Chart#: Date of Initial Visit:

Patient History

(One Patient History form per child)

Full Name: Name child is called:

Birthdate: Gender: Nationality: Adopted? Yes No

Mother's Name: Father's Name:

BIRTH INFORMATION

Weight: Height: Full Term? Yes No If no, explain:

Problems with Pregnancy or Delivery?

Delivered where (Hospital & City):

Type of Infant Feeding (breast, formula, etc):

PREVIOUS MEDICAL HISTORY

Injuries/Hospitalizations: Operations:

Serious Illness/Conditions:

Medications Taken Regularly:

Drug Allergies/Reactions:

Developmental, learning, school hyperactivity, coordination, discipline, or personality problems?

Who was your child's last physician? (Please sign a Medical Records Release provided by the Front Desk before leaving the office – this will provide better continuity of care for your child)

Name:_____

Address:_____

Phone Number:_____

Fax Number:_____

How long was your child seen at this practice? _____

Consent for Treatment by Legal Guardian for Minor Children

As the parent or legal guardian, I _____, give permission for the above child to be seen at Northlake Children's Associates per the guidelines below (check all the apply):

____Sick Visits ____ Well Child Checkups/Physicals ____Immunizations ____Bloodwork/Procedures (as needed)

This patient may: _____Come to the office alone _____May come to the office with a responsible adult

Parent Guardian Signature:_____ Date:_____

Family History

Father's Full Name: Birthdate: Nationality/Race:

Address: City: State: Zip:

Home Phone: Cell phone: Social Security Number:

Employer: Position: Work Phone:

Mother's Full Name: Birthdate: Nationality/Race:

Address: City: State: Zip:

Home Phone: Cell phone: Social Security Number:

Employer: Position: Work Phone:

Parents (circle one) – Married Remarried Separated Divorced Single

Family History of Disease

1.___ High Cholesterol	12.___Heart Murmurs or Defects	23.___Cancer, Leukemia	34.___ Thyroid Disease
2.___Strokes/Heart Attacks	13.___Rheumatic Fever	24.___Chronic Anemia	35. ___Very short child
3.___Diabetes	14.___Asthma	25.___Bleeding (Hemophilia)	36. ___Absent Teeth (child)
4.___Deaths in Childhood	15.___Cystic Fibrosis	26.___Sickle Cell Anemia	37.___STD's
5.___Cleft Lip or Palate	16.___Emphysema by age 40	27.___Joint or Bone Disease	38.___HIV/AIDS
6.___Deafness	17.___Tuberculosis	28.___Reumatoid Arthritis	39.___Gastro-Intestinal Disorder
7.___Chromosomal Abnormality	18.___Nearsightedness	29.___Scoliosis	40.___Psychiatric Illness
8.___Down's Syndrome	19.___Blindness	30.___Multiple Fractures	41.___High Blood Pressure
9.___Congenital Defects	20.___Cataracts	31.___Muscle Disease	42.___Seasonal Allergies
10.___Developmental Disability	21.___Color Blindness	32.___Liver Disease – Hepatitis	43.___Chronic Skin Disease
11.___Seizures (Convulsions)	22.___Severely Obese	33.___ Kidney Disease	44.___Open Spine

(For any checked diseases, please give relationship to child and any other related information):_____

_____

_____

Patient Acknowledgment and Consent

I have been given a copy of Northlake Children's Associates, P.A.'s Notice of Privacy Practices. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative

Date

_____

Print Name

_____

Relationship of Representative to Patient

NCA Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record.

Are you the child's:
A. Mother B. Father C. Self (Are you the patient?)
D. Foster Parent E. Other relative
F. Grandparent
G.
Other_____

How many times have you moved in the last year? _____

Where are you living now?
A. House or apartment with family B. Shelter
C. House or apartment with relatives or friends
D.
Other_____
_____

Besides you, does anyone else take care of the child?
Yes No If yes, who?
_____

Does your child have any medical illnesses/disabilities we need to know about? Yes No
If yes, what?
_____
_____

~~How did you learn about our~~ practice?_____

Do you feel that you live in a safe place? Yes No

In the past year, have you ever felt threatened in your home? Yes No

Please briefly explain any family dynamics we should be aware of (parents separated/child alternates homes/one parent not involved/etc.):_____
_____
_____
_____
_____

What kind of guns are in your home?
A. Handgun B. Shotgun C. Rifle
D. Other_____ E. None

If you have a gun at home, is it locked up?
N/A Yes No

Does anyone in your household smoke? Yes No

Do you currently smoke cigarettes?
Yes No
If yes, how many cigarettes do you smoke per day?
_____cigarettes/day

Does anyone in your home drink

*Office Use only: Family's Chart Number:*_____

Authorization to Release Information

Authorization for Payment

I hereby authorize the release of medical information, including complete medical records, test results, and billing information to my insurance company and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review records for quality improvement initiatives, audit compliance, utilization management and complaint resolution.

I authorize the payment directly to Northlake Children's Associates, P.A. for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, coinsurance, deductibles, and non-covered services at the time the service is rendered. Your insurance may not cover the full amount for vaccines/procedures/labs provided in our office. You will be responsible for any difference that your insurance company does not cover. The amount we charge covers our costs to perform these services as a convenience to you and your family.

Also, our office is contracted with **Solstas Lab Partners/Quest Diagnostics** (Greensboro location) for all labs we send out. It is your responsibility to check with your insurance to make sure they are in network.

A photocopy of this authorization shall be considered effective and valid as the original. By signing this form, I acknowledge that I have read and understood the statements above and will be responsible for any outstanding fees that aren't covered by my insurance company.

_____ _____

Signature of Parent/Legal Guardian Date

Insurance Information (please bring your insurance card to EACH visit at our office):

Name of Insurance Company:_____

Name of Patient(s):_____

Name of Policyholder:_____

Policyholder's DOB:_____

Name of Employer (if applicable): _____

Mailing address of Insurance Company:_____

Acct#

PATIENT RECORD OF DISCLOSURE

Home telephone: _____ Cell phone number:_____

Who's number is this: _____ Who's number is this:_____

___OK to leave a message with detailed information ___OK to leave a message with detailed information

___Leave message with call back number only ___Leave message with call back number only

Work telephone: _____ Other number:_____

Who's number is this: _____ Who's number is this:_____

___OK to leave a message with detailed information ___OK to leave a message with detailed information

___Leave message with call back number only ___Leave message with call back number only

1. If any of the above numbers belong to grandparents, family members, close family friends, etc., can we go over lab results or appt information with them?

____YES ____NO _____Not Applicable

2. May this patient come to the office with a responsible adult whom the parent/guardian has appointed (this includes other family members/grandparents/close friends):

____YES ____NO (if you marked no, see question 4 below)

3. If the patient does come to the office with a responsible adult, may we share medical history/lab results with them if medically necessary? ____YES ____NO

Acct#

4. Is there anyone this patient may not **legally** come to the office with and/or with whom information cannot be disclosed? If yes, please name individual(s) below (note that you will need to provide documentation of this):

_____

5. If a parent/guardian requests, may we fax excuse slips/authorized school forms to the patient's school? In this instance, parents may be required to provide correct the school name and fax number.

____YES ____NO

PLEASE NOTE: You will be asked to verify patient's phone number/address at <u>each visit</u> to our office. Please make sure to check information and then you will be asked to quickly update this form. If you do not notify the front desk of any changes, we cannot be held responsible for information left on a voicemail noted above, or verbally given to a parent/guardian/responsible party listed above. Thank you for your compliance!

SIGNATURE:_____ RELATIONSHIP TO PATIENT:_____

Date: _____

Chart_____

FINANCIAL POLICY FOR NORTHLAKE CHILDREN'S ASSOCIATES

We would like to take this opportunity to state our financial policy. If you have specific questions, we will be happy to assist you further.

- We are contracted with several insurance companies and will bill these insurance companies directly for those patients enrolled with these plans. If you do not have insurance coverage or we do not have a contract with your insurance company, it is expected that any fees be paid in full before services are rendered. The front desk will go over self-pay fees anytime they are asked.
- You must be prepared to provide your insurance card at each visit and notify the front desk of any changes to your plan/coverage.
- We can provide you with a detailed summary of charges to submit to your insurer for your reimbursement upon request.
- You are responsible for any co-insurance, deductible and co-payments based on your plan. If your insurance requires you to pay a co-payment, this *MUST* be done at the time services are rendered
- You will receive statements in the mail if you have a balance with our office. We will charge a $25 administration fee to your account for all overdue accounts
- You understand that you are financially responsible for any services that are not covered by your insurance plan.
- If your child is here for a well child check but is sick and needs to be seen for those issues, it is likely that the WCC will need to be rescheduled. Insurances are no longer accepting both visits to be done the same day. If you need them both to be done, just be aware that your insurance will bill you for the sick visit and you will also be required to pay a co-pay to our office (if you did not have one for the well check).
- We accept only Medicaid as a secondary insurance.
- In accordance to NC general assembly rule §90-411: We do charge a record copy fee (this includes transferring records) of $10. We do offer to fax records for free.
- If a check is returned due to insufficient funds or a debit has insufficient funds, the office will only accept cash or credit card payment thereafter and you will be obligated to pay a fee of $35.00.
- For your convenience, we are able to keep flex spending and a credit card on file.

I have read the above information and understand my financial obligations**.**

Parent/Patient Signature:

_____

Date: _____

CHART_____

CANCELLATION & NO SHOW POLICY

We strive to provide the best medical care for our patients. While we make every effort to provide prompt on-time service, the healthcare needs of each individual do not necessarily lend themselves to an exact schedule. We therefore appreciate your understanding and patience. If you have any suggestion or complaint for our office, please let us know in a constructive way. Angry or foul language directed to our staff, regardless of the issues involved, will absolutely not be tolerated and may be grounds for immediate dismissal from our practice.

If you are unable to keep a scheduled appointment, please let us know in advance. A NO SHOW is when a patient fails to keep a scheduled appointment. We make every effort to provide prompt medical care to all of our patients. Therefore, Northlake Children's Associates reserves the right to charge the fees displayed below:

- First missed appointment: there will be no charge
- Second missed appointment: a $20 fee will be billed to your account
- Third missed appointment: a $40 fee will be billed to your account and you may be discharged from our practice

In the event that you have a special circumstance regarding your missed appointment, please let our front desk staff know. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. Any significant delay may require the visit to be rescheduled.

Please sign that you have read, understand, and agree to this Cancellation and No-Show Policy.

Printed Name: _____

Signature:_____ Date:_____

8/2016