Firefly After Hours Pediatrics
1011 High Ridge Road
Stamford, CT 06905
203-968-1900

PEDIATRIC HEALTH HISTORY **TODAY'S DATE:** ________________

Child's Name: ____

Child's Date of Birth: ________________ Child's Age: ____________ Gender: Male / Female

WHY IS YOUR CHILD HERE TODAY?

IMMUNIZATIONS:

Are your child's immunizations (shots) up to date? YES NO

Has your child had the flu shot in the last 6 months? YES NO

ALLERGIES:

Is your child allergic to Penicillin? YES NO

Is your child allergic to any other antibiotics or medications? YES NO If yes, please list:

Does your child have any other allergies? YES NO If yes, please list:

MEDICATIONS: Does your child take any medications – daily, over the counter, when sick?

PAST MEDIAL HISTORY:

SURGERY: Has your child ever had surgery? If so, please list:

ILLNESSES: Has your child ever been seriously sick or hospitalized? If so, please list:

CHILD'S NAME: ______________________ **CHILD'S DATE OF BIRTH** ______________

GENERAL:

	YES	NO
Is your child's activity level normal?		
Is your child's appetite normal?		
Is your child sleeping normally?		
Is your child growing/developing as expected?		
Is your child's speech and language normal?		

RESPIRATORY:

	YES	NO
Does your child have a history of asthma?		
Is your child coughing?		
Is your child wheezing or have noisy breathing?		
Is your child having difficulty breathing?		

HEENT:

	YES	NO
Does your child have headaches?		
Does your child have vision problems?		
Does your child have ear pain or trouble hearing?		
Does your child have frequent nose bleeds?		

CARDIAC:

	YES	NO
Does your child have chest pain?		
Does your child have an irregular heartbeat?		

HEMEATOPOETIC

	YES	NO
Does your child bleed or bruise easily?		

DERMATOLOGIC:

	YES	NO
Does your child have any rashes?		

MUSCULOSKELETAL:

	YES	NO
Does your child have any limb or back pain?		

ENDOCRINE:

	YES	NO
Does your child have excessive thirst?		
Does your child have increased urination?		

NEUROLOGICAL:

	YES	NO
Does your child have a history of head injury?		
Does your child have a history of concussions?		
Does your child have a history of seizures?		

PSYCHOLOGIC:

	YES	NO
Does your child have anxiety?		
Does your child have depression?		
Does your child have behavioral difficulties?		

GASTROINTESTINAL:

	YES	NO
Does your child have abdominal pain?		
Does your child have diarrhea?		
Does your child have constipation?		
Does your child have vomiting?		

GENITOURINARY:

	YES	NO
Does your child have decreased urine?		
Does your child have increased urinary frequency?		
Does your child have pain with urination?		

BIRTH HISTORY:

	YES	NO
Was your child born prematurely?		
Any problems after birth?		

SOCIAL HISTORY:

	YES	NO
Is your child exposed to tobacco smoke?		
Does your child attend school or daycare?		

What grade? ____________

Is anyone at home sick?		

Who lives at home? (list) ______________

Any other questions or concerns about your child's heath?

____

Parent's signature: ______________________ DATE ____________

PATIENT INFORMATION

Please have your insurance card and driver's license ready at the front desk.

Name: ______________________________ DOB: ____/____/____ Sex: M F
Last First Middle

Address: ______________________________
Street City State Zip

Home Phone: (______) ______-______ Cell Phone (______) ______-______

Information concerning the care provided will be forwarded by Firefly to your primary Care Physician.

Primary Doctor's Name: ______________________ City: ______________ State: ______

PARENT OR RESPONSIBLE PARTY

Name: ______________________________ DOB: ____/____/____
Last First Middle

Address: ______________________________
Street City State Zip

Home Phone: (______) ______-______ Cell Phone: (______) ______-______

PRIMARY INSURANCE POLICY HOLDER

Name: ______________________________ DOB: ____/____/____
Last First Middle

Relationship to Patient: ______________________________

Address: ______________________________
Street City State Zip

Work Phone: (______) ______-______ Cell Phone: (______) ______-______ Email address: ______________

Employer Name: ______________________________

Employer Address: ______________________________

EMERGENCY CONTACT

Name: ______________________________ Phone: (______) ______-______
Last First

Please, how did you hear about us? ______________________________

Please turn over ———

FireFly After Hours Pediatrics Urgent Care
1011 High Ridge Road, 3rd Floor, Stamford, CT 06905
phone 203.968.1900 fax 203-968-0151

Patient Name: ______________________ **Patient Date of Birth:** ______________

We appreciate your selection of our practice for your child's medical care. To prevent any possible future misunderstanding, we have prepared the following summary of our policies.

1. The parent/guardian or guarantor (insured member) is responsible for payment of services.
2. We require a copy of your insurance card, a form of identification and billing information at every visit.
3. If you fail to inform us of any changes in coverage, you will be responsible for payment for services rendered.
4. A credit card is required to be put on file and will be charged AFTER your claim is processed according to your insurance response.
5. Three no-show or three rescheduled appointments is grounds for dismissal from the practice.
6. Records may be destroyed 7 years after last date of service per Connecticut state law.
7. Unaccompanied minors must have written permission to be treated via email or fax from a parent or guardian (see supplemental form).
8. It is our policy to immunize children according to AAP guidelines. You must disclose the immunization status of your child. If your child is completely unimmunized it is our policy to not expose others to possible infection, therefore we do not accept unimmunized patients. If your child is partially immunized and is on a continuous track to fully update of their immunizations, it is at the discretion of the medical director/M.D on shift as to whether we will accept them as a patient.

Responsible Party's Statement, Authorization, and Assignment of Benefits:
I have read all the above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.
I authorize payment directly to Firefly for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse Firefly for any payments my insurance company may have sent me in error.
I understand that I am financially responsible for all co-payments, deductibles, charges not covered under my insurance benefits and the above Fees for Service.
Should your account become delinquent and turned over to our collection agency, we will require payment from you before future treatment can be undertaken. In the event that any legal action is brought to collect my account or any portion thereof, I agree to pay a reasonable sum for attorney's fees in addition to costs and disbursements at provided by the statute.
I authorize the release of any medical information necessary to process claims.
A photocopy of this authorization shall be considered as effective and valid as the original.

______________________	______________________	______________________
SIGNATURE	NAME PRINTED	TODAY'S DATE

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INSURANCE & BILLING POLICIES

Firefly is happy to be in network with many major insurance companies. It is your responsibility to pay co-pays and deductibles, as well as any balance not covered pursuant to your insurance policy. If we are not in network with your primary insurance provider, payment is expected at the time of service.

I authorize the release of any medical information necessary to determine liability for payment and to allow Firefly After Hours Pediatrics, LLC to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my or my child's behalf. I assign the benefits payable to medical and/or surgical benefits, including major medical benefits, private insurance and any other reimbursement. This assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as an original . I understand that I am financially responsible for all charges whether or not paid by any insurance policy. I hereby authorize Firefly After Hours Pediatrics, LLC to release all information necessary to secure such payment.

SIGNATURE NAME PRINTED TODAY'S DATE

BILLING POLICY FOR LABORATORY SPECIMENS

I understand that any specimens collected during my visit will be sent to Quest Laboratory unless otherwise directed. I understand that by signing this form I am confirming that MY INSURANCE MAY NOT COVER the laboratory testing and there I MAY RECEIVE A BILL directly from Quest. I understand that Firefly uses the Quest Laboratory which has its own billing and customer service center and I will contact them directly in the event that I receive a bill for a specimen that was sent to Quest Laboratory. I also understand that Firefly After Hours Pediatrics will NOT BE RESPONSIBLE FOR ANY BILLS incurred by Quest Laboratory.

SIGNATURE NAME PRINTED TODAY'S DATE

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AFTER HOURS PEDIATRICS

Patient Name: ______________________ **Patient Date of Birth:** ______________

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) OF 2010

The Patient Protection and Affordable Care Act of 2010 provides for better access of patients to their medical records. In keeping with this new law, we are required to give you access to your child's electronic health record. In order for us to accomplish this and fulfill the law, we ask that you give us your email address. You will receive an email that states how to login to the medical record and we will print out a temporary password for you to take with you so that you can login to the medical record. You can be assured that your email will be protected within the locked medical record and that it will not be used for any other purposes (other than billing) and your email address will never be sold.

Your e-mail address ____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices, and acknowledge that I have the right to request another copy at any time.

SIGNATURE	NAME PRINTED	TODAY'S DATE

PAYMENT AUTHORIZATION AGREEMENT

I hereby authorize Firefly After Hours Pediatrics to keep my card (as indicated below) on file for payment and to initiate appropriate payment entries against the listed referenced debit or credit card or HSA card as applicable, as amounts are owed by me. I acknowledge that the initiation of all such entries to make payments must comply with the provision of U.S. law and applicable state laws. I understand and agree that these entries may be made to my debit, credit, or HSA card as applicable, periodically to pay amounts owed by me for any balances. I also agree to notify Firefly if the card information listed below changes for any reason. This authorization shall remain in effect until the expiration date of the card or until I communicate to Firefly my intention to cancel authorization in writing.

Cardholder name ______________________ Billing zip code for card ______________

Last four digits of the card ______________________ Card expiration date ______________

SIGNATURE	NAME PRINTED	TODAY'S DATE