MEADE COUNTY PEDIATRICS
NEW PATIENT INFORMATION

Date: _____

E-mail Address:_____ Account No.:_____

Patient's Full Name:_____ Nickname:_____
Patient's Primary Address:_____
Birth Date:_____SSN:_____Sex:_____OB Doctor:_____

1ST Sibling Full Name:_____Nickname:_____
Birth Date:_____SSN:_____Sex:_____OB Doctor:_____

2nd Sibling Full Name:_____Nickname:_____
Birth Date:_____SSN:_____Sex:_____OB Doctor:_____

If necessary, we will be happy to print another form for additional children.

Father's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Address:_____
No. and street City State Zip
Father's Employment:_____Work Phone:_____

Mother's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Address:_____
No. and street City State Zip
Mother's Employment:_____Work Phone:_____

Stepfather/Mother's Name:_____SSN:_____
Home Phone:_____Cell Phone:_____DOB:_____
Stepfather/Mother's Employment:_____Work Phone:_____

Legal Custodian's Name:_____Home Phone:_____
Cell Phone:_____DOB:_____SSN:_____
Custodian's Address:_____
No. and street City State Zip
Custodian's Employment:_____Work Phone:_____

Emergency Contacts

(Please list TWO who live outside your home.)

1st Contact Name:_____Relation:_____
Home Phone:_____Cell Phone:_____
Address:_____
No. and Street City State Zip

2nd Contact Name:_____Relation:_____
Home Phone:_____Cell Phone:_____
Address:_____
No. and Street City State Zip

Patient's Name_____DOB_____ Date_____

I. Prenatal History:

Mother's age at birth of child _____

Any problems with pregnancy (if so, please explain)?

_____

What was the birth weight? _____

Was the baby born via C-section or Vaginal Delivery? _____

If C-section please explain why (i.e. repeat or failure to progress)._____

Did your baby have any problems in the hospital? (eg. Jaundice, infection, other) _____

Name of hospital where child was born._____

II. Past Medical History:

Who was your child's previous physician? _____

Medications taken regularly (please list) _____

Allergies to medications, food, insect bites (please list) _____

Any chronic medical conditions? (please list) _____

Hospitalizations? (please list) _____

Surgeries? (please list) _____

Are Immunizations up to date? Yes No Where are those records located?_____

III. Family History:

Are both parents in good health? Yes No Comments _____

Does your child's parent, grandparent, brother, or sister have any of the following? Please circle

Anemia Asthma Allergies Diabetes High blood pressure Heart trouble

Seizures/ Congenital Malformations or Syndromes Mental Illness Cancer

IV. Social History:

What town do you live in? _____

Do you have city water? Yes No

Do you have pets? Yes No (please list) _____

Does anyone in your home smoke? Yes No

V. Review of Systems:

Please circle any of the following that apply to the patient:

Hearing problems Vision problems Fatigue Eczema, hives, or skin condition

Frequent ear infections Wheeze/Asthma problems Heart murmur or heart problem

Seizure Urine or kidney problems Psychological problems Anemia

Muscle or Joint problems Developmental issues

Has your child had any other medical problems? Please list _____

Primary Pharmacy:_____

Patient's Name_____DOB_____Date_____

HEALTH INFORMATION PRIVACY

This document is to protect the privacy of your child' health information. Please fill it out completely and accurately.

The following people have my permission to bring my child to the office for medical examinations and treatment, including immunizations and injections:

_____ _____

_____ _____

_____ _____

1. May we discuss you child's medical information with anyone other than yourself? YES NO
   If yes, whom? Name _____ Phone # _____
2. May we contact you at home to confirm appointments and/or give you test results or other communications? YES NO
3. If you are not available at home, may we leave a message on your voicemail or with anyone answering the phone asking you to call our office? YES NO
4. May we contact you at work to confirm appointments or give you test results or other communications? YES NO
5. If you are not available at work, may we leave a message for you to contact our office? YES NO
6. If you do not want us to call you at home or work, how may we communicate with you? Please be specific with a telephone number or address. _____
7. Is there a living will in place for this patient? YES NO

I acknowledge that Meade County Pediatrics, PLLC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information. I also acknowledge that the above information is true and accurate**.**

Signature _____ **Date** _____

Printed Name _____

Patient's Name_____DOB_____Date_____

Insurance Information

Primary Insurance:_____
Subscriber's Name:_____SSN:_____
DOB:_____Policy ID No.:_____Group No.:_____

Secondary Insurance:_____
Subscriber's Name:_____SSN:_____
DOB:_____Policy ID No.:_____Group No.:_____

Patient Financial Responsibilities

It is your responsibility to give our office current and up-to-date information. This includes any changes in name(s), address(s), and telephone number(s), as well as new insurance information.
It is your responsibility to know your insurance plan's policies and guidelines. Every insurance company is different.
It is your responsibility to contact your insurance company to verify that our physician is a participating physician with your insurance company and with your specific plan.
Are well checks covered? ___Yes ___No.
Are immunizations covered? ___Yes ___No.
Save all the Explanations of Benefits (EOB) forms you receive from your insurance companies. These EOB forms allow you to know why your insurance company has paid as they did. An EOB form can serve as the basis for an appeal. It will allow us to help you negotiate with your insurance company. Please study these forms closely. They are important.

Collection Policies

After your insurance pays its portion, the remaining balance becomes your responsibility. You will receive 2 monthly statements. If you fail to pay your bill in full or make payment arrangements with us by the date listed on the second statement, your account will then be placed in our collections department. If we do not hear from you, your account will be sent to an outside collection agency. We do accept Visa, MasterCard, and Discover. Please note that our extended limit for patient due is $200.00 on an account. We cannot exceed this amount and need for all accounts to be kept current.

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1. I authorize Meade County Pediatrics to initiate and maintain all medical/surgical treatment of my child/children in an emergency of life threatening situation until proper notification can be given and consent obtained.

2. RELEASE OF INFORMATION – I authorize release of any medical information necessary to file any claims to my insurance carrier. This signature or photocopy thereof irrevocably authorized the release of information necessary to process and insurance claim and further authorized payment of medical benefits to the physician providing services. ***In order to assist you with your insurance company, our office will be glad to submit your claim to your insurance company for you.***

_____

PARENT/LEGAL GUARDIAN SIGNATURE SSN

_____

PARENT/LEGAL GUARDIAN SIGNATURE SSN

Patient Name_____DOB_____Date_____

FINANCIAL POLICIES

At the present time, we participate with most insurance companies. However, it is impossible for us to know what each individual insurance policy will or will not cover. For example, some Humana plans pay for preventive "well" visits while some cover only a portion of the visit, and others none at all. Some policies require a co-payment and/or co-insurance, while others do not.

Copay/Deductibles-We require payment of any co-pays, deductibles, and co-insurance on the date of your child's appointment.

We are legally prohibited from writing off patient responsibility amounts.

If we do not participate with your insurance company, we will be happy to see your child "out of network". This may mean a reduction in your benefits. Since every insurance company has different rules, it is impossible for our staff to know what your insurance will pay. Please check with your insurance company or your human resource department.

Self-pay-If you do not have insurance (i.e. you are self-pay) all charges are to be paid for on the visit date. A prompt payment discount of 25% will be deducted from the office visit. This does not lab work, tests, vaccines, etc.

Consultation-Many insurance companies are now paying for phone calls. We do charge for routine calls such as after-hours calls and/or administrative calls. We reserve the right to bill your insurance for "consultative" type calls. If your insurance does not pay, you will be responsible for the charges.

Fees/Charges-A charge of $25.00 will be added to your account if your check is returned.

We will accept cash, check, money order, VISA, Master Card, or Discover. If needed, we are eager to work with you on a payment plan as long as your intent to pay is evident to us.

There will be a $5.00 late fee charged to any account that is 31-60 days past due. There will be a $10.00 late fee charged to any account that is 60-90 days past due. After 90 days, late accounts will be placed with a collection agency. Any collection fees will be your responsibility.

There will be a $10.00 fee for specialized forms that are filled out by the doctor (FMLA papers, camp forms, school physical forms, insurance forms, disability determination forms, medical necessity forms, pre-op forms, etc.).

There will be a $5.00 fee for prescription refills not related to same day of service.

We value all of our patients and hope to build mutual trust and respect. Our financial policies were established to preserve the doctor/patient/family relationship. We ask that if there are extenuating circumstances regarding your account, that you call us immediately so that we can help you. Thank you for choosing Meade County Pediatrics.

I have read and understand the financial policy of Meade County Pediatrics and agree to these terms.

_____

Signature Date