

ASSOCIATED PEDIATRICIANS, LLC

Information Update/Contact Methods

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Acct# _____

PATIENT INFORMATION

Child's Name: _____ DOB: _____ Sex: _____
Child's Name: _____ DOB: _____ Sex: _____
Child's Name: _____ DOB: _____ Sex: _____
Child's Name: _____ DOB: _____ Sex: _____

FATHER/GUARDIAN'S INFORMATION

NAME: _____ DOB: _____ SS# _____
ADDRESS: _____ CITY _____ ZIP _____
HOME PHONE: _____ CELL: _____ WORK: _____
EMPLOYER: _____ OCCUPATION: _____
EMAIL ADDRESS: _____

MOTHER/GUARDIDAN'S INFORMATION

NAME: _____ DOB: _____ SS# _____
ADDRESS: _____ CITY _____ ZIP _____
HOME PHONE: _____ CELL: _____ WORK: _____
EMPLOYER: _____ OCCUPATION: _____
EMAIL ADDRESS: _____

FAMILY INFORMATION

Language: _____ Ethnicity: _____ Race _____

CHILD/CHILDREN LIVING WITH (Please Check One):

BOTH PARENTS MOTHER ONLY FATHER ONLY MOTHER/STEP-FATHER
 FATHER/STEP-MOTHER OTHER (SPECIFY) _____

INSURANCE HELD BY: FATHER MOTHER OTHER: (If other specify below) _____

ADDRESS: _____ CITY: _____ ZIP: _____
EMPLOYER: _____ WORK PHONE: _____
HOME #: _____ DOB: _____ SS#: _____

CONTACT METHODS

1) FOR MEDICAL ISSUES (CALLS/COMMUNICATION FROM DOCTOR OR NURSE) (Check One)

Home Phone Mom's Cell Dad's Cell Other: _____

2) APPOINTMENT REMINDERS (Check One)

Home Phone Mom's Cell Dad's Cell Text to Dad Text to Mom Mom's Email Dad's Email

3) PATIENT PORTAL (NOTIFICATION OF A MESSAGE TO READ) (Check One):

Text to Dad Text to Mom Mom's Email Dad's Email

4) EMERGENCY CONTACT (OTHER THAN PARENT) :

Name: _____ Phone: _____ Relation: _____

PARENT SIGNATURE: _____ DATE: _____

Office Use: Initial _____ Date _____

ASSOCIATED PEDIATRICIANS LLC

NEW PATIENT QUESTIONNAIRE - TO BE FILLED OUT BY PARENT

Child's Name _____ Mother's Name _____ Maiden _____
 Chart # _____ D.O.B. ____/____/____ Occupation _____
 Date ____/____/____ Father's Name _____
 Who is this child's legal guardian(s) _____ Occupation _____

* If needed go to the back page for more space to answer the question adequately

A. Pregnancy and Birth:

1. Mother's D.O.B. ____/____/____ Dad's D.O.B. ____/____/____
2. Did mother have any illness during pregnancy? No / Yes
3. *Did she take any medications other than vitamins and iron? No / Yes
4. Was the baby on time? No / Yes
5. What was the birthweight? _____ lbs. _____ oz.
6. *Did the baby have any trouble starting to breathe? No / Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other? No / Yes
 *What kind? _____

B. Past Medical History:

1. Where has your child gone for checkups until now? _____
2. Date of last check-up? ____/____/____
3. Date of last dental check-up? ____/____/____
4. Has your child had allergic reactions to any medications, food, insect bites? No / Yes
 *Which ones? _____
5. Has your child had reactions to any immunizations? No / Yes
 *Which ones? _____
6. *Any hospitalizations/surgeries other than for birth? No / Yes
7. Any serious injuries? _____
 *What kind? _____
8. Are any medications taken regularly? No / Yes
 *Which ones? _____

C. Family History:

1. Are the child's parents both in good health? No / Yes
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others _____
3. List age, sex, and general health of brothers and sisters: _____

*Have any of your children died? No / Yes

Feeding and Nutrition:

- Is your child's appetite usually good? No / Yes
 Is it good now? No / Yes
 *Was there severe colic or any unusual feeding problem during the first 3 months? No / Yes
 Do any foods disagree with him/her? No / Yes
 For the first 6 months, is he/she (was he/she) breast or bottle fed? _____
 If still on formula, which one do you use? _____

Does he/she take vitamins? No / Yes

E. Review of Systems:

1. Has your child had frequent ear infections? No / Yes
2. Any eye problems? No / Yes
3. Has he/she had any problems with teeth? No / Yes
4. Does he/she have frequent colds or sore throats? No / Yes
5. Is there asthma, pneumonia, or recurrent cough? No / Yes
6. Does he/she have a heart murmur or any heart problems? No / Yes
7. Any problems with urination? No / Yes
8. Any problems with diarrhea or constipation? No / Yes
9. Have there been any convulsions or other problems with the nervous system? No / Yes
10. Any eczema, hives, or other skin conditions? No / Yes
11. Has your child been anemic? No / Yes
12. *Please list any other medical problems: _____

F. Development/Behavior:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 18mos. old? No / Yes
4. How does this child compare to others his or her age? _____
5. Does he/she have any trouble sleeping? No / Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No / Yes
8. Does he/she get along with other children? No / Yes
9. Circle if your child has had any of the following nail biting, thumb sucking, bed-wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others _____

G. Safety/Environment:

1. Do you live in a private house, apartment, mobile home, other? _____ (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? No / Yes
3. Is there a working smoke alarm on each floor in the house? No / Yes
4. Does your child always use a car seat/seat belt when riding in a car? No / Yes
5. Are there any smokers in the household? No / Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) No / Yes
7. Does your child always wear a helmet when biking and skating? No / Yes

H. Do You Have A Record Of Immunizations? No / Yes

Chicken pox status? _____

How did you find out about our practice? _____



FINANCIAL PAYMENT POLICY

Please provide us with your correct Insurance / Medicaid information at the time services are rendered. If we do not receive the correct insurance information within 90 days from the date of service, you will be responsible for all charges. Intentionally providing false or misleading insurance information is a crime. Likewise, if you were to receive payment directly from your insurance company for a service that has not been paid by you, it is your responsibility to remit the insurance payment to our office.

Failure to show your insurance card or let us know of any changes will result in any and all bills becoming your responsibility. You are responsible at the time of service:

- To remit payment for any and all co-pays.
- To remit payment for any and all deductibles.
- To know your insurance policy. If your insurance covers immunizations and if services require a referral or prior authorization, please let us know.
- To know if your labs are covered and what facility to go to for your lab work.

If you are uninsured, payment is due at the time of service. If needed, we are willing to work with you on a payment plan. Ask to speak to our patient billing staff.

If you have health insurance, the contract to pay your benefits is strictly between you and your insurance company. If for some reason your health insurance company pays your claim and then retroactively denies the benefits, it is your responsibility to remit payment to us upon receipt of a statement.

If you decide not to present your information today, you will be considered a self-pay patient and will be expected to pay at today's visit.

By signing below, I hereby certify that all the information I have provided regarding my personal information and my health insurance information is true and correct as of this date. I understand that providing false information is a crime. I certify that I have been made aware of my responsibilities to ensure that the medical bills I incur are my medical bills and its my responsibility to ensure that these bills are paid. I fully understand that any unpaid debts will be sent to a professional collection agency and that any unpaid debts could adversely affect my credit.

Signature

Date



PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.

Signed this _____ day of _____, 20____.

List Patient(s) Names Below:

_____	_____
_____	_____

Signature _____

Relationship to Patient(s) _____



Childhood Vaccination Policy

Effective 5/14/2015

In the best interest of the health and safety of all patients in our practice, effective 5/14/2015 Associated Pediatricians will no longer be accepting any new families who refuse to immunize their children. Families that are already established with our practice who, for reasons other than valid medical contraindications, have not completed age appropriate immunizations will be expected to begin the process of completing these immunizations within six months and to have completed them within two years. Associated Pediatricians follows the immunization schedule recommended by both the American Academy of Pediatrics and the Advisory Committee on Immunization Practices (AAP/ACIP).

It is well proven that vaccination for childhood diseases is safe and effective. Deciding to not vaccinate or to postpone vaccination is not supported by the medical literature. Delaying immunization places both the individual child and those around him/her at risk. We live in a global society. Recent outbreaks of whooping cough and measles and the persistence of polio in foreign countries highlights just how real these risks are.

If you have vaccine questions we are more than happy to discuss them with you. Although we do not recommend any immunization schedule other than that recommended by the AAAP/ACIP, if you intend to **fully** vaccinate your child using an "alternative schedule" we will make every effort to work with you to complete vaccinations in a timely manner.

If you are unwilling or unable to comply with our vaccination policy, we are not the practice for your family. In that event we will help you transfer your records to another health care provider of your choosing. Our goal at Associated Pediatricians is to provide the best medical care for each of our patients. Routine childhood immunizations are the cornerstone of that care. We sincerely hope you can appreciate and share our goals.

I have read and understand the Associated Pediatricians Vaccination Policy:

Signed this _____ day of _____, 20_____.

List Patient(s) Names Below:

Signature _____

Relationship to Patient(s) _____

Patient Name:

Date of Birth:

Account #:

ASSOCIATED PEDIATRICIANS WELL CHILD VISIT POLICY

The well child visit is an opportunity to discuss your child's growth and development and discuss important age-related safety and behavior topics. This visit also allows us to do a complete physical exam so we can identify medical problems that may not be readily apparent without a thorough physical exam. The purpose of your child's visit is what is called "preventative care"—looking for and discussing issues that may affect your child's growth, development and general well being so that we can identify and prevent smaller issues from progressing into larger problems.

Things that are included in your child's well visit:

- Measurement of weight, height/length, head circumference (2YO and under), blood pressure (3YO and up)
- A complete head-to-toe physical exam done by your provider (doctor or nurse practitioner)
- A discussion with your provider about your child's growth and nutrition/diet
- A discussion with your provider about normal developmental milestones and your child's progression in achieving these
- A discussion with your provider about normal age-related development and safety topics
- Discussion of sports-related screening questions for student athletes and completion of related forms

If needed, your child will receive immunizations (shots) at the well child visit. Please note that these are billed separately to your insurance company. As a courtesy, we verify insurance eligibility for these shots prior to your child's visit. We, however, have limited access to coverage and benefit information and you are ultimately responsible for knowing your plan limitations. If the immunizations are not covered by insurance, you will receive a bill from our office.

In addition to the above, many of our visits include other screening or preventative care. The following are a list of some of the items that fall into this group. These are billed separately to your insurance company and may or may not be covered under your insurance plan. Rest assured that our recommendations for these services are made because they are a part of the American Academy of Pediatric's Bright Futures Guidelines. These guidelines are the gold-standard of care in pediatrics and are important to identifying any issues EARLY before they become larger problems. Most, but not all, insurance companies pay for services recommended under these guidelines.

- Standardized Developmental Surveys (ASQ, MCHAT, etc.)
- Hemoglobin and lead blood test
- Vision Screening (Pediavision)
- Hearing Screening
- Depression, Anxiety, ADHD, lead, and other standardized screening questionnaires
- Application of fluoride varnish

Please also note that well child care does not include care of other chronic medical conditions (asthma, ADHD, allergies, mental health issues) or acute illnesses (ear infections, strep throat, gastrointestinal illnesses, etc) that occur at the same time as the well visit. ***If we evaluate and treat chronic or acute conditions during the course of the well visit we are mandated by your insurance company to document and bill separately for those issues.*** As such, you may be required to pay a copay. Please know that this is required by the insurance companies and we are forced to comply with this policy, as failure to do so would constitute insurance fraud.

I acknowledge I have read and understand the above policy. I agree I am responsible for any and all charges deemed to be my responsibility by my insurance carrier. These include, but are not limited to, co-pays, deductibles, co-insurance, benefits, and any services not covered by my insurance carrier

Parent/Guardian Signature

Date