PEDIATRIC & NEONATAL SPECIALISTS, P.S.C.

PEDIATRIC HISTORY

PNS-146 (Rev. 2-16-12)

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Name: ______________________________ Date of Birth: ______________

Sex: Female ☐ Male ☐

Birth History: Yes No

Where there any problems with pregnancy or delivery of this child? ☐ ☐

If yes, please explain: ______________________________

____

______________ Term? __________ Premature?

____

Type of Delivery:

Vaginal ______________ C-section ______________

Birth length ______________ Birth Weight ______________

Problems:

Jaundice ☐ Respiratory Distress ☐

Feeding Problems ☐ Rash ☐ Breech ☐

Hospitalizations / Operations of child:

Hospital	Reason	Year

Current Medications and Dosages: **None** ☐

____

____

____

____

____

____

Allergies to any medication?: Yes ☐ **None known** ☐

If yes, please list: ______________________________

____

____

____

____

Immunizations Yes No

Are your child's immunizations up to date? ☐ ☐

Unsure? ☐

____

Parent/Guardian Signature Date

Social and Environmental History:

Who does the child live with? ______________________________

____

Is the home tobacco free: Yes ☐ No ☐

Are there smoke detectors in the home? Yes ☐ No ☐

Do you use your seat belts/car seats? Yes ☐ No ☐

Is your child in school or day care? Yes ☐ No ☐

Does your child wear a bike helmet while riding? Yes ☐ No ☐

Are there guns in your home? Yes ☐ No ☐

Do you have the poison-control center phone number near your telephone? Yes ☐ No ☐

Medical History:

Check if your child has had any of the following:

- ADD/ADHD ☐
- Asthma ☐
- Anemia ☐
- Chicken Pox ☐
- Diabetes ☐
- Chronic diarrhea ☐
- Ear problems ☐
- Eczema (overly dry skin) ☐
- Eye or vision problems ☐
- Kidney/Bladder problems ☐
- Liver disease/Jaundice ☐
- Rheumatic fever ☐
- Seizures ☐
- Tuberculosis ☐
- Other (Please explain) ☐

Family History:

Please check all that apply	Siblings	Father	Mother	Grandfather paternal or maternal	Grandmother paternal or maternal
Heart disease					
High blood pressure					
Stroke					
Cancer/Type					
Glaucoma					
Diabetes Type 1 or 2					
Seizures					
Bleeding disorder					
Kidney disease					
Thyroid disease					
Mental Illness					
Parkinson's disease					
Alzheimer's disease					
High Cholesterol					
Other					

PEDIATRIC & NEONATAL SPECIALISTS, P.S.C.
PNS-86 (Rev. 7-17-12)

PATIENT REGISTRATION

Ethnicity: ❑ Hispanic/non Latino ❑ Hispanic/Latino ❑ Declined ❑ Unknown ❑ Other

Location: ❑ **Suburban** ❑ **Preston** ❑ **Broadway** **Date:**__________

Physician: (patient normally sees) __________

CHILD'S INFORMATION

Last name:__________ First name:__________ M.I._____

Address:__________ Apt.#_____

City:__________ State:_____ Zip Code:_____

Home phone:__________ Sex:_____ SS#:__________ Race: _____

Date of birth:__________ Primary language spoken: __________

Medical alert:__________

Persons listed in this section have authorization to consult and discuss patients treatment and billing information.

MOTHER OR GUARDIAN INFORMATION

Patient lives with: ❑ Both parents ❑ Mom ❑ Dad ❑ Guardian

Last name:__________ First name:__________ M.I._____

Address:__________ City:__________ State:_____ Zip Code:_____

Home phone:__________ Work phone:__________ Cell: __________

DOB: _____ SS#:__________ Language:_____ email address: __________

Employer: __________ Employer phone: __________

FATHER OR GUARDIAN INFORMATION

Patient lives with: ❑ Both parents ❑ Mom ❑ Dad ❑ Guardian

Last name:__________ First name:__________ M.I._____

Address:__________ City:__________ State:_____ Zip Code:_____

Home phone:__________ Work phone:__________ Cell: __________

DOB: _____ SS#:__________ Language:_____ email address: __________

Employer: __________ Employer phone: __________

Preferred pharmacy and location: __________

INSURANCE INFORMATION - Primary coverage:

Insurance Co.__________

Address:__________

Policy#__________ Group#__________

Effective date: __________

Pt's relationship to insured:__________

Insured's name: __________

Insured's address:__________

Insured's phone:__________

Insured's date of birth:__________

Insured's employer:__________

Employer's address: __________

INSURANCE INFORMATION - Secondary coverage:

Insurance Co.__________

Address:__________

Policy#__________ Group#__________

Effective date: __________

Pt's relationship to insured: __________

Insured's name:__________

Insured's address:__________

Insured's phone: __________

Insured's date of birth:__________

Insured's employer:__________

Employer's address: __________

IN CASE OF EMERGENCY CONTACT:

Name of person **NOT** living with patient: __________ Relationship to patient: __________

Home phone:__________ Work phone: __________

NAME OF OTHER PHYSICIAN(S) WHO CARE FOR PATIENT:

__________ __________

__________ __________

LIST BROTHERS/SISTERS WHO ARE PATIENTS HERE:

Last name__________ First name__________ DOB_____

Last name__________ First name__________ DOB_____

Last name__________ First name__________ DOB_____

...please complete other side...

NO SHOW APPOINTMENTS

I understand that it is my responsibility to notify, ***24 hours in advance***, Pediatric & Neonatal Specialists, PSC in the event that I must cancel an appointment. I am fully responsible for the charge of $20.00 which will be applied to my account for appointments that are missed without notifying the office.

Authorized person's signature ______________________________ Date ______________

CONSENT TO TREAT / INFORMATION RELEASE

I ______________________________ (print name) hereby consent to the use and disclosure of my childs health information for the purposes of treatment, payment and health care operations. I authorize the physicians / nurse practitioners to render medical treatment as needed for my child. I also request payment be made to Pediatric & Neonatal Specialists, PSC. **The undersigned is responsible for all fees, regardless of insurance coverage. A copy of this authorization is as valid as the original.**

Authorized person's signature ______________________________ Date ______________

Persons listed in this section have authorization to consult and discuss patients treatment and billing information.

I authorize ______________________________ to accompany my child to your office for treatment by your physicians / nurse practitioners.

Authorized person's signature ______________________________ Date ______________

HOW DID YOU HEAR ABOUT THIS PRACTICE?

- ❑ Referral by another patient/relative?
- ❑ Referral by another physician?
- ❑ Insurance plan/provider?
- ❑ Physician Referral Service/Hospital?
- ❑ Advertisement? ❑ Yellow Pages?
- ❑ Internet?

REASONS WHY YOU SELECTED THIS PRACTICE

- ❑ Convenient location?
- ❑ Type of service available?
- ❑ Other, please specify ______________________

____

____

____

Name of person who referred patient to this office:

❑ Dr. ❑ Mr. ❑ Ms. ______________________________

PATIENT CONSENT FORM

PNS-139 (Rev. 10-11-11)

Pediatric & Neonatal Specialists, PSC's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

This Consent was signed by: ______________________________

Printed Name — Patient or Representative

Relationship to Patient (if other than patient): ______________________________

Date: ______/______/______

In front of ______________________________

Printed name — Practice representative

PEDIATRIC & NEONATAL SPECIALISTS, P.S.C.
PNS-87 (Rev. 7-17-12)

FINANCIAL POLICIES

Thank you for choosing Pediatric & Neonatal Specialists to care for your child(ren). The following information is provided as a guide to understanding our financial requirements. Should you have any questions please call our Billing Department at (502) 893-5502, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Patients with insurance will be asked to provide insurance card(s) at every visit. We accept most insurance. If insurance coverage should change please notify the receptionist at the next office visit and provide us with the new insurance card(s). **If there is more than one insurance carrier** (one insurance is primary and the other is secondary), **you must provide the insurance cards for both.** Be advised that your primary insurance will not pay any claims without first receiving information from you on your secondary insurance.

The parent/legal guardian is responsible for all fees whether or not the insurance company pays. As a courtesy for our patients we will file a claim to the insurance company for services provided. Any fees not paid by the insurance company will be billed to the parent/legal guardian and immediate payment is expected. We do not act as an intermediary between the insured and the insurance company. Please contact the customer service representative of the insurance company if you are dissatisfied with the result of a claim and feel a service should be covered.

The parent/legal guardian that registers the child with our practice is recognized as the responsible party. We only bill the responsible party regardless of who brings the child for an appointment or if another person has been legally designated as financially responsible. **Co-payments are due at the time of the office visit** regardless of who brings the child to the appointment. You may arrange in advance credit card payment of the co-pay by calling the Billing Department at least one day prior to the appointment date. If the co-pay is not paid at the time of the office visit you may be asked to reschedule the appointment. We accept cash, money order, check, MasterCard or Visa. Checks must include name and current address. Returned checks will incur a $20.00 charge and no further checks will be accepted. If at the appointment the account is showing a balance due, payment in full will be expected as well as the co-pay for that visit.

There is a $20 charge for no shows. Notify us 24 hours in advance to cancel or reschedule the appointment to avoid this fee.

Read your insurance policy so you are informed about what is covered. It is the parent/legal guardian's responsibility to ensure we are an in-network provider, to know what services are covered and co-pay requirements. Please note certain immunizations are not covered by most insurance and the patient may have a co-pay amount that is different from the office visit co-pay or there may be no co-pay required.

We send statements monthly. Balances due from the responsible party that are two (2) months old will be placed in collection. The responsible party will have seven (7) days from the date we send a collection letter to pay the balance. **Balances that remain unpaid after collection will be turned over to an outside agency and the patient will be discharged. The parent/legal guardian agrees to pay all costs of collection, including reasonable legal fees.**

Self pay (patients without insurance coverage or where insurance coverage cannot be verified) are expected to pay their bill in full at the time of service unless prior arrangements have been made with the Billing Department.

I have read, understand and agree to these financial policies.

Signature of Parent/Legal Guardian ______________________________ Date ______________