PEDIATRIC PATIENT INFORMATION

PATIENT NAME _____ SEX _____ DOB_____
(FIRST) (MIDDLE) (LAST)

NAME YOU CALL YOUR CHILD_____

FATHER'S NAME_____DATE OF BIRTH_____
S.S.#_____EMPLOYER_____OCCUPATION_____
EMP. ADDRESS_____EMP. PHONE_____
CITY_____STATE_____ZIP CODE_____CELL #_____

HOME ADDRESS_____HOME PHONE #_____
CITY_____COUNTY_____STATE_____ZIP CODE_____

MOTHER'S NAME_____DATE OF BIRTH_____
S.S.#_____EMPLOYER_____OCCUPATION_____
EMPLOYEE ADDRESS_____EMP. PHONE_____
CITY_____STATE_____ZIP CODE_____CELL#_____

HOME ADDRESS_____HOME PHONE_____
CITY_____COUNTY_____STATE_____ZIP CODE_____

EMAIL ADDRESS _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone other than parent):
NAME_____RELATIONSHIP_____PHONE#_____

INSURANCE INFORMATION

1. INSURANCE COMPANY_____GROUP#_____
INSURED'S NAME_____I.D.#_____
DATE OF BIRTH_____ IS THIS INS. THROUGH YOUR EMPLOYER? _____
2. INSURANCE COMPANY_____GROUP#_____
INSURED'S NAME_____I.D.#_____
DATE OF BIRTH_____IS THIS INS. THROUGH YOUR EMPLOYER? _____

SIGNATURE_____DATE_____
PARENT OR LEGAL GUARDIAN

PATIENT AGREEMENT

Thank you for selecting Kelliwood Family Practice (KFP) as your healthcare provider. Please take a moment to review our financial policy.

By signing below, you agree to and understand the following policies:

HIPAA – Privacy Notice

I am aware that I may review Kelliwood Family Practice HIPAA privacy notice at any time and understand that I may request a copy.

_____Initials

KFP Medical Care Agreement

I authorize the physicians of KFP to administer medical treatment as deemed necessary. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. Although the doctors are participating providers with many insurance companies, it is the responsibility of the patient or guarantor to be familiar with his/her plan. We make every attempt to verify insurance eligibility and benefits prior to your visit; however, all insurance carriers state that verification is not a guarantee of payment. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits to otherwise payable to me to Kelliwood Family Practice. If we are unable to verify your benefits, payment will be due at the time of service. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance.

_____Initials

Medical Care Agreement

I authorize the physicians of KFP to instruct their Physician Assistant/Nurse Practitioner and Physical Medicine Providers to assist in certain aspects of my medical care.

I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervisions/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of KFP if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduler with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

_____Initials

Patient Name (please print): _____ DOB:_____

SIGNATURE_____DATE_____

PARENT OR LEGAL GUARDIAN

Kelliwood Family Practice Fees & Services

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Genesis Laboratories (GL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by GL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand there is a $35 fee for bounced checks and an additional $20 processing fee for balances that go in to collections.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

$10 Controlled substance prescriptions without an appointment
$25 School forms
$35 Disability forms
$45 FMLA
$25 Physician dictated letter
$25 Prior authorizations
$25+ for extensive medical records

Thank you for your cooperation.

Patient Name (please print): _____ DOB: _____

SIGNATURE_____DATE_____
PARENT OR LEGAL GUARDIAN

CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth:_____

Cell Phone#:_____Email:_____

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of your lab results and/or physician instructions and to discuss billing issues pertaining to your healthcare.

Please check the sections that apply, then sign at the bottom of the page:

_____**I do not give KFP permission** to release my information to anyone other than myself.

or

_____**I give KFP permission** to release my information with the following emergency contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please indicate how you would like to be notified with the information. (Check all that apply)

_____ Home phone #_____

_____ Cell Phone #_____

If you have and answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?
_____ YES _____ NO

_____ Work Phone #_____

If you have and answering machine, may we leave a detailed message regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?
_____ YES _____ NO

SIGNATURE_____DATE_____
PARENT OR LEGAL GUARDIAN

(A signature is required for this form to be considered valid)

Today's Date: ____ / ____ / _____

Patient Name: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Phone #: _____

Past Medical History (PMHx)			
	Yes		Yes
Abdominal Pain (Recurrent		Eczema	
Acne		GERD(spitting), digestive issues	
ADHD		Headache/Migraine (Recurrent)	
Allergy Symptoms		Heart Disease	
Anemia		High Blood Pressure	
Anxiety		High Cholesterol	
Asthma		Kidney Problems	
Bed Wetting (incontinence)		Learning Problems	
Behavior Disorder/ Problems		Pneumonia	
Bronchitis, chronic		Rash	
Cancer (Type?)		Seizures	
Chronic Ear Infection		Sleep Apnea/ issues	
Constipation		Thyroid Problems	
Depression (Recurrent)		Tuberculosis Exposure	
Developmental Delay		Urinary Tract Infection	
Diabetes (Type?)		Weight loss/gain issues	

Newborn problems (jaundice or difficulties during delivery yes no

Past Surgical History (PSHx)	
Surgery	Date

Medications (Meds)			
Drug	Dosage	Frequency	Reason

Allergies
Medications: No ____ Yes ____ (please describe):
Food: No ____ Yes ____ (please describe):
Allergic to Latex? No ____ Yes ____

Family Medical History (FMHx)										
	Mother	Father	Brother	Sister	Grandmother (Paternal)	Grandfather (Paternal)	Grandmother (Maternal)	Grandfather (Maternal)	Aunt	Uncle
Anemia										
Arthritis										
Cancer (Type?)										
Cystic Fibrosis										
Diabetes (Type?)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Kidney Problems										
Lung Problems										
Mental Problems										

Family Medical History (FMHx)										
Seizures										
Thyroid Problems										
Tuberculosis										
Learning Issues (Type)										
Behavior Issues (Type)										
Digestive Issues (EX. Constipation or Reflux)										

Social History (SHx) over 13 yrs or household	
Alcohol Use	Never ____ Current ____ Former ____
Tobacco Use	Never ____ Current ____ Former ____
Drug Use	Do you use recreational drugs? Yes ____ No ____ Any Guns kept in household Yes ___ No ___ Locked _____

Are there any guns in the child's house? Yes ___ No ___
Does the child use a toothbrush daily? Yes ___ No ___
Does the child use a car seat or seat belt all the time? Yes ___ No ___
Are there smoke detectors in the child's home? Yes ___ No ___
Is the hot water temperate less than 125 degrees? Yes ___ No ___
Do you have rules/limits for television viewing? Yes ___ No ___
Are medications and potential poisons out of reach? Yes ___ No ___
Do you have syrup of ipecac? Yes ___ No ___
Do you know child resuscitation or choking management? Yes ___ No ___