NEW PEDIATRIC PATIENT INFORMATION

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

Pediatric Medical History Form

(Your answers on this form will help your provider understand your child's medical history)

PERSON COMPLETING FORM/RELATIONSHIP: _____

MEDICATIONS: (LIST ALL)

Medication Dosage How many time/day

_____
_____
_____
_____

MEDICATION ALLERGIES: YES NO

If yes, to what medication(s) and what was the reaction: _____

IMMUNIZATION HISTORY: UP-TO-DATE? YES NO

If no, why?_____

BIRTH HISTORY:

Name of hospital where infant was born: _____
Please list any medical problems during pregnancy: _____
Please list any medications taken during pregnancy: _____
Any drug or alcohol use during pregnancy: YES NO _____
Delivered by: ▫ normal vaginal delivery ▫ elective C-section ▫ emergent C-section ▫ forceps ▫ vacuum extraction
If not normal vaginal delivery, why? _____
Number of weeks gestation_____Birth weight_____Discharge weight_____
APGAR scores: 1 minute_____5 minute_____
Did the baby receive the Hepatitis B vaccine? YES NO If yes, date given? _____
Please indicate any medical problems during the newborn period _____

PATIENT MEDICAL HISTORY:

Please check if your child has had any of the following medical problems:

▢ ADD/ADHD	▢ Chicken pox	▢ Headaches	▢ Liver disease/Hepatitis
▢ Allergies	▢ Concussion	▢ Hearing problems	▢ Recurrent Ear Infections
▢ Anemia	▢ Diabetes	▢ Heart murmur	▢ Seizures
▢ Asthma	▢ Eczema	▢ Congenital heart disease	▢ UTI(s)
▢ Bleeding Disorder	▢ Fracture	▢ High blood pressure	▢ Vesicoureteral reflux
▢ Bronchiolitis	▢ Handicaps/Disabilities	▢ Kidney disease	▢ Vision problems

HISTORY OF HOSPITALIZATIONS:

Has your child ever stayed overnight in a hospital? YES NO
If yes, when and why?_____

SURGICAL HISTORY:

Please list any **surgeries or procedures** your child has had, include the **year** of the surgery/procedure:

_____
_____

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SPECIALITY DOCTORS:

Please list any specialist your child sees and why:

_____

_____

FAMILY HISTORY:

Please indicate child's family history: (M=Mother, F=Father, S=Sibling, GM=Grandmother, GF=Grandfather,, A=Aunt, U=Uncle, C=Cousins to the child) of any of the following:

DIAGNOSIS	FAMILY MEMBER	DIAGNOSIS	FAMILY MEMBER
☐ADD/ADHD	_____	☐Hearing disability	_____
☐Alcohol/Drug abuse	_____	☐High cholesterol	_____
☐Allergies	_____	☐High blood pressure	_____
☐Asthma	_____	☐HIV/AIDS	_____
☐Birth defects	_____	☐Learning disability	_____
☐Blood disorders	_____	☐Mental illness	_____
☐Cancer, type	_____	☐Mental retardation	_____
☐Heart disease	_____	☐Migraines	_____
(Heart attack, bypass, stents)	_____	☐Scoliosis	_____
☐Deafness/Hearing problem	_____	☐Seizure disorder	_____
☐Depression	_____	☐Speech problems	_____
☐Developmental delay	_____	☐TB/Lung disease	_____
☐Diabetes	_____	☐Stroke	_____
☐Genetic disorder	_____	☐Thyroid disease	_____
☐Infections	_____	☐Other	_____
☐Hepatitis/Liver disease	_____	☐Other	_____

SOCIAL HISTORY:

Who lives at home?

Name	Relationship	DOB

Is child cared for by anyone other than parent(s) or guardian(s)? YES NO

If yes, by whom and how often? Daycare?_____

Does anyone in your home smoke? YES NO

Provider Signature_____Date reviewed_____

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FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

Mailing Address:_____ Apt #:_____

City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____

Mother's name: _____ Work: _____ Cell: _____

Father's name: _____ Work: _____ Cell: _____

E-Mail: _____

Would you like access to our patient portal via email? ❑ Yes ❑ No, I decline
Country Meadows Clinic will not share your contact or email info with any third parties.

Preferred Language: ❑ English ❑ Spanish ❑ Other_____

Gender: ❑ Male ❑ Female

Primary Race: ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian or Alaskan Native
❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Declined to Specify

Ethnicity: ❑ not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown

Employment Status: ❑ Employed ❑ Disabled ❑ Retired ❑ Part-time ❑ Not Employed ❑ Student
❑ Unknown

Student Status: ❑ Full time ❑ Part Time ❑ N/A School Name: _____

Emergency Contact

Name:_____ Relationship:_____ Phone:_____

Primary Care Physician

Doctor Name: _____ Office Phone: _____

Pharmacy

Name: _____ City: _____ Phone: _____

Referral Source: ❑ Facebook ❑ Radio ❑ Newspaper ❑ Google ❑ Insurance List ❑ Other:

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Release and Assignment

Because your child is a minor, it becomes necessary that a signed permission be obtained from a legal parent/guardian before any and/or all necessary medical services can be started and accomplished by the provider at Country Meadows Clinic. I authorize the release of any medical or other information required in the processing of claims.

I authorize my insurance benefits to be paid directly to the CMC Healthcare, PLLC for services rendered. My signature as legal parent/guardian affixed below authorizes the rendering of medical services. This consent shall remain in full force and effect until cancelled by either party. I understand that I am financially responsible for all charges incurred as a result of medical services rendered.

MANAGED CARE POLICY

If you have a managed care plan, you need to be aware that most managed care plans require the policy holder to use certain laboratories, radiology or hospitals. If you do not, your plan will not cover the service. With several different plans, Country Meadows Clinic **cannot be responsible** to direct you to the facilities that are approved by your plan. It is your responsibility to know what your plan covers. Please read your policy or call your human resources department or insurance carrier if you are unsure what facilities your plan covers. **Country Meadows Clinic is not responsible for any procedures not covered by my insurance company.**

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with the billing office or the Patient Account Representative. We are dedicated to providing the best possible care and service to you and regard the complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience, we will accept cash, check or money order. VISA, MasterCard and Discover will be accepted for payment of $10.00 or more.

APPOINTMENTS

There will be a $35.00 charge for missed appointments that are not cancelled 24 hours prior to the scheduled time. The fee will apply to all patients who do not cancel in a timely manner; however; exceptions can be made for certain circumstances (e.g. severe weather, auto accident, or emergencies). Any patient with three or more missed appointments (without cancelling) may be terminated from the practice.

NO SHOW POLICY

We kindly request that you give us 24 hours' notice if you are unable to keep your appointment. Failure to give 24 hours' notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

SELF PAY - NO INSURANCE

Patients without insurance will be required to pay in full prior to the appointment.

INSURANCE

We have made prior arrangements with several insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-pay. It is our policy to collect co-pays for the preset amounts when you arrive for your appointment and check in with the receptionist. Our cashier will collect co-pays determined by a percentage upon completion of your visit. Any services that are not covered by a co-pay, are due in full at the time you check out. We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected (i.e. deductible plan)
- We obtain a denial from your insurance company
- We have not received payment from the insurance within 60 days of our filing the claim

MEDICAID

Medicaid requires all Medicaid recipients to always present their card when seeking medical attention. Failure to do so may result in the rescheduling of your appointment. If the visit is for a well check or immunization, the appointment will be rescheduled until proof of Medicaid is presented.

RETURNED CHECKS

A $30.00 service charge will be added to your account for all returned checks and must be paid before additional appointments will be scheduled. Restitution of the check must be made within 10 days or check will be given to the County Attorney for prosecution.

COLLECTION AGENCY

Any account that is given to our collection agency due to non-payment will have a 10% collection charge added to the account. Our collection agency will then collect the past-due amount plus the 10% collection charge.

PRIVACY

By signing below you acknowledge that you have reviewed or received a copy of CMC's notice of privacy practices.

MINOR PATIENTS

For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian for payment.

I HAVE READ AND UNDERSTAND THE AUTHORIZATION AND POLICIES ABOVE OF THIS PRACTICE AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE.

_____ _____

Signature of guardian or responsible party Date

_____

Printed name of the guardian or responsible party

NEW PEDIATRIC PATIENT INFORMATION

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

VACCINATION POLICY

We are vaccine providers. Giving children vaccines not only protects the child from preventable disease but it also protects everyone else who may have a compromised immune system. According Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP), it is recommended that children receive the following vaccines at certain intervals:

- Hepatitis B
- Diphtheria,tetanus,acellular pertussis (DTaP or TdaP)
- Diphtheria tetanus (DT or Td)
- Haemophilus influenza type b (Hib)
- Pneumococcal conjugate or polysaccharide
- Inactivated poliovirus (IPV)
- Measles-mumps-rubella(MMR)
- Varicella(chickenpox)
- Influenza(flu)
- Meningococcal conjugate or polysaccharide
- Hepatitis A
- Rotavirus
- Human papillomavirus
- Other

Why have your child(ren) vaccinated?

- Vaccines protect your child from diseases which can be fatal or have lasting health consequences
- Having a high vaccination percentage in a group of children protects children who have immune-deficiencies and those too young to receive vaccines
- Appropriately vaccinated children also protect adults, especially the elderly, from preventable disease outbreaks
- Children who are unvaccinated or under vaccinated can spread preventable diseases to all children who are not old enough to be fully immunized. This can happen at the grocery store, the mall, office waiting rooms etc.

Please contact your primary care provider to discuss any issues or hesitations you may have with vaccinating your child. If you are not willing to have your child appropriately immunized, consistent the CDC and AAP, we do not feel comfortable being your child's health care provider. If after 30 days of refusal we are unable to convince you of the necessity of vaccinating your child, we respectfully ask you to find another health care provider as declining vaccination will result in dismissal from the practice. CMC will provide medical care for a month (30 days) after notification to allow you time to look for another provider.

I authorize that the vaccines may be entered into/released from the ImmTrac system (Texas immunization registry) to track immunizations. I am an adult who **can legally** consent for the person receiving vaccines and freely/voluntarily give my signed permission for the vaccines to be administered if needed. I have received a VIS/explanation for vaccine(s) being administered, I know the risks/benefits of each vaccine being given and know that I can ask if I have any questions concerning vaccination.

By signing this document, you have acknowledged CMC is a PRO-vaccine practice. Refusal to receive vaccines will result in dismissal from the practice.

Patient Name: _____

Patient / Legal Guardian's name (print): _____

Patient / Legal Guardian's signature: _____Date:_____

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Patient Name: _____ DOB: _____

PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑ Same as above

Name:_____ Relationship: _____

Mailing Address: _____ Apt # _____

City_____ State:_____ Zip: _____

DOB: _____ Phone (home): _____ (cell): _____

PRIMARY MEDICAL INSURANCE ***all HMO and Medicaid verify PCP prior to appointment****

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____

SECONDARY MEDICAL INSURANCE

Insurance Company : _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

DOB (*Required) : _____ SSN: _____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

The above information is accurate and complete to the best of my knowledge.
**WILL NEED COPIES OF INSURANCE CARD(S) & GOVERNMENT ISSUED PICTURE ID*

_____

Signature of Patient/Responsible Party Date Signed

NEW PEDIATRIC PATIENT INFORMATION

COUNTRY MEADOWS CLINIC
FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

CONSENT TO CONTACT

Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

____ CONTACT PERMISSION

In the event that Country Meadows Clinic needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:
(check all that apply)

- ❑ Leave a message on an answering machine or voice mail. Phone # _____
- ❑ Speak with spouse/significant other. Name: _____
- ❑ Speak with other family members. Name: _____

____ CONSENT TO TELEPHONE/EMAIL COMMUNICATION

I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is not secure, not to be used for any emergent matters, and response will be given back within three to five business days.

_____ _____
Signature Date Signed

_____ _____
Patient Printed Name/Legal Guardian Relationship to patient

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

- ❑ Individual waived signature
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other:

_____ _____
Practice Representative Date

NEW PEDIATRIC PATIENT INFORMATION

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FAMILY PRACTICE & PEDIATRICS

Date: _____

Patient Name: _____ DOB: _____

QUEST DIAGNOSTICS

If your provider performs a biopsy or orders a lab test during your appointment, it will be sent to an outside laboratory. The pathology or lab results will be communicated to your provider and your provider will notify you of these results.

The outside laboratory will submit a bill to your insurance company. You may receive a bill from them should you have deductibles*, co-insurance, or co-payments. If you are a self-pay patient, rates will be discussed with you during your visit. Medicare: You may be asked to sign a Waiver of Liability in the event a service is not covered by Medicare.

**Those with high deductible plans have the option to bill as self-pay, please discuss this with the front desk or your provider.*

If you have any questions regarding this process, please do not hesitate to ask your provider or nurse.

By signing below, you understand that you may be billed by an outside laboratory in the event that you receive a biopsy or lab test during your examination.

_____ _____

Signature Date