ALL STAR PEDIATRICS

Office Hours: **Mon-Thur** 8:30 am to 5:00 pm **Friday** 10:00 am to 2:00 pm

PLEASE INITIAL EACH STATEMENT AND SIGN BELOW

Appointments:

_____ All Star Pediatrics requires 24 hour notice if unable to make your appointment time. There will be a $100.00 charge for repeat missed appointments.

_____ I understand after two missed appointments, the physician may release the patient from care.

_____ If I arrive 15 minutes late, my appointment time may be rescheduled.

Payment: We accept Visa, Mastercard, Discover, and American Express, as well as cash and checks.

_____ I understand all copayments/coinsurance and allowables for high-deductible plans are due at the time of service.

_____ There is a $25.00 fee for any returned checks.

_____ If your account becomes 90 days overdue, it will be turned over to an outside collection agency

_____ I understand that All Star Pediatrics is not always aware of the particular details of each insurance plan, and I am ultimately responsible for confirming any exclusions, provisions, and/or terminations with my insurance plan.

_____ I understand that I am responsible for all services whether or not paid by my insurance plan.

_____ I understand that any diagnosis and/or services performed outside the scope of a well-child visit may be charged an office visit copay by your insurance company.

Transfer of Records:

_____ Before records can be forwarded to another physician, a release will need to be signed by the parent.

_____ There will be a $25 charge assessed for records transfers of over 20 pages.

After Hours: As a service to our patients, we provide after-hours nurse triage line. This service is only for urgent medical questions that cannot wait until the next business day. Calls received by the service for other reasons are subject to a $15 charge, which will be billed to your account.

Medication Refills: Please give 48 hours' notice for all prescription refills.

_____ Patient's Name

_____ Parent/Guardian Name

_____ Parent/Guardian Signature

_____ Date

Acknowledgement of Receipt of Notice of Privacy Practices

These policies are to provide a description of the uses and disclosures of certain health information for your child. I understand that this information serves as:

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

Medical Records: For your child's protection, no medical records will be released without a written authorization from a parent or guardian.

All Star Pediatrics has the right to change its Notice of Privacy Practices and Office Policy at any time. A copy of any changes will be given to the patient upon request.

In complying with Health Insurance Portability and Accountability Act, HIPAA, we want to make sure we protect your child's privacy. Please answer the following questions.

-May we leave messages concerning your child's appointments?	**YES**	**NO**
-May we leave messages on your cell phone voicemail?	**YES**	**NO**
-May we leave messages on your voicemail at work?	**YES**	**NO**
-Are there people <u>other than</u> the child's parents/ legal guardians that we may discuss your child's care and/or treatment?	**YES**	**NO**

If so please list names and relationship:

_____ _____

Name Relationship

_____ _____

Name Relationship

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and any individual(s) he deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my child's medical condition. This information may be changed upon written request.

_____ _____

Patient's Name Date of Birth

_____ _____

Parent/ Guardian Signature Relationship

ALL STAR PEDIATRICS

Patient Registration Form

Patient First Name: _____ **Last:** _____ **Nickname:** _____

Date of Birth: _____ **Birth Sex/Circle one:** Male Female

Address: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Primary phone _____ (mom/dad) **Secondary Phone** _____ (mom/dad)

Email Address _____ (*for office use only)*

Parent Marital Status: ____Married ____Separated ____Divorced ____Other
Child lives at home with: ____Mother ____Father ____Both ____Other

Other Children Living in the Home **Date(s) of Birth**

_____ _____
_____ _____
_____ _____

How did you hear of our office? (circle one) Flyer Friend/Relative Internet
Drive-By Insurance Co Other

Father's/Guardian's Legal Name: _____ SS# _____
Date of Birth: _____ DL# _____
Father's/Guardian's Employer: _____

Mother's/Guardian's Legal Name: _____ SS#_____
Date of Birth: _____ DL#_____
Mother's/Guardian's Employer: _____

Preferred Pharmacy: _____
Cross Streets: _____

Previous Primary Care Physician: _____

Primary Insurance Company
Name of Insurance: _____
Policy Holder Name: _____ DOB: _____

ALL STAR PEDIATRICS

HISTORY QUESTIONNAIRE

(TO BE COMPLETED BY THE LEGAL GUARDIAN)

Patient Name: _____ Date of Birth: _____

A. Mother's Prenatal History

Number of pregnancies ____ Number of living children ____ Name of Obstetrician _____
Did you have any of the following problems during your pregnancy: Bleeding _____ High Blood Pressure____
Surgery _____ Anemia _____ Infections _____ Accidents _____ Swelling _____ Other _____
Were any of the following used or taken during your pregnancy: Medications _____
Cigarettes _____ Alcohol _____ Drugs _____

B. Birth History

Where was your child born: _____ Number of weeks pregnant: ____
Was labor induced: _____ Hours of labor: _____ Was this a multiple birth: _____
Medication: _____ Type of delivery (circle all that apply) Vaginal Forceps Cesarean
Problems or complications during labor or delivery: _____
Child's birth weight: _____lbs _____oz Length: _____ APGAR Score: _____
Time of Birth: _____ Type of feeding: Breast ___ Formula:____ Both:_____
Did the child have problems in the hospital: Breathing ___ Color _____ Feeding ____ Temperature_____
Other _____
Did the child go home with you? _____ If no, when? _____ Discharge weight: _____

C. Family History

Age of the child's mother at delivery: _____ Father: _____
Health problems of the child's parents: _____
Health problems of the child's siblings: _____

D. List below any of the child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, T.B.			
Birth Defects			

ALL STAR PEDIATRICS

CONDITION	NO	YES	FAMILY MEMBER
Blood Disease			
Bone/Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Diabetes: Adult ( ) Juvenile ( )			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disorder			
Nerve Disorder (Epilepsy, C.P.)			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			