

# Young Pediatrics

## Registration Form

**Please Print**

Today's Date \_\_\_\_\_

### *Patient Information*

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address \_\_\_\_\_ Sex \_\_\_\_ M \_\_\_\_ F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell/Alternate (\_\_\_\_) \_\_\_\_\_

Patients Social Security # \_\_\_\_\_

### *Parent Information*

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Address if different than patient's \_\_\_\_\_ Occupation \_\_\_\_\_

Employer name and address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_

Address if different than patient's \_\_\_\_\_ Occupation \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Employer name and address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Siblings Name & Ages \_\_\_\_\_

Emergency contact (other than parents) \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Phone \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Relation to Patient \_\_\_\_\_

### *Insurance Information*

Primary Insurance \_\_\_\_\_ HMO or PPO

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective date \_\_\_\_\_

Person who carries this insurance \_\_\_\_\_ S.S. # \_\_\_\_\_

Relation to patient \_\_\_\_\_

Employer name and address (if not previously listed) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ HMO or PPO

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Effective date \_\_\_\_\_

Person who carries this insurance \_\_\_\_\_ S.S. # \_\_\_\_\_

Relation to patient \_\_\_\_\_

Employer name and address (if not previously listed) \_\_\_\_\_

Who can we thank for referring you to Young Pediatrics? \_\_\_\_\_

*Young Pediatrics*  
*History Questionnaire*

Form Completed By \_\_\_\_\_

Date Completed \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Male or Female \_\_\_\_\_

*Household* Please list all those living in the child's home

Name	Relationship	Birth date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live. \_\_\_\_\_

If mother and father are not living together or if child does not live with parents, what is the child's custody status? \_\_\_\_\_

If one or both parents are not living in the home, how often does he/she see the parent (s) not in the home? \_\_\_\_\_

*Birth History*

Birth Weight \_\_\_\_\_ Birth Height \_\_\_\_\_

Mom's Gestation \_\_\_\_\_ weeks

Did mom have any illness or problem with her pregnancy? \_\_\_\_\_

If yes, explain \_\_\_\_\_

During pregnancy did mom

Smoke \_\_\_\_\_ Drink alcohol \_\_\_\_\_

Use drugs or medications \_\_\_\_\_ If yes please list what and when \_\_\_\_\_

Was the delivery Vaginal? Or Cesarean?

If cesarean, why? \_\_\_\_\_

Did baby have any problems right after birth? \_\_\_\_\_

If yes, explain \_\_\_\_\_

Was initial feeding Breast? Or Bottle?

Did baby fo home with mother form hospital? \_\_\_\_\_

If no, explain \_\_\_\_\_

*General*

Do you consider your child to be in good health? Yes No Explain \_\_\_\_\_

Does your child have any serious illness or medical condition? Yes No Explain \_\_\_\_\_

Has your child had serious injuries or accidents? Yes No Explain \_\_\_\_\_

Has your child had surgery? Yes No Explain \_\_\_\_\_

Has your child ever been hospitalized? Yes No Explain \_\_\_\_\_

Is your child allergic to any medications or drugs? Yes No Explain \_\_\_\_\_

*Development*

Are you concerned about your child's development? Yes No Explain \_\_\_\_\_

Are you concerned about your child's mental or emotional development? Yes No Explain \_\_\_\_\_

Are you concerned about your child's attention span? Yes No Explain \_\_\_\_\_

If your child is in school:

How is his/her behavior in school? \_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_

Is he/she in special or resource classes? \_\_\_\_\_

## Family History

Have any family members had the following:

Deafness	Yes	No	Who _____	Comments _____
Nasal Allergies	Yes	No	Who _____	Comments _____
Asthma	Yes	No	Who _____	Comments _____
Tuberculosis	Yes	No	Who _____	Comments _____
Heart disease (before age of 50 years)	Yes	No	Who _____	Comments _____
High Blood Pressure (before 50 years)	Yes	No	Who _____	Comments _____
High Cholesterol	Yes	No	Who _____	Comments _____
Anemia	Yes	No	Who _____	Comments _____
Bleeding Disorder	Yes	No	Who _____	Comments _____
Liver Disease	Yes	No	Who _____	Comments _____
Kidney Disease	Yes	No	Who _____	Comments _____
Diabetes (before 50 years)	Yes	No	Who _____	Comments _____
Bed-Wetting (after 10 years of age)	Yes	No	Who _____	Comments _____
Epilepsy or Convulsions	Yes	No	Who _____	Comments _____
Alcohol Abuse	Yes	No	Who _____	Comments _____
Drug Abuse	Yes	No	Who _____	Comments _____
Mental Illness	Yes	No	Who _____	Comments _____
Mental Retardation	Yes	No	Who _____	Comments _____
Immune Problems, HIV, or AIDS	Yes	No	Who _____	Comments _____
Additional family history	_____			
	_____			
	_____			

## Past History

Does your child have or has he/she ever had:

Chickenpox	Yes	No	When _____
Frequent ear infections	Yes	No	Explain _____
Problems with ears or hearing	Yes	No	Explain _____
Nasal Allergies	Yes	No	Explain _____
Problems with eyes or visions	Yes	No	Explain _____
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	Yes	No	Explain _____
Any heart problem or heart murmur	Yes	No	Explain _____
Anemia or bleeding problem	Yes	No	Explain _____
Blood transfusion	Yes	No	Explain _____
Frequent Abdominal pain	Yes	No	Explain _____
Constipation requiring doctor visits	Yes	No	Explain _____
Bladder or kidney infection	Yes	No	Explain _____
Bed-Wetting (after 5 years of age)	Yes	No	Explain _____
(for girls) Has she started her menstrual periods?	Yes	No	When _____
(for girls) Are there any problems with her periods?	Yes	No	Explain _____
Any chronic or recurrent skin problems	Yes	No	Explain _____
Frequent headaches	Yes	No	Explain _____
Convulsions or other neurologic problems	Yes	No	Explain _____
Diabetes	Yes	No	Explain _____
Thyroid or other endocrine problems	Yes	No	Explain _____
Any other significant problem	Yes	No	Explain _____
Use of alcohol or drugs	Yes	No	Explain _____

List any medications child is currently taking \_\_\_\_\_



# YOUNG PEDIATRICS

## Notice of Privacy Practices

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

This notice takes effect on November 6, 2006 and remains in effect until we replace it.

### **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your child's medical information is important to us. We understand that medical information is personal and we are committed to protecting it. We create a record of the care and services your child receive at our organization. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **2. OUR LEGAL DUTY**

*Law Requires Us to:*

1. *Keep your child medical information private.*
2. *Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.*
3. *Follow the terms of the notice that is now in effect.*

*We Have the Right*

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

*Notice of Change to Privacy Practices:*

1. Before we make an important change in privacy practices, we will change this notice and make the new notice available upon request.

### **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Note every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your child's medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

**For Treatment:** We may use medical information about your child to provide he/she with medical treatment or services. We may disclose medical information to doctors, nurses, technicians, medical students or other people who are taking care of your child. We may also share medical information about your child to your other health care providers to assist them in treating them.

**For Payment:** We may use and disclose your child's medical information for payment purposes.

# Young Pediatric

## Appointment Policy

It is our intention to provide your children the best care possible at all times and to accommodate as many requests as is realistic and feasible. It is within this context that we ask you to take a few moments to review policies that affect the way services are provided.

- **Arrive early.** Please remember that all insurance requires that your insurance data be updated prior to each encounter. This usually takes a few minutes. If this is not done, your insurance may deny your claim. We do not want time spent on administrative requirements to limit your time with the doctor.
- **Schedule an appointment by calling 618-288-9305 option #2.** Walk-in patients are offered the first available appointment. There is a \$ 10.00 fee for this service, in addition to visit fee, and it is not covered by insurance.
- **Schedule same-day appointments for ill visits.** Appointments are used on a first-available appointment basis.
- **Patients who arrive on time are seen at their appointment time.** Patients who have arrived on time will be seen ahead of those who arrive late. If you arrive late, we may need to abbreviate or reschedule your child's visit.
- **Call ahead if you are late or unable to make your appointment time.** We will do all that we can to accommodate your child's appointment and to minimize the need to reschedule your appointment.
- **Late arrivals ( $\geq 15$  minutes after scheduled appointment) will be offered the next available appointment.** In these cases, a no-show charge for the lost appointment will apply. While we will do all that is possible to accommodate requests, the first-available appointment may *or may not* be on the day the appointment was missed.
- **The no-show charge will be waived if you contact the office 24 hours before your appointment.** Remember that appointments canceled more than 24 business hours prior to when they were scheduled do *not* incur a no-show fee.
- **Appointments for additional children should be made by phone prior to coming to the office.** An additional \$10.00 charge is applied for the add-on appointments. If you would like another child to be seen, please schedule appointments for *both* children *by phone* prior to coming to the office.
- **Turn off cell phones in the office and examination rooms.**

## After-hours Call Service

- **Please limit after-hour calls to urgent issues and emergencies.** For refills, appointment requests, and other nonurgent matters, you may leave a message or call the office during regular hours. Please also do the following when leaving a message:
  - Please speak slowly.
  - Be sure to leave a callback number.
  - Disable your call block feature.
  - Follow the doctor's instructions.

**We are here to provide the *best* care we can to your children should the need arise. As always, we welcome the opportunity to care for your children and appreciate your trust in the services we provide.**

### *Young Pediatric* Staff

Physician	-	Dr. Staci Young
Pediatric Nurse Practitioner	-	Stefanee Keth
Nurse & Office Manager	-	Denise Gray
Triage Nurse	-	Jackie
MAs	-	Mendy, Kari, Natalie, Sher
Reception	-	Sher
Office Assistant	-	Libby

*Young Pediatrics*  
**Missed Appointment Policy**

**Office Policy Addressing Missed Appointments**

- After the first missed appointment, a \$25.00 fee will be charged. The appointment may be rescheduled.
- If a second scheduled appointment is missed, a \$25.00 fee will be charged. Missed appointment letter is sent, again reiterating our policy. The appointment may be rescheduled.
- If a third scheduled appointment is missed, it will be necessary to terminate our professional relationship with the patient and family. Termination letter is sent.

As a parent/guardian of a patient of Young Pediatrics I agree to pay any charges that may accumulate from missed appointments.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

## Health Form Policies

It is the goal of the physicians and staff to accommodate as many requests as possible to the furthest reasonable extent, bearing in mind the following limitations:

1. **Blank forms will not be accepted.** Forms will only be accepted for completion if the patient's name and other information has been completed. *In some cases we may not be able to complete or certify a form if parents have not completed their parts of the forms prior to form submission.*
2. **Turnaround time for form completion is usually fewer than 10 business days.** While every effort will be made to complete forms as quickly as possible, parents should realize that at certain times of the year we may receive hundreds of health forms in one week, and remember that *each* of these has to be carefully reviewed by a physician before it is released. *Parents are strongly advised not to wait until the last moment to look at the paperwork they have received from the program their child is scheduled to attend.*
3. **Forms will be held here for parents to pick up.** Because of Health Insurance Portability and Accountability Act (HIPAA) regulations, forms will be released *to parents only*. Federal law prohibits doctors' offices from faxing or mailing medical information to nonmedical facilities. We cannot be responsible for delays or losses in the mail.
4. **Forms are completed for those whose accounts are in good standing.** Delinquent accounts must be brought current before forms will be released. Forms must be paid for before they are released.
5. **Many forms require the information to be based on an examination completed within 12 months** of the date the form is completed. These requirements notwithstanding, no form will be completed for any patient who has not had a physical examination in our office in more than 12 months.
6. **Forms are completed on the basis of examinations conducted by physicians in this medical group.** Examinations performed by "checkup centers" will not be cosigned by your physician, nor will he or she complete any forms based in whole or in part on any information provided by such centers.
7. Forms are completed based on information abstracted by staff from your child's chart. All forms are reviewed by a physician for completeness and accuracy. In some cases, forms mandate that only the physician may complete them.

8. There is **no charge for Women, Infants, and Children (WIC) forms.**
  
9. **The minimum charge for review or completion of a non-WIC form is \$5 per form.** Charges vary with duration of physician involvement and time. *The physician completing the form determines the charge.* The front office staff does not have the authority to alter, reduce, or change charges.
  
10. **Insurance companies do not reimburse for form completion,** and we do not bill insurance for completing any form.