

## Village Pediatrics Medical History Form

<b>PATIENT NAME:</b>	<b>DATE OF BIRTH:</b>
<b>ALLERGIES:</b>	
<b>CURRENT DIAGNOSES:</b>	

### PAST MEDICAL HISTORY: Please check box and explain

Serious Injury/Accident		Eye Condition/Corrective Lenses	
Surgeries		Problems w. Ears/Hearing	
Hospitalizations		Skin Problems (acne, eczema, etc)	
Frequent Ear, Throat, Sinus or Other Infections		Anemia or other Bleeding Problem	
Allergies		Seizures, Developmental Delays, ADHD, or other Neurological Disorder	
Asthma/Wheezing		Mental Health Issues or Concerns	
Heart Murmur or Condition		Orthopedic Problem	
Abdominal Pain or GI Condition		Diabetes, Thyroid or other Endocrine Problem	
UTIs or other Urologic Problem		Other Significant Problem	

### FAMILY HISTORY: Please specify which family member and if applicable, maternal (mom's side) or paternal (dad's side).

Allergies		Headaches/Migraines	
Asthma/Lung Condition		Mental or Developmental Delay	
Heart Disease or Condition		GI or Liver Disease	
High Blood Pressure		Kidney Disease	
High Cholesterol		Hearing Impaired	
Diabetes, Thyroid or other Endocrine Problem		Vision/Eye Problem	
Cancer (specify type)		Immune Problem, Recurrent Infections, HIV/AIDS, Etc	
Anemia or Bleeding Disorder		Drug/Alcohol Abuse	
Epilepsy, ADHD, or other Neurological Condition		Mental Illness	

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Medical History Form

SOCIAL HISTORY/ HOME ENVIRONMENT:			
Lives with Intact Family?			
Non-Intact Custody Status			
Visitation Status of Non-Custodial Parent			
Siblings? How many?			
Any Pets? What kind?	Yes	No	Type:
Any Smokers in the home?	Yes	No	Indoors
Any Guns in the home?	Yes	No	Decline to Answer
Are Guns locked and separate from ammunition?	Yes	No	
PARENTS' STATUS:			
Parents' Marital Status:	Married	Divorced	Single Other:
Mother's Occupation:			
Father's Occupation:			

BIRTH HISTORY: (IF UNDER 1 YEAR)		
Gestational Age:	Birth Wt:	Discharge Wt:
Delivery Method: Vaginal or C-Section	Reason for C-Section:	APGAR Scores:
Hep B Given in Hospital? Yes No	Newborn Hearing Screen: Pass Fail	Birth Hospital/Name of OB/GYN:
Any pregnancy or delivery complications?		

## Village Pediatrics Patient Registration Form

<b>PATIENT INFORMATION</b>			
Child's Full Legal Name (Last, First, Mid)	Date of Birth	Sex	Preferred Name
Child's Home Address (Street, City, State, Zip)	Telephone #	Parent's Email Address	
Other Children in Family (Name/DOB): 1. 2. 3. 4. 5.	Race: <input type="radio"/> African American/Black <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Caucasian/White <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Other _____	Ethnic Group: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	
	Patient's Primary Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____		
	Parent's/ Legal Guardian's Primary Lang: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____		
<b>EMERGENCY CONTACTS</b>			
Mother's Name	Phone #:	Alternate Phone #:	
Mother's Home Address (if different from patient)			
Father's Name	Phone #:	Alternate Phone #:	
Father's Home Address (if different from above)			
Additional Contact's Name	Relationship to Patient	Phone #	
Additional Contact's Address			
Who may we thank for referring you to our practice?			
<b>GUARANTOR INFORMATION (Person financially responsible)</b>			
Name	Date of Birth	Relationship to Patient	
Street Address (if different from patient)		Phone Number	
Employer Name/Address		Work Phone Number	
<b>INSURANCE INFORMATION</b>			
Insurance Name/Type	Claims Address	Telephone #	
Subscriber/Member ID	Group #	Patient Relationship to Subscriber	
Subscriber's Name		Subscriber's Date of Birth	
Subscriber's Address (if different than guarantor)		Subscriber's Employer	

# Village Pediatrics, P.C.

## Patient Contact Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

Patient Names: \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I wish to be contacted in the following manner (check all that apply):

Home Telephone: \_\_\_\_\_

O.K to leave message with normal results

or

Leave message with call back number only

Work Telephone: \_\_\_\_\_

O.K to leave message with normal results

or

Leave message with call back number only

Cell Phone: \_\_\_\_\_

O.K to leave message with normal results

or

Leave message with call back number only

Written Communication:

O.K to mail to my home address

O.K to leave test results with:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT OF CHILD  
IN ABSENCE OF PARENT/LEGAL GUARDIAN**

*Child's Name:*

*Date of Birth:*

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*Authorization Given To:*

*Name:----- Relationship to Child-----*

*Name:----- Relationship to Child-----*

*Name:----- Relationship to Child-----*

*Name:----- Relationship to Child-----*

*I, the undersigned parent or legal guardian of the above named child, give permission to the adult(s) named above to act on my behalf to obtain medical care and treatment for my child as deemed advisable by the providers at Village Pediatrics.*

*Parent/Legal Guardian:----- Date:-----*

## OFFICE/FINANCIAL POLICY

Our goal at Village Pediatrics is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. On arrival at your first visit, you will need to provide your driver's license or other form of government identification.
3. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
4. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances. All outstanding balances must be paid prior to scheduling any further visits.
5. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**
6. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
7. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
8. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
9. Co-payments are due at time of service.
10. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
11. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 60 days will be charged a \$10 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
12. We require 24-hour notice for canceling any appointments. There is a **\$35** charge for appointments if they are not canceled OR if 24-hour notice is not given.
13. A **\$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
14. We charge **\$15** per child to copy or transfer medical records.
15. One school, camp, or sports form will be completed free of charge if brought to your well child check/sports physical. If your child needs any additional forms to be completed there is a **\$5** charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms.
16. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
17. Before making an annual physical appointment, check with your insurance company to confirm the visit will be covered as a well child check or preventative care visit. Not all plans cover annual

physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

18. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
19. We require a parent or legal guardian to accompany the child to all visits unless specifically designated on the Authorization to Treat form.
20. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. We will NOT call in medications after-hours.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Responsible party's name

\_\_\_\_\_  
Relationship to child (parent/legal guardian)

\_\_\_\_\_  
Responsible party's signature

\_\_\_\_\_  
Date

## PRIVACY NOTICE

I have read and understand Village Pediatrics' Privacy Notice. My signature below is my acknowledgment that I have been provided access to this policy.

Patient Name: \_\_\_\_\_

Responsible party's name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Responsible party's signature: \_\_\_\_\_

Date: \_\_\_\_\_

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This form applies only to the release or disclosure of your health information. It is not consent for treatment and is not intended for any other purpose.

By signing this form, I authorize the release or disclosure of the protected health information (PHI) described below:

**TO: Village Pediatrics, P.C.** **FROM: Pediatric Office/Doctor**  
Name: 1862 Auburn Road, Ste 107 Name: \_\_\_\_\_  
Address: Dacula, GA 30019 Address: \_\_\_\_\_  
PH 678.288.4142 FAX 678.288.4143

Reason for transfer: \_\_\_\_\_

**Note: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization.**

Patient(s) full name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*\*Our office requires 3 to 5 business days to copy medical records and there is a \$15.00 fee.**

I authorize the following information to be sent to the address above:

\_\_\_\_ Copies of all records for the period  
\_\_\_\_ Copies of the information described below  
\_\_\_\_ Problem list & vaccine record From \_\_\_\_\_  
\_\_\_\_ History & physical examination To \_\_\_\_\_  
\_\_\_\_ X-ray reports  
\_\_\_\_ Lab reports  
\_\_\_\_ Other (please specify)

I understand that this information is of personal medical nature and may include any history of or references to Acquired Immunodeficiency Syndrome (AIDS); Sexually Transmitted Diseases (STDs); Human Immunodeficiency Virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released, even if occurring during dates above: \_\_\_\_\_  
Special requirements: certified mail, extended expiration date, and the like: \_\_\_\_\_

I have been provided a copy of Village Pediatric P.C.'s notice of privacy practices and am aware that there are charges for copies of records made pursuant to this authorization. I understand that Village Pediatrics P.C. assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Village Pediatrics P.C. from all legal liability that may arise from release of my information under this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(parent or legal guardian)

The patient or their representative may revoke this authorization by notifying in writing to Village Pediatrics P.C. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Village Pediatrics P.C.

Prepared by: \_\_\_\_\_ Date sent out: \_\_\_\_\_

**\*\*\*\* PLEASE DO NOT FAX RECORDS OVER 15 PAGES \*\*\*\***