PEDIATRIC HISTORY SHEET

Child's Name:_____ Child's Birthdate:_____ Sex:_____ Race:_____

Child's Father:_____ Child's Mother:_____

Siblings & Ages:_____

Child's Birth Weight:_____ Length:_____Head Circumference:_____

Doctor delivering child:_____Hospital born in:_____

Type of delivery: Vaginal (natural):____ C-section:_____ Why?:_____

How far along were you at time of delivery?:_____

IslWas your baby: breast fed:_____ bottle fed:_____ Formula name:_____

PREGNANCY HISTORY

		Yes	No
1.	Smoking	_____	_____
2.	Alcohol	_____	_____
3.	Infections	_____	_____
4.	Medications	_____	_____

Names _____
_____

		Yes	No	
5.	Bleeding	_____	_____	When?:_____
6.	Toxemia	_____	_____	
7.	High blood pressure	_____	_____	
8.	Premature labor	_____	_____	
9.	Diabetes	_____	_____	

10. Other problems_____

PROBLEMS WITH NEWBORN

		Yes	No
1.	Breathing problems	_____	_____
2.	Feeding problems	_____	_____
3.	Infections	_____	_____

		Yes	No	
4.	Jaundice	_____	_____	Treatment needed?:_____
5.	Other problems	_____		

_____

DEVELOPMENT

At what age did your child: sit alone_____ crawl_____ walk_____

What grade is your child in?_____ What school?_____

Repeat any grades?_____ What grade? _____

ALLERGIES:_____

CURRENT MEDICINES: _____ _____
_____ _____

Ever hospitalized?_____ For What?_____When?_____

FAMILY HISTORY

		Yes	No	In who?
1.	Diabetes	_____	_____	_____
2.	Asthma	_____	_____	_____
3.	Cancer	_____	_____	_____
4.	Birth defects	_____	_____	_____
5.	Mental retardation	_____	_____	_____
6.	Heart disease	_____	_____	_____
7.	High blood pressure	_____	_____	_____
8.	Thyroid disease	_____	_____	_____
9.	Bleeding disorder	_____	_____	_____
10.	Seizures	_____	_____	_____
11.	Others not listed	_____	_____	_____

REGISTRATION

Date_____ **Chart Number** _____ **(office use only)**

PATIENT INFORMATION

Patient Name _____ Date of Birth _____
LAST NAME FIRST NAME MIDDLE INITIAL

Address _____ Phone (_____)_____

City _____ State _____ Zip _____

Patient's Social Security Number (SSN) _____ – _____ – _____

Check the appropriate status: Minor ____ Single ____ Married ____ (Gender) M / F

Person to contact in case of emergency:

Name: _____ Phone (_____)_____

RESPONSIBLE PARTY FOR THE PATIENT

(Name of person responsible for this account)_____
LAST NAME FIRST NAME MIDDLE INITIAL

Address _____ Phone (_____)_____

City _____ State _____ Zip _____

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Insured's birth date _____ Insured's Social Security Number (SSN) _____ – _____ – _____

Name of Employer _____

Insurance Company_____ ID#_____ Group# _____

Address _____ Phone (_____)_____

City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Name of Insured _____ Relationship to patient _____

Insured's birth date _____ Insured's Social Security Number (SSN) _____ – _____ – _____

Name of Employer _____

Insurance Company_____ ID#_____ Group# _____

Address _____ Phone (_____)_____

City _____ State _____ Zip _____

I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of Insurance benefits otherwise payable to me directly to **Helping Hands Pediatric & Adolescent Medicine, Inc.**

Signature of parent or legal guardian_____ Date _____

PATIENT FINANCIAL POLICIES

Below are the financial policies of Helping Hands Pediatric & Adolescent Medicine, Inc. It is the patient's responsibility to understand their insurance policy and the coverage it provides. Please read the following policies so you may understand your financial responsibility. By signing, you agree to all the policies.

1. All co-payments are due at the time of service. We are required by contract to advise all insurance companies of non-payments.

2. It is the responsible party's obligation to review and understand their insurance policy with regards to referrals, preventative health visits, and immunizations.

3. The responsible party is required to provide our office with current and accurate insurance information. Failure to do so may result in a balance on the patient's account.

4. We will bill primary and secondary insurances as a courtesy. After the insurances have paid, the responsible party becomes liable for all balances.

5. It is the patient's responsibility to confirm that Helping Hands Pediatric is an active participant with their insurance company.

6. A return check fee of$30.00 may be applied to all checks returned for insufficient funds or closed accounts.

7. This office understands financial hardships. Agreed payment schedules can be arranged by contacting our office but will follow the criteria below. These criteria must be followed before further service can be rendered. Failure to make agreed payments may result in referral to a collection agency.

   Balances of$100.00 or less requires a minimum payment of$25.00/mth.
   Balances of $100.00-$300.00 require minimum payment of $50.00/mth.
   Balances of more then $300.00 require half the balance immediately and payments of$75.00/mth.

8. Newborn billing information must be established prior to the second visit or the second visit may be self pay until insurance is established.

IF YOU HAVE ANY QUESTIONS CONCERNING THESE POLICIES PLEASE ASK BEFORE SIGNING BELOW.

Patient/Responsible Party Date

REGISTRATION / HIPPA

With the implementation of HIPPA, we are required to ask the patient or guardian the following questions:

1. May we leave a message at your home with other residents? **Y / N**

2. May we communicate with you via e-mail? **Y / N**
   If Yes, what is your e-mail address?

   _____

3. May we provide other physicians with update information? **Y / N**

4. Who may we talk to about your medical concerns?

   _____
   Name

   _____
   Phone Relationship to Patient

5. Is the above for emergency purposes only? **Y / N**

6. Can we talk to the above person when needed? **Y / N**

INFORMATION REVIEWED _03 _04 _05 _06 _07 _08 _09

PRACTICE PRIVACY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. It is important that all patients and staff understand the importance of guarding patient information.

II. This practice bas a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results and other information that may be of a confidential nature. Patient information about health care is identified as “PHI” or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or reregistration with this practice who we can talk to, how we can leave information on your behalf and the process for ongoing continuity of your medical care. **You can change this information at any time with either written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point in time forward.

III. Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services such as lab, x-rays, other diagnostic testing or treatment related to your condition or medical care needs. This may also include conversations with other physicians.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form.
- Disclosure to your family and friends concerning any related health care information with you on the registration form which can be modified at any time orally, followed by written consent.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity required immediate and full Information for care on your behalf.**

Certain disclosures can be made without your consent, and they are as follows:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person’s death or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program.
- Information related to organ donation.
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.

- Information provided to avoid harm if there is a threat to patient or other safety.
- Specific governmental functions.
- Workers compensation review.

IV. Yours rights with respect to your protected health information.

- The right to request limits on the uses and disclosure at registration or any time during your care.
- The right to choose how we send this information to you, including any alternate address.
- The right to see and obtain copies of this information, but there may be copy and postage fees.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process if appropriate.

V. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

VI. If you have a concern or complaint about how your protected health information is being used, from this time forward, you should first contact our office to see if we can resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Contact the office manager and complete a complaint form for review and discussion:

Helping Hands Pediatric & Adolescent Medicine, Inc.
5030 North Walnut Street
South Bloomfield, Ohio 43103
Attn : Tim Stevenson
Phone: 740/ 983-0015

If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights, Regional Manager
Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601 Phone: 312/886-1807

Or the local Medicare Part B intermediary:

GBA Palmetto I HIPPA Compliance Concern
PO Box 182957
Columbus, Ohio 43218

This Privacy statement is effective on or after November 10, 2003.

Patient/Guardian Signature on receipt of Privacy Notice _____ Date_____

Patient unable to sign due to:_____ Date_____

Patient/Guardian refused to sign – witness: _____ Date_____

PATIENT PRIVACY

This consent is required by the ***Health Insurance Portability and Accountability Act of 1996*** to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to **Helping Hands Pediatric & Adolescent Medicine, Inc.** to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/ function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health cares professional for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDs or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship: _____

COPY OF PRACTICE PRIVACY STATEMENT SIGNED OR INITIATED WITH PATIENT/GUARDIAN ON: _____

Patient unable to sign privacy statement due to: _____

REVOCATION

Patient/Guardian _____ Date _____

Name Printed _____ If not patient, relationship: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources. as required by my contact with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Patient /Guardian_____ Date _____