Mt. Washington Pediatrics Patient Information

Patient Information:

Name:_____

Date of Birth: _____ Sex: M / F **Mother's Maiden Name:** _____

Address:_____

City:_____ State:_____ Zip:_____

Home #: _____

SIBLINGS:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

****Preferred Pharmacy (Name, Address, Phone Number and/or Cross Street):**

_____

Parents or Guardians:

Child lives with: Mother____ Father____ Other_____

Mother's Name:_____ DOB _____

Relationship to Child: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone _____ Cell Phone: _____

E-Mail: _____

Father's Name:_____ DOB _____

Relationship to Child: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone _____ Cell Phone: _____

E-Mail: _____

Alicia Anderson, APRN, NP
138 Eastbrooke Court, Suite 115
Mount Washington, KY 40047
(502) 617-4068

Mt. Washington PEDIATRICS

Emergency Contact:(other than Parent/Guardian NOT living with you)
Name: _____ **Relationship**: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Insurance through: Mother___ Father___ Other: _____ Effective Date: _____

Subscriber Name: _____ Subscriber DOB: _____
Primary Insurance: _____
ID Number:_____ Group Number: _____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____

HOW DID YOU HEAR ABOUT US: *Please take a moment and let us know ~ THANK YOU!*
___Friend / Family Referral ___Internet Search ___Chamber of Commerce __Facebook __Norton Cares
___OB/GYN Referral ___Norton Hospital _____Other _____

Alicia Anderson, APRN, NP
138 Eastbrooke Court, Suite 115
Mount Washington, KY 40047
(502) 617-4068

Mt. Washington PEDIATRICS

Name: _____ Date of birth: _____

Permission to Discuss PHI: I authorize Mt. Washington Pediatrics and its agents to release my protected health information to the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Consent to Treatment: I understand that as part of my healthcare, Mt. Washington Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- 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.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand Mt. Washington Pediatrics reserves the right to change their notice and practices, a current version of which is available on the Mt. Washington Pediatrics Web site (https://www.gertitashkomd.com). I also understand that I have the right to restrict how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Mt. Washington Pediatrics is not required to agree to the restrictions requested. I have the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. Such request must be in writing and Mt. Washington Pediatrics will accommodate any reasonable requests. By providing a cell number, I agree that Mt. Washington Pediatrics, its affiliates, or those acting on their behalf, may call or text using an automatic telephone dialing system and/or a prerecorded message. With this consent, Mt. Washington Pediatrics may call my home, cellular telephone, or other designated location and leave a message on voice mail or in person in reference to any items that assist Mt. Washington Pediatrics in carrying out treatment, payment, and operations activities, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results. With this consent, Mt. Washington Pediatrics may mail to my home or other designated location any items that assist Mt. Washington Pediatrics in carrying out treatment, payment, and operations activities, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Mt. Washington Pediatrics may e-mail and text me appointment reminders and patient statements. By signing this form, I am consenting to Mt. Washington Pediatrics's use and disclosure of my PHI to carry out my treatment, payment, and operations activities. I may revoke my consent in writing except to the extent that Mt. Washington Pediatrics has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Mt. Washington Pediatrics may decline to provide treatment to me.**

Mt. Washington PEDIATRICS

Insurance Authorization: I authorize the release of any medical information to any insurance company, Medigap Insurance, third party administrator, or other payer that is necessary to process the claim and request payment of benefits either to myself or to GT Health. I authorize Mt. Washington Pediatrics and its agents to release medical information contained in my medical record to any insurance companies, federal programs or state programs with which I am insured or who are responsible for payment of my claim. If applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished to me by or in Mt. Washington Pediatrics including physician services. I understand that I am financially responsible for all charges, whether or not covered by insurance. Also, if my account has to be turned over to an attorney or collection agency for collections, I agree to pay all costs of collection including attorneys' fees.

Assignment of Benefits: In consideration for healthcare and subsequent services provided to me by Mt. Washington Pediatrics, I hereby assign to Mt. Washington Pediatrics and any holder of medical or other information about me, and their agents, any and all rights, benefits, and claims I may have under any policy of insurance and the proceeds from any claim that I may have for injuries. Such assignment hereby authorizes direct payment to Mt. Washington Pediatrics under and/or from any such policy of insurance or proceeds. I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked in writing by me.

Virtual Check-Ins: For established patients and when appropriate, Mt. Washington Pediatrics may offer brief communication technology-based services, i.e., phone consultations. I consent to virtual treatment if I and my provider agree it is the most appropriate method of treatment. I understand that there is a fee for this service and I will be responsible for the copay and any co-insurance due per my health insurance policy.

PRINT PATIENT NAME: _____ _____ _____

PATIENT SIGNATURE _____DATE _____

PARENT/GUARDIAN NAME (PRINT) _____
(If Patient is a minor, under age 18)

PARENT/GUARDIAN SIGNATURE _____DATE _____

Mt. Washington Pediatrics
Payment Plan Policy

UNDER $100	If balance is $100 or less then patient must pay 20% down and the remaining balance should be paid in equal installments over the next 2 months
FROM $101- $200	If balance is between $101 and $200, the patient must pay 20% down and the remaining balance should be paid in equal installments over the next 3 months
FROM $201 - $300	If balance is between $201 and $300, the patient must pay 20% down and the remaining balance should be paid in equal installments over the next 4 months
FROM $301 - $400	If balance is between $301 and $400, the patient must pay 20% down and the remaining balance should be paid in equal installments over the next 5 months
	If balance is over $401, the billing manager will discuss arrangements with the patient.
	As a tool, employees can offer a 10% discount to entice the patient to pay the entire amount if the balances is greater than $300.

Mt. Washington PEDIATRICS

Pediatric Health History Form – Initial Visit

Child's Name _____ Date of Birth _____ Age _____ Male _____ Female _____

Mother's Name _____ Father's name _____

Form filled out by _____ Date _____

Child's Past Medical History

Pregnancy/Neonatal Period

Where was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Pregnancy complications _____

Delivery by ☐vaginal ☐c-section

Reason for c-section _____

Complications _____

Was your child premature ☐No ☐Yes, born at _____ weeks

Complications _____

Apgar scores 1 minute _____ 5 minutes _____

Birth weight _____ Length _____

Other problems in the newborn period _____

_____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with: (explain)

- ☐ Asthma or reactive airway disease _____
- ☐Wheezing or bronchiolitis _____
- ☐ Seasonal allergies or eczema _____
- ☐ Food allergy _____
- ☐ Recurrent ear infections _____
- ☐ Pneumonia _____
- ☐ Urinary tract infections _____
- ☐ Genetic syndrome _____
- ☐ Seizures _____
- ☐ Anemia _____
- ☐ Broken bone _____
- ☐ Mental retardation or learning disability _____
- ☐ Depression/anxiety _____

Other chronic medical conditions _____

_____

Has your child ever been hospitalized ☐No ☐ Yes (explain)

_____

_____

Previous surgeries and dates _____

_____

Previous pediatrician _____

Please list any specialist your child is currently seeing and reason:

_____

_____

Social History

Who lives in the child's household? ☐ Mom ☐ Dad ☐ Step_____

☐ Siblings (# _____) ☐ Grandparents ☐ Other _____

Mother's occupation _____

Father's occupation _____

Child's parents are ☐ married ☐ unmarried ☐ divorced ☐ other

Childcare ☐ parents ☐ relatives ☐ daycare ☐ babysitter/nanny

Days per week in childcare (not with parents) _____

School's name _____ Grade _____

Any concerns about school performance? ☐ No ☐ Yes, explain

_____

Do any household members smoke ☐ Yes ☐ No

How many hours per day does your child spend:

Watching TV _____Computer _____Video games _____

Sports/exercise: Type _____

How often? _____ How long _____min

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives. _____

_____

_____

_____

Mt. Washington PEDIATRICS

Medications

ALLERGIES to medicine/vaccines (list and describe reaction)

_____

_____

Current medications and dose: _____

_____

_____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Development/Nutrition

At what age did your child:

Walk alone _____ Sit alone _____

Toilet train(day) _____ Say words _____

1st period (females) _____

Was your child breastfed ☐ No ☐Yes, how long? _____

Has your child had any unusual feeding/dietary problems? Explain.

_____

_____

Review of Systems (*Check all that apply*)

Constitutional

☐ Fever, chills ☐ Fatigue

☐ Unexplained weight loss/gain

☐ Excessive thirst

Ear, Nose, and Throat

☐ Loud voice, hearing problem

☐ Mouth-breathing, snoring

☐ Ear pain

☐ Frequent runny nose

Respiratory

☐ Cough, short of breath

☐ Chest tightness, wheeze

Musculoskeletal

☐ Muscle pain, weakness

☐ Joint pain, swelling

☐ Bone pain

Other (eye,skin,blood)

☐ Blurry vision ☐ Squinting

☐ "Crossed" eyes ☐ Itchy eyes

☐ Rashes ☐ Abnormal moles

☐ Abnormal bruising, bleeding

Gastrointestinal

☐ Nausea, vomiting, diarrhea

☐ Constipation, blood in stool

☐ Abdominal pain

Cardiovascular

☐ Chest pain, palpitations

☐ Tires easily with exertion

☐ Fainting

Genitourinary

☐ Frequent or painful urination

☐ Bedwetting, frequent accidents

☐ Vaginal or penile discharge

Neurologic

☐ Headaches ☐ Seizures

☐ Clumsiness ☐ Milestone delay

Psychiatric/emotional

☐ Anxiety/stress ☐Depression

☐ Sleep problem ☐ Anger concern

☐ Concerns with attention, impulsivity