Milestone
pediatrics, inc

We are beyond excited and honored that you have chosen our team at Milestone Pediatrics, Inc. to care for your child! We take great pride in our mission and we value your confidence in our team.

To return your paperwork please choose from the following:

-Email to info@milestone-pediatrics.com

-Fax to (559) 746-7746

Or you may drop off during business hours. We apologize for the inconvenience we cannot make any appointments until all insurance information including copies of insurance (front/back) and photo ID are submitted with completed paperwork. This is so that we can ensure there are no insurance issues and no additional information needed prior to scheduling.

Please watch for a text message to set up your patient portal!

This is a very easy & important method of communication between us.

Username: Cell phone with area code

Password: whatever you choose it to be

Access to the portal at mspeds.pcc.com/portal or via our website www.milestone-pediatrics.com

Milestone pediatrics, inc

Today's Date_____ Previous Primary Care Provider_____

Patient's Name_____ Date of Birth_____

Mailing Address_____

City _____State_____ Zip _____ Male____ Female____

Cell# for Appt Reminders_____Email_____

Portal Access: Please circle Mom / Dad / Both

How did you hear about us? Friend/Family:_____Advertisement:_____

Insurance company website:_____Other:_____

Mother: ___Married ___ Divorced ___Physical Custody ___Joint/Legal custody ___ Sole/Legal custody

Name: _____ DOB_____ SS# _____

Home Phone_____ Cell Phone_____ Work Phone_____

Employer Name & Address_____

****

Father: ___Married ___ Divorced ___Physical Custody ___Joint/Legal custody ___ Sole/Legal custody

Name: _____ DOB_____ SS#_____

Home Phone _____Cell Phone_____ Work Phone_____

Employer Name & Address_____

Primary Insurance Co. Name_____

Subscriber_____DOB_____

Relationship to patient _____

Member ID#_____Group#_____

Secondary Insurance Co. Name_____

Subscriber_____DOB_____

Relationship to patient _____

Member ID#_____Group#_____

Responsible Financial Party/Guarantor for Patient's Acct: Mother _____Father_____

Emergency Contact who is **NOT** a parent and this does not give permission for this person to bring to appointments, this is for contact purposes only, in event of an emergency and a parent cannot be reached.

Name _____Relationship:_____Phone:_____

Parent/Guardian Signature: _____

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Vaccine Policy

We firmly believe in the effectiveness and importance of vaccines to prevent serious illness and death. We firmly believe in the safety of our vaccines. At Milestone Pediatrics, Inc. we adhere to the vaccine schedule that is published by the Centers for Disease Control and the American Academy of Pediatrics. If you choose to research vaccines, we do encourage all parents to visit websites with reliable and scientific information/data. We do not require the Influenza, Covid-19, or HPV (Gardasil) vaccines. We are always happy to answer any questions or concerns you may have about childhood vaccinations. If you wish to do an alternate schedule, please ask the receptionist for a copy, it is our only approved alternate schedule.

I acknowledge that if I change my mind after establishing care with Milestone Pediatrics, Inc, and do not adhere to their schedule options, I understand that my child(ren) will be discharged. **Initials:**_____

Patient Name:_____DOB:_____

Parent Name:_____Date:_____

****If you wish to review our alternate immunization schedule, please as the receptionist for a copy.**

Financial Policy

• Milestone Pediatrics, Inc does not allow patients to incur balances on an account. Co-pays must be collected at time of service as required by our insurance contracts. Any account balance **MUST** be paid at the time services are rendered. Milestone Pediatrics, Inc reserves the right to reschedule your appointment if you do not have payment or do not have a method of secure payment on file for co-pays, co-insurance, deductible amounts, or balances on the day of your appointment.
X_____(Initials)

We realize that temporary financial problems may affect timely payment and we will be happy to assist you in the management of your account. A payment plan, if eligible, may be set up however, no further appointments will be allowed until the account is paid in full. Interest will be applied. Any billing questions can be directed to our in-house billing specialist, Melissa at melissa@milestone-pediatrics.com. You may also use your portal account to address billing questions.

•If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 50% of the collection balance. Our billing company will make EVERY effort to resolve or help you with balances and payment plans, if needed.
X_____(Initials)

• PLEASE LET US KNOW IF YOU HAVE MEDI-CAL AS A SECONDARY, YOU WILL NEED TO SIGN AN ADDITIONAL FORM.

• If you have a private, Exclusive Provider Plan (EPO) or Employer Group HMO ie Foundation for Medical Care or Key Medical you will need to assign your child to a primary care provider with Milestone Pediatrics. We will not be able to provide services if this has not been completed or has changed with/without your knowledge. You are responsible for doing so, NOT Milestone Pediatrics Inc.
X_____(Initials)

• You are responsible for confirming that we are in your Insurance Plan Network regardless of if we accept your insurance, that does NOT mean we are in your particular plan network. X_____(Initials)

•If your insurance has requested a Coordination of Benefits (COB), we ask you to respond to these immediately. This indicates that any prior visits/claims have not been paid to us while waiting for your

response. If you do not respond in a timely matter, no further appointments will be allowed, until we have confirmation that you have handled this matter. X_____(Initials)

•If you do not have insurance, please come prepared to pay at the time of service. A price list of services is available upon request and is subject to change.

•Returned checks are subject to a $30 charge for non-sufficient funds.

No-Show/Late Cancellation (less than 24 hours) fees are as follows:

$50.00 for a missed general appointment

$75.00 for a missed Well-Child Exam

Other fees are as follows:

Entire Medical Record Copy (Parent Request)	0.25 cents per page up to $25.00
Typed Letters (parents request)	$25.00
Disability/Insurance Form (Per form)	$15.00
School/Work Excuses (greater than 72 hours from appointment)	$5.00
Forms (ie school /sports physical) greater than 30 days from appt	$5.00

X_____(Initials)

We require 48 business hours (excluding weekends) for any request of copies and signed forms.

We realize that temporary financial problems may affect timely payment and we will be happy to assist you in the management of your account. Any billing questions can be directed to our in-house billing specialist, Melissa at melissa@milestone-pediatrics.com. You may also use your portal account to address billing questions.

You also authorize Milestone Pediatrics, Inc to bill your insurance company and a copy of this authorization can be considered an original for insurance purposes. You are consenting to and authorize all examinations, treatments, and medical services by Milestone Pediatrics, Inc. and their staff, which may be deemed advisable.

Please sign below stating that you have read, understand and agree to abide by all Milestone Pediatrics policies and financial agreement.

Signature of Parent/Legal Guardian

_____**Date** _____

Print Name of Parent/Legal Guardian

_____**Relationship** _____

Milestone pediatrics, inc

Office Policies

Thank you for choosing Milestone Pediatrics as your child's health care provider. We are committed to providing your family with the best possible pediatrics care. Your signature at the end of this document will indicate that you have read, understand, and agree to the policies outlined below and that you will be financially responsible for any and all charges not paid by your insurance. Feel free to contact our office to clarify any of the information prior to submitting your new patient forms.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship.

• Newly accepted applicants are not considered patients until they have been seen by a provider for an appointment.

• Any patient that has had a three-year absence and has not had an appointment by a provider in our office will be considered a new patient. Former patients that would like to be reestablished as patients will need to go through our New Patient process and be reaccepted.

• We keep same day appointments available for our patient's acute care needs. However, you may need to see a provider other than your regular provider for these appointments depending on schedules. We assure you, the care you receive from any of our providers will be exceptional.

• Milestone Pediatrics has a no-show/late cancellation policy. Any time you fail to give us a 24-hour notice of a cancellation, the missed appointment may be considered a No-Show Appointment. (Please refer to financial policy for fees). More than three (3) No-Show appointments in a one-year period may result in termination of our relationship. **X_____(Initials)**

•Our system does attempt to send appointment reminders via text when made more than 2 days in advance, however not even technology is perfect. Claiming to have not received a text message appointment reminder is not a valid excuse to have missed an appointment or a reason that we waive no show fees. We thank you for your understanding! **X_____(Initials)**

•We kindly ask that when you make your appointment that let the receptionist know of any and all concerns. This ensures we allow enough time to address your concerns while still respecting the time of the patients that follow.

• Patient's arriving more than 5 minutes late for a scheduled non-urgent appointment and 10 minutes for a well child check will be asked to reschedule and may be subject to missed appointment fees. **X_____(Initials)**

•Our system does attempt to send appointment reminders via text when made more then 2 days in advance, however not even technology is perfect. Claiming to have not received a text message appointment reminder is

not a valid excuse to have missed an appointment or a reason that we waive no show fees. We thank you for your understanding! **X_____(Initials)**

•Please bring your insurance card and ID EVERY time. **X_____(Initials)**

•**NEWBORNS ONLY** – must be added to insurance within 30 days of their date of birth. They are "covered for the first 30 days" but this does not mean ENROLLED. 30 days is a grace period from your insurance provider. We will make every attempt to remind you prior to the 6-8 week well-child check, however this is the parent's responsibility and we are not responsible for any charges that may occur. We may have to reschedule a visit should insurance not be active. **X_____(Initials)**

•Our patient portal is a highly efficient and effective way of communicating during and after business hours however this is not meant as a way to conduct a visit, nor an appropriate way in which to discuss all questions/concerns. You may be asked to schedule an appointment. As well, excessive use may result in termination of this method of communication. We thank you for your understanding! **X_____(Initials)**

•If your child is pending lab, imaging, referrals, or other results and you haven't heard from us with in a timely matter, please reach out via the portal. Please do not assume that no news is good news as sometimes we do not receive your results via fax as we should. **X_____(Initials)**

Signature of Parent/Legal Guardian

_____**Date** _____

Print Name of Parent/Legal Guardian

_____**Relationship** _____

Milestone pediatrics, inc

Medical History Questionnaire

Patient Name:_____ **Nickname:**_____

Sex: M / F **Date of Birth:**_____ **Completed by:**_____

Medications	Dose	Frequency

****Turn over page if more space needed**

Pharmacy choice and location:_____

Allergies & Please describe reaction (Medication, Food or otherwise):_____

As far as you know, are your child's immunizations up to date? Y/N

Birth History:

Birth Weight:_____Born at Term: Y/N If no, how many weeks:_____ Twin or multiples:_____
NICU: Y/N Where:_____ Adopted: Y/N _____ Birth Hospital:_____
Vaginal Or Caesarean (Circle One) If cesarean, why? _____
Pregnancy Complications: _____

Medical History: Please indicate with X if your child has had any of the below, and then explain below:

_____Asthma/Allergies	_____Heart or Lung condition	_____Headaches
_____Neurological condition ie seizure	_____Diabetes	_____Concussion
_____Anemia or blood disorder	_____Recurrent infections ie ear	_____Injuries ie fracture
_____Constipation or abdominal condition	_____Skin Conditions ie Eczema	_____Urinary or Bladder Conditions
_____Eye Condition	_____Genetic Conditions	_____Infectious Diseases ie Tuberculosis
_____Ear Condition	_____Developmental Delays	_____Thyroid Disorder
_____Bone Disorders ie scoliosis	_____Sleep Problems ie snoring	_____Anxiety or Depression
_____Cancer (list below)	____Other (list below)	

Please explain any of the above marked with an "X":_____

_____

_____

Surgeries (If yes, please provide date, location, and type of surgery):_____

Hospitalizations: (If yes, please provide date, location, and reason)_____

Approximate date of last Well Child Check:_____Immunizations up to date: Yes/No

Biological Family History: (If unknown, please check this box ☐)

****Please circle the condition that runs in the family and write the family member beside ie "mom", or "maternal aunt" etc**

Asthma/Allergies _____Anxiety or Depression_____ Anemia or blood disorder_____

Bone Disorders ie scoliosis_____ Constipation or abdominal condition_____ Cancers (type)_____

Diabetes_____Developmental Delays_____ Eye or Ear Condition_____ Genetic Conditions_____

Heart or Lung condition_____ Headaches or Neurological condition ie seizure_____

Injuries ie fracture or Concussions_____ Infectious Diseases ie Tuberculosis_____

Recurrent infections ie ear_____Skin Conditions ie Eczema_____ Sleep Problems ie snoring_____

Thyroid Disorder_____Urinary or Bladder Conditions_____Other_____

Social History:

Parents: (circle one) Married/Divorced/Separated If divorced/separated, how long?:_____

Who lives at home? (List below) Name of School:_____

Name	Age	Relationship

Are there any social issues / concerns you have regarding your child? (Please comment below) Ie bullying, drug/alcohol usage, custody issues, behaviors towards others,

abuse:_____

_____

Other:_____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

From Previous Primary Care Provider/Specialists/Hospitals

SECTION A: Must be completed for all authorizations. I hereby authorize the use/disclosure of my information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of authorization is as valid as the original.

Note: Request form and medical record inquiries may be emailed to info@milestone-pediatrics.com but we may not send your records back via email in order to comply with HIPAA privacy laws. Thank you for your understanding.

Patient Name:_____ **Date of Birth:**_____

Person(s)/organization authorized to use/disclose the information is

Name of Provider or facility :_____

Address:_____ City_____ St_____ Zip_____

Phone:_____ Fax#:_____

Email:_____

Person(s)/organization authorized to use/disclose the information (**To**):

Name: Milestone Pediatrics, Inc.

Address: 3435 S. Demaree, Ste A **City:** Visalia **State:** CA **Zip:** 93277
Phone: (559) 746-7337 **Fax#:** (559)746-7746

SECTION B: Need copy of records for (Please check one):
___Personal Use ___Moving ___School ____Changing Providers

SECTION C: Check information that may need used/disclosed:
(Please check one & include dates if appropriate or additional information at the bottom):

___Entire Medical Record	___Immunization Record	___Record Visit(s)
___PE/History report	___Laboratory Report	___Radiology Report
___Medication Record	___Mental Health	___ Consultation Report

Specific Dates or Other Requests_____

SECTION D: **Check which format you want to request:** Paper (Parent Picks up)_____ or Faxed _____

_____ _____
Signature of Patient Representative Date

_____ _____
Printed Name Relationship to Patient

Milestone Pediatrics, Inc.
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(559)746-7337 **Fax (559)746-7746** Email: info@milestone-pediatrics.com