Pressley Pediatrics

Patient Information

Last Name: _____ **First:** _____ **Middle Name:** _____

D.O.B.: _____ **Social Security #:** ____-_____-_____ **Sex:** M☐ F☐

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Secondary Phone:** _____

E-mail address: _____

Race: (circle one)

Caucasian American Indian Other_____

Black/African American Hispanic

Asian Pacific Islander

Language: (circle one)

English Spanish Other_____

Responsible Party

Name: _____ **D.O.B.** _____ **Social Security #:** ____-____-____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Secondary Phone:** _____

Employer's Name: _____ **Work Phone:** _____

Employer's Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Parent or Guardian e-mail address: _____

Insurance Information

Name of Insurance: _____ **Policy #:** _____ **Group #:** _____

Name of Cardholder: _____ **Relationship to Patient:** _____

Social Security#: _____ **D.O.B** _____

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MEDICAL HISTORY

Patient's name:_____ D.O.B:_____

Birth History: Birth Weight:_____ Birth Length:_____

Gestational Age:_____ Pregnancy Complications:_____

Delivery type:_____ Birth Place:_____

Previous hospitalizations:_____

Previous surgeries:_____

Allergies:_____

Current medications:_____

Family history:_____

Past medical history:_____

_____

_____

_____

Previous primary care provider:_____

Preferred pharmacy name:_____

Pharmacy phone number:_____

Pharmacy address:_____

X _____

Parent/Guardian signature

Pressley Pediatrics

GENERAL OFFICE POLICIES/CONSENTS/INFORMATION

Welcome to Pressley Pediatrics where caring for our children is what we do best! Thank you for choosing our clinic as your child's Primary Care Provider. Our staff is committed to providing you with the best medical care in a professional, child friendly, and caring environment. Outlined below are our office policies and other important information. In order to better serve you, please take the time to read and understand them. If you have any questions, please approach any of our office staff.

Appointments: As a courtesy to our patients, we will call to remind you of appointment. However, it is your primary responsibility to make sure that every appointment is kept. You must call at least 24 hours in advance to cancel your appointment, so that your space may be given to another patient. You may be discharged from the clinic because of repeated "no shows". A patient who is late to their schedule appointment may need to reschedule or wait to be seen until the schedule allows.

Patient Payments due at time of service:

Copays and deductibles

Service and purchases made at time of service

Professional service rendered: If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed.

Medical records: When requesting medical records or other information to be released to you, you must be listed as responsible party and submit a valid picture identification card. There is a fee for medical records and a fee for immunization records. However, records can be sent directly to a requesting facility free of charge, provided you have completed and signed a records release form. Please fill out the AUTHORIZATION TO RELEASE HEALTH INFORMATION form in case your provider would like to obtain your records or share with another facility.

Conduct: Please watch your children closely making sure that they are safe always. Please make sure that they do not destroy any of the clinic's properties and play with our instruments and medical supplies. Please avoid use of foul or threatening language and display of inappropriate behavior.

Physician-Patient Relationship: The clinic reserves the right to refuse to provide service or terminate the physician-patient relationship at any time.

HIPPA: Your signature below acknowledges that you have read the Notice of Privacy Practice for Pressley Pediatrics which was either given to you or posted in the waiting room.

Client Acknowledgement Statement: I agree to pay for any and all medical services I receive from this practice that my insurance company refuse to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay (e.g. non- covered services that may include but are not limited to vaccines, developmental screenings, vision and hearing screenings, strep test, flu test and urine dips or insurance does not pay for preventive medicine visit) I will pay for same upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical records. I have read and authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information.

Consent for the treatment: I have read and understood all the form on the new patient packet and give permission for the patient to receive service at Pressley Pediatrics and be treated by its medical provider and staff.

Name of Patient: _____ D.O.B. _____

Parent/Guardian signature: _____ Date: _____

Pressley Pediatrics

Insurance Consent

Insurance Benefit/Payments:

I authorize direct payment of insurance benefits to Pressley Pediatrics for services rendered to my dependents, I agree to pay any co-payments, deductibles or any balance due that the clinic is unable to collect from my insurance company. I understand that it is my responsibility to pay for the services that I have requested and receive that are not determined to be medically necessary by the physician or insurance company.

Beneficios Del Seguro/Pagos:

Autorizo el pago directo de beneficios de seguro a Pressley Pediatrics por los servicios prestados a mis dependientes, acepto pagar cualquier copago, deducible o saldo debido a que la clínica no puede cobrar de mi compañía de seguros. Entiendo que es mi responsabilidad pagar por los servicios que he solicitado y recibido que no están determinados a ser médicamente necesarios por el médico o la compañía de seguros.

Parent/Guardian: _____ Date: _____

Pressley Pediatrics

PHOTO USE RELEASE FORM

I, _____ herby grant and authorize the right to take edit, alter, copy exhibit, publish distribute and make use of any and all pictures or videos taken of me to be used in and/ or for legally promotional material including, but not limited to, newsletters, flyers, posers, brochures, advertisements, fundraising letters, annual reports, press kits and submission to journalists, website, social networking sites and others print and digital communications, without payment or any other consideration. This authorization extends to all languages, media, formats and markets now known or hereafter devised. This authorization shall continue indefinitely unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of and will not be returned.

I hereby hold harmless, and release from all liability petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other person may make while acting on my behalf or on behalf of my estate.

X _____

Guardian signature

Pressley Pediatrics

PARENT DESIGNATION TO CONSENT FOR HEALTHCARE

Other contact information: People you authorize the clinic staff to:

1. Contact in case of an emergency
2. Receive and release information regarding your child's medical care
3. Bring your child for doctor's appointment and consent for medical treatment (must bring photo ID)

Name: _____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient's name:_____ D.O.B:_____

Guardian's name:_____ Relationship:_____

Signature:_____ Date:_____

Pressley Pediatrics

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

I, _____ the undersigned. Parent/legal guardian of, a minor, do hereby authorize the medical staff for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to all such diagnosis, treatment or hospital care which physician(s) in the exercise of his/her best judgment may deem advisable.

These authorizations shall remain effective unless revoked in writing and delivered to said agent(s) or until minor reaches 18 years of age.

_____ _____

Date Parent/Legal Guardian Signature

AUTORIZACION DE CONSENTIR EN EL TRATAMIENTO DE UN MENOR

Yo, _____ padre legal de un menor de edad, autorizo el personal medico como agente(s) para el abajo firmante de consentir en cualquier examen de rayos-X, anestesia, tratamiento medico o quirurico diagnostico o tratamiento y hospitalizacion que sean sugeridos o administrados bajo la supervision general o especifica de, cualquier medico o cirujano licenciado bajo las provisiones del Medical Practice Act, del personal medico de cualquier hospital, no importa si el diagnostico o tratamiento sea proveído en la oficina del dicho doctor(a) o en dicho hospital.

Se entiende que esta autorizacion se da antes de que se de cualquier diagnostico especifico, tratamiento o hospitalizacion que se requiere pero se da para proveerle la autoridad y poder a dicho(s) agente(s) para su consentimiento especifico a todo y cualquier diagnostico, tratamiento O hospitalizacion que dichos doctores en su mejor juicio sugieran,

Estas autorizaciones seran validas hasta que su revocacion (por escrito) sea entregada a dicho(s) agente(s) o hasta que el menor tenga 18 anos.

_____ _____

Fecha Firma de padre/madre/tutor legal

5	Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes ☐ No ☐ *NOTE: If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact your manager or human resources representative when: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved;* ***and*** *at least 7 days have elapsed since your symptoms first appeared.*
6	In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐
7	In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐
8	Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation. Yes ☐ No ☐ Explanation: _____.

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to your manager or your human resources representative.

Access to worksite (circle one): Approved Denied

COVID-19 SCREENING QUESTIONNAIRE

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our other employees.

Name:
Phone Number (mobile/home):
Position:

	Representations
1	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? ***(Please take your temperature before you answer this question.)*** Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) Yes ☐ No ☐ Cough Yes ☐ No ☐ Shortness of breath or difficulty breathing Yes ☐ No ☐ Sore throat Yes ☐ No ☐ New loss of taste or smell Yes ☐ No ☐ Chills Yes ☐ No ☐ Head or muscle aches Yes ☐ No ☐ Nausea, diarrhea, vomiting
2	In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes ☐ No ☐
3	In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes ☐ No ☐
4	Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No ☐