Patient Name: _____ Date of Birth: _____ Sex: M F

Address: _____ City, St, Zip _____

Siblings in this practice: _____

With whom does your child live: Mother _____ Father _____ Other _____

Email Address: _____

Pharmacy: _____ **Location:** _____

Race: _____ Preferred Language: _____

Ethnicity: (please circle) **Hispanic/Latino** **Not Hispanic/Latino** **Decline to Answer**

Religion: _____ None _____ Decline to Answer _____

Please Circle your Childs Primary Care Provider (Who you want to see for Well Check and most visits)

Charlotte Ellis APRN **Ann Macke MD** **Jessi Ester APRN** **Paul Janson MD** **Jessica Baumann MD**

Sharon Wynn MD **Josie Napier APRN** **Robert Tagher MD** **Lauren Pack FNP**

Name of Mother/Guardian: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

Best number to reach you: _____ Home _____ Cell _____ Work _____

Name of Father/Guardian: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

Best Number to reach you: _____ Home: _____ Cell _____ Work _____

Who should be listed as the Responsible party on the account? _____

Name of Primary Insurance: _____ Insurance ID # _____

Who carries insurance: _____ Relation to patient _____ DOB: _____

Address if different than Patient _____ City, St, Zip _____

Name of Secondary Insurance: _____ Insurance ID # _____

Who carries Insurance: _____ Relation to patient _____ DOB: _____

Address is different than Patient _____ City, St, Zip _____

In case of Emergency and we are unable to contact parent or guardian, who should we call?

Name: _____ Phone: _____

Relationship to patient: _____

I hereby authorize Pediatrics of Florence, PSC to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by this practice. I direct my insurance carrier and/or its intermediaries to issue payment directly to Pediatrics of Florence, PSC. I am aware of the financial policy of Pediatrics of Florence and I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. A copy of this is as valid as the original.

Signature: _____ **Date:** _____

PEDIATRICS OF FLORENCE
FINANCIAL POLICY

Our Doctors and staff are dedicated to providing the best possible care and treatment for your children regardless of source of payment. When the office runs efficiently and appointments are kept on time, our patients are happier. In order for this to occur and to benefit everyone involved, we have implemented the following policies.

INSURANCE

With the ever changing amount of insurance companies and plans that are offered today it is impossible for Pediatrics of Florence to be aware of what each insurance plan covers. It is important for you to be aware of what your specific plan covers. You are responsible for knowing if it covers well care, sick office visits, immunizations, and if you have a copay, coinsurance or deductible and what those amounts are. We require you to have a current copy of your insurance card at every visit. This card is a way of confirming your child's coverage. If you do not have a copy of your insurance card and cannot provide us with verification of insurance coverage, you will be treated as a self-pay account until we have received your insurance information. If we are not listed as the primary care physician on your child's insurance card, you will be required to change this with your insurance company before we can see your child.

PAYMENT

If your insurance contract requires a copayment, we will collect that at the time of service. A $10 administrative fee will be assessed for any copayment that is not paid on the date of your visit. If there is an outstanding balance on your account then your copay must be paid at time of service, No exceptions.

If your insurance is a high deductible plan, we will require a payment of $75 per child to be paid at the time of service. The remainder of the balance is due in 30 days and we will invoice you for this amount. Many deductible plans cover preventative care and we will not collect payment at these visits.

Self- pay patients are required to pay their balance in full before leaving the office.

All balances not covered by insurance must be paid in full within 30 days unless other arrangements have been made. If your balance becomes 90 days past due and you have not contacted us to make payment arrangements, we will be forced to send your account to a collection agency. You will be responsible for any collection fees or services that are charged. Once the account leaves our office, we must permanently terminate the patient/ physician relationship.

There will be a $30 charge for any returned checks and the complete balance must be paid in full within 10 days.

NO SHOW/ CANCELLATION

It is important to arrive on time and keep all scheduled appointments. If you arrive to your appointment late you may be asked to reschedule or may have to be moved to another time so that the patients who did arrive on time do not have to be kept waiting. Appointments that are not cancelled with 24 hour notice will be charged a fee of $40. We realize that emergencies do arise and if you must cancel an appointment same day, allowances will be made. If you have missed 3 appointments without cancellation within a year, you will be dismissed from the practice.

It is our primary goal to make sure that your family is well taken care of and receive the best care possible. It is the policy of this office that whoever brings in the patient is responsible for payment at the time of service. We understand that a custody decree will sometimes name one party the responsible party for medical bills. This however is matter that should be resolved between the parents outside of the office before the visit so the payment is made at the time of service. If you are sending your child to their visit with another representative such as a grandparent or relative, please call with payment prior to visit or make sure to send the payment with them.

Please read and sign below:

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and for any professional service rendered. I have read all of the above information and understand it fully. I will notify the office of any changes in medical insurance or any other personal information that I have provided on the registration forms. I certify this information is true and correct to the best of my knowledge.

I hereby authorize the physician to furnish information to the insurance carrier concerning medical services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances due in full within 30 days of receiving a statement unless arrangements have been with our billing department.

_____

Children(s) Names

_____ _____

Signature of Parent /Guardian Date

_____

Printed Name

Created 6/25/14 Revised 5/31/18

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as the Omnibus Rule and the "Health Information Technology for Economic and Clinical Health (HITECH) Act" I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

In Addition:

- Pediatrics of Florence may call my home or office and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations (TPO) such as appointment reminders, insurance items and any call pertaining to your clinical care, including laboratory results among others _____(initial)

- Pediatrics of Florence may mail or fax to my home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. _____(initial)

- Upon my request, Pediatrics of Florence may fax medication information, immunization cards, physical forms, etc. to my child's day care or school. _____(initial)

- I authorize Pediatrics of Florence to disclose immunizations to my child's school or daycare that are required to obtain proof of immunization._____ (initial)

- Pediatrics of Florence may provide my child's PHI electronically through a secure patient portal Next MD upon my request _____(initial)

A Notice of Privacy Practices has been made available to me containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Pediatrics of Florence
7409 US 42
Florence, KY 41042

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Parent/Guardian's Signature: _____

Relationship to Patient: _____

Date: _____

PEDIATRICS of Florence

We realize that the parents or legal guardians of a child may not always be available to bring the child into the office themselves. Children under the age of 18 cannot be treated without a parent or legal guardian present, due to Kentucky law.

If a parent or legal guardian cannot be present, anyone on this form is authorized to consent for treatment. This form must be completed by the parent or legal guardian.

I, _____, as parent or legal guardian of _____, give consent for the following people to authorize treatment of my child at Pediatrics of Florence. This document will remain valid unless the office notified in writing of any changes.

Authorized people:	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Parent or legal guardian : _____

Date: _____

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE ☐ M ☐ F

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, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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