PARENT AND INSURANCE INFORMATION

PARENT INFORMATION

Mother's Information

Mother's Name: _____ _____ _____
LAST FIRST MI

Mother's Address: _____ Apt # _____

City _____ State _____ Zip _____

Mother's Home Phone #: ( )_____ Work #: ( )_____ Cell #: ( )_____

Mother's Email Address: _____

Mother's Work Place: _____

Address: _____

City _____ State _____ Zip _____

Mother's Date of Birth: _____ Mother's Social Security #: _____

Mother's Marital Status: S M D W Mother's Race: _____ Ethnicity: _____ Preferred Language: _____

Father's Information

Father's Name: _____ _____ _____
LAST FIRST MI

Father's Address (if different from above): _____ Apt # _____

City _____ State _____ Zip _____

Father's Home Phone #: ( )_____ Work #: ( )_____ Cell #: ( )_____

Father's Email Address: _____

Father's Work Place: _____

Address: _____

City _____ State _____ Zip _____

Father's Date of Birth: _____ Father's Social Security #: _____

Father's Marital Status: S M D W Father's Race: _____ Ethnicity: _____ Preferred Language: _____

Insurance Information

PRIMARY INSURANCE

Company Name: _____ Copay Amount $_____

Subscriber Name: _____ _____ _____
LAST FIRST MI

Subscriber Date of Birth: _____ Social Security #: _____

I.D.# _____ Group # _____ Effective Date: _____

SECONDARY INSURANCE

Company Name: _____ Copay Amount $_____

Subscriber Name: _____ _____ _____
LAST FIRST MI

Subscriber Date of Birth: _____ Social Security #: _____

I.D.# _____ Group # _____ Effective Date: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone #: ( ) _____ Cell #: ( ) _____

Name: _____ Relationship: _____

Phone #: ( ) _____ Cell #: ( ) _____

I hereby give authorization for medical treatment by CHILDREN'S CARE PEDIATRICS (CCP) and I understand that I am fully responsible for payment of services including co-pays, co-insurances, and out-of-pocket expenses and that insurance is filed as a courtesy. I further understand that by CCP filing my insurance, that it does NOT constitute a contract between the physician and my insurance company. I authorize my insurance carrier to make payment to CCP for services rendered.

Patient/Insured Signature _____ **Date** _____

I hereby authorize the release of my medical records/documents to my insurance company, physicians, or other entities necessary in the collection and/or processing of my medical claim.

Patient/Insured Signature _____ **Date** _____

HIPAA

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- To review and receive a paper copy of our privacy practices.

( ) I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Patient

_____ _____ _____

Signature of Patient or legal representative **Date** **Witness Signature**

OFFICE USE ONLY

( ) ACCEPTED
( ) DENIED

_____ _____ _____

SIGNATURE **TITLE** **DATE**

INITIAL HISTORY QUESTIONNAIRE

TODAY'S DATE: _____/_____/_____

PATIENT INFO

NAME _____ _____ _____
LAST FIRST MI

DATE OF BIRTH _____ SEX: M OR F

RACE _____ ETHNICITY _____ PREFERRED LANGUAGE _____

SCHOOL'S NAME _____ GRADE _____

CURRENT MEDICATIONS: _____ _____

_____ _____

LIST ANY KNOWN ALLERGIES: _____ _____

_____ _____

MOTHER'S NAME: _____ _____
LAST FIRST

FATHER'S NAME: _____ _____
LAST FIRST

HOUSEHOLD

PLEASE LIST ALL THOSE LIVING IN THE CHILD'S HOME

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	HEALTH PROBLEMS

Are there siblings not listed? If so, please list their names and ages and where they live.

_____

_____

If mother and father are not living together or if the child does not live with parents, what is the child's custody status?

_____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

_____

BIRTH HISTORY

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks gestation? _____

Did mother have any illness or problem with her pregnancy? ( ) Yes ( ) No

Explain _____

During pregnancy, did mother

Smoke ( ) Yes ( ) No Drink alcohol ( ) Yes ( ) No

Use drugs or medications ( ) Yes ( ) No

What _____ When _____

Was the delivery ( ) Vaginal? ( ) Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?

( ) Yes ( ) No Explain _____

_____

Was initial feeding ( ) Breast? ( ) Bottle?

Did your baby go home with mother from the hospital?

( ) Yes ( ) No Explain _____

_____

GENERAL

Do you consider your child to be in good health? ( ) Yes ( ) No Explain _____

Does your child have any serious illness or medical condition? ( ) Yes ( ) No Explain _____

Has your child had serious injuries or accidents? ( ) Yes ( ) No Explain _____

Has your child had any surgery? ( ) Yes ( ) No Explain _____

Has your child ever been hospitalized? ( ) Yes ( ) No Explain _____

Is your child allergic to any medicines or drugs? ( ) Yes ( ) No Explain _____

OVER

DEVELOPMENT

Are you concerned about your child's physical development? ( ) Yes ( ) No Explain_____

Are you concerned about your child's mental or emotional development? ( ) Yes ( ) No Explain_____

Are you concerned about your child's attention span? ( ) Yes ( ) No Explain_____

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

FAMILY HISTORY

Have any family members had the following:

Deafness	( ) Yes	( ) No	Who_____	Comments_____
Nasal allergies	( ) Yes	( ) No	Who_____	Comments_____
Asthma	( ) Yes	( ) No	Who_____	Comments_____
Tuberculosis	( ) Yes	( ) No	Who_____	Comments_____
Heart disease (before 50 years old)	( ) Yes	( ) No	Who_____	Comments_____
High blood pressure (before 50 years old)	( ) Yes	( ) No	Who_____	Comments_____
High cholesterol	( ) Yes	( ) No	Who_____	Comments_____
Anemia	( ) Yes	( ) No	Who_____	Comments_____
Bleeding disorder	( ) Yes	( ) No	Who_____	Comments_____
Liver disease	( ) Yes	( ) No	Who_____	Comments_____
Kidney disease	( ) Yes	( ) No	Who_____	Comments_____
Diabetes (before 50 years old)	( ) Yes	( ) No	Who_____	Comments_____
Bed-wetting (after 10 years old)	( ) Yes	( ) No	Who_____	Comments_____
Epilepsy or convulsions	( ) Yes	( ) No	Who_____	Comments_____
Alcohol abuse	( ) Yes	( ) No	Who_____	Comments_____
Drug abuse	( ) Yes	( ) No	Who_____	Comments_____
Mental illness	( ) Yes	( ) No	Who_____	Comments_____
Mental retardation	( ) Yes	( ) No	Who_____	Comments_____
Immune problems, HIV or AIDS	( ) Yes	( ) No	Who_____	Comments_____

Additional family history _____

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox	( ) Yes	( ) No	Explain_____
Frequent ear infections	( ) Yes	( ) No	Explain_____
Problems with ears or hearing	( ) Yes	( ) No	Explain_____
Nasal allergies	( ) Yes	( ) No	Explain_____
Problems with eyes or vision	( ) Yes	( ) No	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	( ) Yes	( ) No	Explain_____
Any heart problem or heart murmur	( ) Yes	( ) No	Explain_____
Anemia or bleeding problem	( ) Yes	( ) No	Explain_____
Blood transfusion	( ) Yes	( ) No	Explain_____
Frequent abdominal pain	( ) Yes	( ) No	Explain_____
Constipation requiring doctor visits	( ) Yes	( ) No	Explain_____
Bladder or kidney infection	( ) Yes	( ) No	Explain_____
Bed-wetting (after 5 years old)	( ) Yes	( ) No	Explain_____
(For girls) Has she started her menstrual periods?	( ) Yes	( ) No	Explain_____
(For girls) Are there problems with her periods?	( ) Yes	( ) No	Explain_____
Any chronic or recurrent skin problem (acne, eczema, etc)	( ) Yes	( ) No	Explain_____
Frequent headaches	( ) Yes	( ) No	Explain_____
Convulsions or other neurologic problem	( ) Yes	( ) No	Explain_____
Diabetes	( ) Yes	( ) No	Explain_____
Thyroid or other endocrine problem	( ) Yes	( ) No	Explain_____
Any other significant problem	( ) Yes	( ) No	Explain_____
Use of alcohol or drugs	( ) Yes	( ) No	Explain_____

Children's Care Pediatrics

Rx Consent Form

_____ _____
Patient Name *Patient Date of Birth*

Consent

By signing this consent form you are agreeing that your provider at Children's Care Pediatrics may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Children's Care Pediatrics to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Preferred Pharmacy Name *Preferred Pharmacy Address*

(_____)_____
Preferred Pharmacy Phone

_____ _____
Signature of Patient or Guardian *Relationship to patient*

_____
Date

Summary of Financial Policy and Authorization

Thank you for choosing Children's Care Pediatrics as the provider for your child (ren) healthcare needs. Please read the following summary of our financial policy and sign where indicated. You may also ask for a copy of the Children's Care Pediatrics financial policy or review it on our website at www.childrenscarepediatrics.com.

PAYMENT POLICY

Payment is expected at the time of service. We accept cash, check, and credit cards-American Express, MasterCard, Visa, and Discover. Under Georgia State Code #13-6-15, there will be a charge of $30 or 5% of face amount of the returned instrument (whichever is greater) plus the fee incurred by Children's Care Pediatrics from the processing bank.

INSURANCE

We agree to accept assignment for any insurance plan with which we are participating providers, and will file insurance claims on your behalf. CO-PAYMENT, any ESTIMATED CO-INSURANCE and/or DEDUCTIBLE are EXPECTED AND DUE AT THE TIME OF SERVICE. In the event you do not have insurance coverage, payment is expected in full at the time of service. We do offer a self pay plan that could be applied to the visit if needed.
Charges are ultimately your responsibility. Your benefits coverage is based on your plan with your insurance carrier; therefore it is your responsibility to know your benefits. We ask that you contact your insurance carrier prior to any visit and that you follow-up with your insurance company in the event of any dispute or issues with a claim.

DELINQUENT AND COLLECTION ACCOUNTS

You will receive up to two (2) statements for any balances on your account after the insurance payments and adjustments have been applied. Any unpaid delinquent debt (no payment received after 60 days of services rendered), including no-show fees, owed to Children's Care Pediatrics will be referred to an outside collection agency.
You are responsible for all additional collection agency expenses incurred by Children's Care Pediatrics in the course of obtaining payment, and the family on the account will be subject to permanent dismissal from the practice. The collection agency expense could be a much as 50% of any outstanding balance.

AUTHORIZATION

- I hereby certify that the information I have provided regarding my (child's) insurance, our address and phone numbers is correct.
- I understand that fees charged are due at the time of service and charges are ultimately my responsibility, regardless of insurance.
- I hereby authorize Children's Care Pediatrics to apply for benefits on my (child's) behalf for covered services rendered. I request payment from my insurance carrier be made directly to Children's Care Pediatrics.
- I authorize the release of any medical information necessary to process insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time by submitting a request to Children's Care Pediatrics in writing.
- I acknowledge by my signature that I have read and do understand this financial policy and authorization. I also acknowledge that I will be responsible for payment of services, co-pays co-insurances, deductibles, or non covered services by my insurance company.

Print Child's name_____ Date of Birth:_____

Parent/Guardian Signature_____ Date _____