WAVERLY
Health Care
URGENT CARE
& Family Practice

Pediatric Health History

PATIENT INFORMATION

Name:	Date:
Date of Birth:	Age:
Address 1:	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address 1:	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group #:	Group #:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Social Security #:	Social Security #:
DOB:	DOB:

____

Mother's Name: Home Phone: Work Phone/Employer:

____

Father's Name: Home Phone: Work Phone/Employer:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Waverly Health Care Urgent Care, when he/she accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Waverly Health Care Urgent Care, to release any information necessary for my course of treatment.

____ ______________________

Signed (patient or parent if minor) Date

Please provide your pharmacy:___________________

Pediatric Health History (page 1 of 3)

Name:____ DOB:__________________

Current Medical Problem: ____

____

Past History:

Birth Weight:____ Birth Length: __________________________

Pregnancy: Any problems during this child's pregnancy (bleeding, infection)? _______________________________
____

Labor: Any problems during this child's labor (breech, baby's heart rate slow)?____________________________
____

Delivery: Any problems during this child's delivery (c-section, forceps, late)?_____________________________
____

Hospital: Any problems during this child's hospital stay (jaundice, infection)?_____________________________

____

Allergies: Penicillin? Yes No Sulfa? Yes No

Other Allergies *(reactions)*____

Surgeries: List any surgeries this child has had and the dates performed: __________________________________
____

Other Hospitalizations and Illnesses: ____
____

Past or Present (on going) Medical Problems: ____
____

Current Medications:	Dosages:	How Often:
______________________	__________________	____________________
______________________	__________________	____________________
______________________	__________________	____________________
______________________	__________________	____________________
______________________	__________________	____________________

Pediatric Health History (page 2 of 3)

Name:____ DOB:________________

Immunization: *(please give dates or provide a copy of previous immunization record)*

Influenza ____

DTP:	1st	2nd	3rd	4th	5th
Polio:	1st	2nd	3rd	4th	5th

Measles, Mumps, Rubella (MMR): ____

Hepatitis B: ____

HIB: ____

Tetramune (DTP & H flu B): ____

Pneumovax: ____

Td: ____

If current please write up to date.

Family History: *(List relatives with any of the following problems)*

Heart Disease: ____

High Blood Pressure: ____

Diabetes: ____

Cancer: ____

Other Inherited Diseases: ____

Emotional Problems: ____

Health Habits: *(Circle most appropriate)*

Tobacco Use:	Never	Rarely	Frequently	How Long_______________
Tobacco exposure:	Who__________	How Much____________	Outside/Inside	
Alcohol:	Never	Rarely	Frequently	How Much______________
Street Drugs:	Never	Rarely	Frequently	What___________________
Exercise:	Never	Rarely	Frequently	How Much______________
Seatbelt:	Never	Sometimes	Always	
Nutrition:	Poorly	Meet Daily Needs	Excessively	
Caffeine:	Never	Sometimes	Frequently	How Much_______________
Helmet use:	Never	Sometimes	Always	

School Activities: ____

Development:

Age Child....

Sat Up Alone: ____

Crawled: ____

Walked: ____

Talked in Phrases: _______________________________________

Primary Physician____

Pediatric Health History (page 3 of 3)

Name:____ Date: _________________________________

Has this child had any of the following problems: *(include both recent, past and present)*

Mark with X current symptoms, √ for past symptoms

General

Anemia ___ ___
Recent Weight Change ___ ___
Thyroid Problems ___ ___
Diabetes/High Blood Sugar ___ ___
Frequent Fever or Chills ___ ___
Frequent Large Lymph Glands ___ ___
Other ______________ ___ ___

Skin

Frequent Rashes ___ ___
Changing Mole ___ ___
Other ______________ ___ ___

Head

Frequent Headaches ___ ___
Visual Problems ___ ___
(not corrected by glasses)
Frequent Dizziness ___ ___
Fainting ___ ___
Epilepsy or Seizures ___ ___
Weakness in Arms or Legs ___ ___
Numbness in Arms or Legs ___ ___
Frequent Ear Infections ___ ___
Hearing Difficulties ___ ___
Ringing in Ears ___ ___
Frequent Nosebleeds ___ ___
Frequent Nasal Congestion ___ ___
Difficulty Swallowing ___ ___
Persistent Hoarseness ___ ___
Other ______________ ___ ___

Lungs

Severe Shortness of Breath ___ ___
Asthma or Emphysema ___ ___
Frequent Cough ___ ___
Coughing up Blood ___ ___
Tuberculosis ___ ___
Frequent Bronchitis ___ ___
Other _______________ ___ ___

Heart

High Blood Pressure ___ ___
Rheumatic Fever ___ ___
Chest Pain or Pressure ___ ___
Irregular Heartbeat ___ ___
Heart Murmur ___ ___
Racing Heart ___ ___
Other ______________ ___ ___

Digestive Tract

Indigestion or Heartburn ___ ___
Ulcers ___ ___
Frequent Abdominal Pain ___ ___
Vomiting Blood ___ ___
Hepatitis or Liver Problems ___ ___
Gallbladder Problems ___ ___
Frequent Diarrhea ___ ___
Hemorrhoids ___ ___
Rectal Bleeding ___ ___
Black Tarry Bowel Movements ___ ___
Recent Change in Bowel Habits ___ ___
Other ________________ ___ ___

Urinary

Bladder or Kidney Infection ___ ___
Kidney Stones ___ ___
Burning with Urination ___ ___
Difficulty Passing Urine ___ ___
Difficulty Controlling Urine ___ ___
Getting Up at Night to Urinate ___ ___
Blood in Urine ___ ___
Venereal Disease ___ ___
Other ________________ ___ ___

Genitalia

Boys
Undescended Testes ___ ___
Girls
Breast Lump ___ ___
Irregular Periods ___ ___
Abnormal Vaginal Bleeding
or Spotting (not with periods) ___ ___
Age of Onset of Periods __________
Cycle _________ days (start to start)
Birth Control Method ___________________

Psychological

Frequent Anxiety ___ ___
Frequent Depression ___ ___
Recently Thought About Suicide ___ ___
Loss of Interest in Activities ___ ___

Behavior

School Problems ___ ___
Sleeping Difficulties ___ ___
Nightmare/Terrors ___ ___
Unusual Fears ___ ___
Problems playing with other kids ___ ___
Poor Appetite ___ ___
Temper Tantrums ___ ___

CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I, ________________________, certify that I am the parent/legal guardian of ___________________________, a minor ("Child"), their DOB:______________and that I am authorized to provide informed consent for any medical treatment provided to my Child. I hereby give my express consent for the health care providers at Waverly Health Care Urgent Care to perform the following procedures on my Child:

_______ Diagnostic procedures such as laboratory tests (e.g., urinalysis, blood work, cultures), X-rays and physical examination;

_______ Medical treatment as deemed necessary by Waverly Health Care Urgent Care healthcare providers;

_______ Immunizations; and

_______ Ongoing treatments or therapy (e.g., allergy shots)

I understand the nature of the treatment or procedures, and I acknowledge that no guarantees have been made to me or my Child as to the results of treatment or examination performed at Waverly Health Care Urgent Care.

Furthermore, I acknowledge that I am financially responsible for any and all medical examinations and treatments provided to my Child at Waverly Health Care Urgent Care. I hereby assign and authorize payment directly to Waverly Health Care Urgent Care any and all third party payor benefits otherwise payable to me. I hereby agree that Waverly Health Care Urgent Care may issue a receipt for any such payment and that this receipt shall be a conclusive acknowledgment by me that I have received insurance benefits from the insurance company(ies) in the sum specified in such receipt, and agree that such payment shall discharge the insurance company(ies) of any and all obligations under the policy(ies) to the extent of such payment and for that purpose. I expressly authorize Waverly Health Care Urgent Care to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to Waverly Health Care Urgent Care for charges not covered by this assignment and further agree to guarantee prompt payment in full of any balance due.

I further authorize ________________________ to be present during medical treatment of my Child.

A photocopy of this document shall be considered as valid as the original.

Dated this ____ day of _____________, _____.

___________________________ ___________________________
Witness Signature of Parent or Legal Guardian

Pine Lake Health, LLC & Waverly Health Care
Patient Information

(Please Print)

Patient Name: ______________________________________ **DOB:**_______________

Receipt of Notice of Privacy Practice

_________ I have been offered or received a copy of Pine Lake Health, LLC's Notice of Privacy Practices.
Initial

Message Authorization

Representatives of Pine Lake Health, LLC are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email. I realize this information may include pertinent health status and/or financial information.

□ DO NOT leave a message *(Check box if applicable)*

Authorization to Communicate Personal Health Information:

Pine Lake Health, LLC may communicate information to the following people regarding my health status as needed:

Name ___________________________Phone Number ______________ Relationship ____________________

Name ___________________________Phone Number ______________ Relationship ____________________

____

Patient Authorized Signature

____

Relationship to patient Date

For MEDICARE Patients ONLY

MEDICARE Authorization

I request that payment of authorized MEDICARE benefits be made either to me, or, on my behalf, to Pine Lake Health, LLC for any services furnished to me by its physician. I authorize my holder of medical information to release to the Centers for MEDICAID and MEDICARE Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization

I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Pine Lake Health, LLC for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

____

Patient Authorized Signature

____

Relationship to patient Date

Pine Lake Health, LLC & Waverly Health Care
Financial Policy and Patient Responsibilities

Thank you for choosing Pine Lake Health, LLC as your primary health care provider. We are committed to assisting you with timely insurance filing and payment of your account. The following is a statement of our Financial Policy, which we require you to read and sign prior to initial visit.

Pine Lake Health, LLC is committed to providing the best treatment possible for our patients. Patients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our practice participates with many insurance plans and a current listing is available at each location and on our website www.pinelakehealth.com. If your insurance plan does not cover our services, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa, Discover, and debit cards.

Updated insurance information must be given to us at the time of service. We will require a copy of your insurance cards before services are performed and these will be scanned into our system. We file all insurance claims in a timely manner. After filing, we allow 30 business days for your insurance company to pay. If your insurance company fails to make payment, you will be responsible for payment in full.

If the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. We cannot become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee If you have a past due personal balance on your account, you will need to contact the billing office to make payment arrangements prior to receiving most services. Any account that is over 90 days past due will be sent to an independent collection service and may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship.

Copays, Co-insurance and /or Deductibles **–** There may be some copay, co-insurance or deductible charges associated with certain medical services and tests. Patient payment of the copay, co-insurance, or deductible is required at the time of service.
Pre-certification **–** Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. It is your responsibility to confirm that you have been granted approval of certification before your appointment so you do not incur any unnecessary personal charges.

Other physician charges **–** Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as Pathology, Laboratory, and/or Radiology interpretation services, unless Pine Lake Health, LLC purchased these services.

Motor Vehicle Accident – Medical insurance will be filed and any co pay, co-insurance or deductible is required to be paid at the time of service. If no payment is received from the insurance company after 30 business days, it will become the patient's responsibility. Filing claims to the auto insurance is the responsibility of the patient.

Unless contractually prohibited by your insurance carrier, you may be personally charged the following additional fees. These fees will not be filed to your insurance carrier and are the direct responsibility of the patient. Please initial to the left of each category to indicate your acknowledgement.

______ ***No Show Appointments & Returned Checks*** **–** Unless canceled at least 24 hours in advance,
(INITIAL) depending on the type of appointment, you may be charged a fee of $25.00 to $50.00 for each occurrence. After the 2nd no show appointment you will be dismissed from the practice. All returned checks will be charged a fee of $25.00 for each occurrence.

______ ***Patient Billing Fee*** – Unless other suitable arrangements are made in advance, patients who fail to pay their co-payment,
(INITIAL) co-insurance, deductible, or estimated balance due at the time of service may be billed a fee up to $25.00 for each occurrence. I agreed to be billed a fee of 35% of a bad debt balance for any extraordinary costs associated with collection of funds owed to Pine Lake Health, including but not limited to, collection agency fees, attorneys' fees and court costs.

_____ ***Forms / Letters / Copy of Medical Records*** **–** There is a charge for completion of all forms, letters, or copying of medical records. (INITIAL) Payment must be made before the completion or release of any forms, letters, or medical records.
Forms for disability, FMLA and etc…will range $20.00 to $50.00. Letters may be billed up to a maximum of $40.00. Copying of medical records is charged of $5.00 handling fee plus $.25 per page.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about me to release to any third party payers (including Medicare and Medicaid) information needed for claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for the physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer, including Medicare and Medicaid, on my behalf. I request payment of benefits under Title XVIII (Medicare and XIX Medicaid) of the Social Security Act to Pine Lake Health, LLC. I understand that I am financially responsible for charges not covered by the assignment, and I hereby guarantee timely payment in full of any such charges.

By signing below, I acknowledge that I have read and fully understand this Policy and my financial responsibilities as a patient of Pine Lake Health, LLC.

Print Patient Name: ____Date ___________

Signature of Patient or Responsible Party ______________________________________