurance companies. Please check with the office to see if we participate with your plan. All patients will be responsible for presenting their insurance card at every visit and for completing a new patient registration yearly.

If we DO participate with your Primary or Secondary insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All copays, co-insurances, deductibles, including non-covered after-hours charges, are the patients' responsibility. All patients are responsible for ALL copayments at the time of service. Deductibles, co-insurances, and non-covered services will be billed to you by our billing office. It is our primary goal to provide the best healthcare for your children. In order to do this, we provide a variety of services in our office. These services include labs, tests, procedures and "After Hours Care"; which are after 6:00 PM, Saturdays & Sundays during regular business hours. This is considered a convenience service. Some of these services have additional charges associated with them. Most are recognized by insurance companies. Patients may be required to pay additional amounts for these services depending on the type of insurance plan you have and your coverage.

If we DO NOT participate with your insurance company, this means that we do not bill your insurance carrier: and, we will not accept payment from them as payment in full for the services performed. We do not participate with PIP plans. Any balance not covered by the insurance company becomes the responsibility of the patient. Payment for services rendered in the office IS due at the time of service. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

If you do not have insurance, or, an insurance card is not presented, all services performed will become the responsibility of the patient. Payment for services rendered in the office IS due at the time of service.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account.

Records, Forms and After-Hour Calls: If you would like a copy of your record sent to another doctor or organization, you will need to request in writing, and pay a $20.00 fee per medical record, or the fee that is charged by an outside company, (no family discounts). You will also be asked to pay a reasonable fee of $15.00 for completion of each summary and immunization form. In addition, you will be charged a fee of $15.00 for all after-hour calls.

Missed Appointment Charge: Effective November 1, 2008, we will begin charging $25.00 for all missed appointments.

Telehealth: Depending on your concern, your provider may feel that a telehealth appointment is indicated. By signing, you give consent for a virtual visit. You acknowledge the limitations of a virtual visit through a synchronous telecommunication system and that a provider may decide that a face to face visit may be indicated after the telehealth visit. You also acknowledge that this virtual visit will be submitted to your insurance company for payment but that ultimately you are responsible for any copayments, deductibles, or uncovered portions that your insurance company deems is the patient's responsibility.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and your doctor's bill for the services provided to you is an agreement between you and your doctor.

Payment for services performed:
Our office accepts AM/EX, VISA, Discover and Mastercard for your convenience, as well as cash or a check. Each bounced check will be assessed a fee of $36.00. This fee is the responsibility of the patient and not the insurance company. **All copayments not paid at the time of service will be assessed a service charge of $10.00 per copay. All payments are expected at the time of service and any outstanding balances are due within 30 days of billing unless prior arrangements have been made with the Billing Department.** All balances that reach 90 days may be sent to a collection agency. Balances sent to the collection agency will be reported to a credit reporting agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future unless prior arrangements have been made with the billing office.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PEDIATRIC PARTNERS LLC, AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____

Signature of Patient and/or Guardian (SEAL) Date

Patient Name(s) _____

Updated:12/10, 5/11, 12/11,12/13,12/14,12/15,3/17,1/18,6/19,10/19,1/20

PEDIATRIC PARTNERS, LLC

Patient Custom Screen Information

DATE: _____

PATIENT NAME: _____

PATIENT'S SOCIAL# _____

FATHER'S NAME: _____
DOB: _____

FATHER'S SOCIAL # _____

FATHER'S HOME # _____

FATHER'S WORK # _____

FATHER'S CELL # _____

MOTHER'S NAME: _____
DOB: _____

MOTHER'S SOCIAL # _____

MOTHER'S HOME # _____

MOTHER'S WORK # _____

MOTHER'S CELL # _____

OTHER ADDRESS: _____

_____

PEDIATRIC PARTNERS, LLC

PARENTAL AUTHORIZATION TO TREAT MINOR CHILD WHEN NOT ACCOMPANIED BY PARENT OR GUARDIAN

This authorization is for patients under 18 years of age.

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

Patient's Name_____ **Date of Birth**_____

Yes____No____ Patient listed above may present and be treated unaccompanied by an adult.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	**Relationship**

Signature: Parent/Legal Guardian _____ **Date** _____

This authorization will be in effect until changed by the Parent or Legal Guardian above.

Pediatric Partners, LLC

BENEFICIARY AGREEMENT

I have been notified by my physician's staff that there is a possibility my insurance carrier will deny payments for services rendered today if my PCP listed on my child's insurance card is not part of Pediatric Partners, LLC.

I agree to be personally and fully responsible for payment of all services denied by my insurance company.

_____

Patient's name

_____

Signature of Parent/Guardian

_____

Date

Pediatric Partners, LLC

Offer of Notice of Privacy Practices
Written Acknowledgment Form

I,_____, have been offered a copy of the Notice of Privacy Practice.

I allow the practice to leave a message for me on my answering machine and/or voice mail. (Cross out if you do not allow this)

I allow the practice to contact me by telephone. (Cross out if you do not allow this.)

I allow the practice to contact me in writing. (Cross out if you do not allow this.)

_____ _____
Patient Name Date

_____
Signature of Parent/Guardian

Initial History Questionnaire

Form Completed By:	Name:			
Initial Date Completed:	ID Number:			
Date(s) Updated:	Birth Date:	Age:	Sex: M ○ F ○	

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ Don't know Explain: _____

Does your child have any special health care needs? ☐ Yes ☐ No ☐ Don't know Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ Don't know Explain: _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

Name	Relationship to child	Birth Date/Age

Please list other siblings not living in the home.

Name	Sex	Birth Date/Age	Where are they living?

Does the child live with both biological parents? ☐ Yes ☐ No

If no, what is the child's current living situation?

☐ Single-parent custody ☐ Joint custody ☐ Adoptive family

☐ Other family members: _____ ☐ Foster care

How often does the child have visitation with parent(s) not living in the home?

_____

BIRTH HISTORY

Birth weight: _____

☐ Full-term ☐ Preterm _____ weeks ☐ Post-term _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean ☐ Reason: _____

Any complications during birth or after birth? ☐ No ☐ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

☐ No ☐ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	☐ Yes	☐ No	☐ Unknown
Smoke or use e-cigarettes?	☐ Yes	☐ No	☐ Unknown
Drink alcohol?	☐ Yes	☐ No	☐ Unknown
Use marijuana?	☐ Yes	☐ No	☐ Unknown
Use illicit drugs?	☐ Yes	☐ No	☐ Unknown
Take other medications?	☐ Yes	☐ No	☐ Unknown

If yes, please list:

Blood type:

Mother: _____ ☐ Unknown

Baby: _____ ☐ Unknown

Mother's lab results:

Hepatitis B	☐ Pos	☐ Neg	☐ Unknown
HIV	☐ Pos	☐ Neg	☐ Unknown
Group B streptococcus (GBS)	☐ Pos	☐ Neg	☐ Unknown

After birth, did the baby get:

Vitamin K shot?	☐ Yes	☐ No	☐ Unknown
Erythromycin eye ointment?	☐ Yes	☐ No	☐ Unknown
Hepatitis B shot?	☐ Yes	☐ No	☐ Unknown

How was the baby fed? ☐ Bottle formula ☐ Bottle breast milk

☐ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? ☐ Yes

☐ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

HE0564

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of surgery/Child's Age	Where completed	Details

Other surgical/procedural problems (Please list.)

Initial History Questionnaire

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	Mom	Dad	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition