IMPACT PEDIATRICS, LLC

Patient Information: This information refers to the patient only.

Social Security Number:______________________________

Last Name:____________________________ Jr., II, ______

First Name:_______________ Middle Name____________

Sex: ☐ Male ☐ Female

Address:____

Zip Code:__________ City:______________State: ______

E-mail Address: _________________@__________. _____

Home Phone: (_______)______________________________

Work Phone: (_______)__________________ext: ________

Birth Date (mm/dd/yy): ______________Age ______

Race: ☐ Caucasian ☐ Hispanic ☐ African-American ☐Other:__________

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self(skip to next section) ☐ Parent ☐ Spouse ☐ Other:__________

Social Security Number:______________________________

Last Name:____________________________ Jr., II, ______

First Name:____________________________ MI_________

Address:____

Zip Code:__________ City:______________State: ______

Home Phone: (_______)______________________________

Work Phone: (_______)__________________Ext__________

Birth Date (mm/dd/yy):_________________________

If Employed, Employer:____________________

____

Address:_________________________________

____

Zip Code:________________________________

City/State:_______________________________

If Student ☐ Full-Time ☐ Part-Time

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED

Relationship to Patient: ☐ Self(skip to page 2) ☐ Parent ☐ Spouse ☐ Other:______________

Social Security Number:______________________________

Last Name:____________________________ Jr., II, ______

First Name:____________________________ MI_________

Address:____

Zip Code:__________ City:______________State: ______

Home Phone: (_______)______________________________

Work Phone: (_______)__________________Ext__________

Birth Date (mm/dd/yy):_____________

If Employed, Employer:____________________

____

Address:_________________________________

____

Zip Code:________________________________

City/State:_______________________________

If Student ☐ Full-Time ☐ Part-Time

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Please ensure the office has a copy of your most recent insurance card(s)

INSURANCE COVERAGE INFORMATION: Please show all numbers on your card(s).

PRIMARY INSURANCE COVERAGE:

Insured (Name on card):_________________________ **Insured ID Number:**_____________________________

Insurance Co. Name:_____________________________ **Group/Member/Policy Number:**___________________

Address:______________________________________ **Effective Date:**_________________________________

SECONDARY INSURANCE COVERAGE:

Insured (Name on card):_________________________ **Insured ID Number:**_____________________________

Insurance Co. Name:_____________________________ **Group/Member/Policy Number:**___________________

Address:______________________________________ **Effective Date:**_________________________________

IN CASE OF EMERGENCY . . . .

Name and Phone number of nearest relative NOT living with you (include relationship):

____ ____

AUTHORIZATION FOR TREATMENT AND TO PAY BENEFITS TO THE PHYSICIAN . . . .

I attest that this information is true and correct to the best of my knowledge. I confirm that I have received a copy of the Impact Pediatrics, LLC *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I authorize the office of Impact Pediatrics, LLC. to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept financial responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

___________________________________ ____

Date **Signature of Patient and / or Guardian, if patient is Minor**

NEW PATIENT MEDICAL HISTORY

Date_____________________

Patient Name ____DOB___________

Birth weight______________________If premature, how many weeks?______________

Any problems at birth that required special treatment? Yes____ No_________________

If yes, please list____

____

Chronic or recurrent illnesses____

____

Surgeries/Fractures/Serious injuries____

____

Current Medications____

____

Drug Allergies and reactions: ____

*Please initial above

Food/other allergies and reactions____

____

Are Immunizations up to date?
Yes___ No___ (we will need copy of shot record)

Developmental or Learning problems____

____

Form Completed by:________________________ Reviewed by: _________________

FAMILY MEDICAL HISTORY

Date_______________

Patient and Siblings Names:
____

MOTHER'S NAME_______________________________________**DOB**______________

Occupation__________________ Medical Problems________________________________

____ Smoker? __________

FATHER'S NAME_______________________________________**DOB**_______________

Occupation__________________ Medical Problems ________________________________

____Smoker? __________

*****List all other relatives of child with significant medical problems, their age at death (if applicable):**

Relative: **Medical Problems/Cause of Death:**

____

____

____

____

____

Is there a Family History of: Asthma ____

Allergies____

High Cholesterol____________________________________

Heart attack or stroke before age 60____________________

Diabetes____

***Significant medical family history include, but are not limited to: Cancer(type), Thyroid problems, Heart attack, Stroke, Seizure disorders, Psychiatric illness, Alcoholism, Hearing loss, Kidney problems, Congenital problems, Arthritis, Colitis, Asthma

Form Completed by:______________________________________ Reviewed by:____________________________

IMPACT Pediatrics Patient Financial Policy

IMPACT pediatrics strives to provide the best medical care for your child. In doing so, we assist you with filing insurance claims to help you receive the maximum benefits allowed. Therefore, at the time of service, it is your responsibility to provide us with complete and up to date insurance information. If you do not have insurance, our staff will provide you with information regarding payment plan options.

All patients or legal guardians must complete and sign the Patient Information Form before being seen by a provider.

Co-payments must be paid upon check in. We accept cash, checks, and some credit cards such as Visa. There will be a $30.00 return check fee. Co-payments are required to be paid by your insurance company so IMPACT Pediatrics can not change or waive co-pays. There may be a charge for non-payment of co-pays at the time of service.

A current insurance card and I.D. must be provided for verification. If you have changed insurance companies, please complete an address/insurance information update sheet.

Insurance Responsibility

Payment of medical care may be your responsibility if your insurance does not pay or does not cover the services provided for you and your child. Please be aware that we may provide services for your child that your insurance may deny as “not covered”. We suggest you review your policy in full so that you understand which services are covered and which are not. If you have questions regarding your policy, please contact your insurance company, as we do not know the specifics of each patient’s plan. Please know the extent of coverage and potential for personal liability before we provide services to you.

We send our labs to Nationwide Children’s Hospital. Most plans allow Children’s to provide laboratory services but there may be plans that have another preferred provider. It is the parent’s responsibility to know the preferred lab for your plan. Please inform us if your child’s labs need to be sent to another lab and we will make every effort to have that lab pick up your child’s labs. Common labs sent out include strep tests, urine for analysis and culture and wound cultures.

Records Transfer and Copy Requests

IMPACT Pediatrics charges $10.00 per child/$15.00 per family to have records copied for transfer to another provider.

I have read, fully understand and agree to all terms set forth in the above Financial Policy.

__________________________________ ________________________
Printed Name of responsible party Date signed

____
Signature of responsible party

Child’s Name Date of Birth	Child’s name Date of Birth
Child’s Name Date of Birth	Child’s Name Date of Birth

Notice of Privacy Practices

This notice describes how medical information about you and your child (our patient) may be used and disclosed and how you can get access to this information. Please review it carefully.

Our responsibility to you:

We our required by law and obligated to maintain the privacy of your medical information and provide you with this notice of our legal duties and practices.

We are responsible for abiding by the current terms listed in this notice.

We are responsible for providing our patients with a notice of any changes to or revisions of this notice of privacy practices.

We are responsible for maintaining documentation of privacy notices and written acknowledgements for a period of six years from the date of creation or the date last in effect, whichever is later.

How we may use and disclose health information about you:

We may use and disclose medical information about you for treatment (by sending medical information about a visit to another physician involved in your care as part of a referral): to obtain payment for your treatment and to support our healthcare operations.

We may disclose medical information about you to our business partners that provide us with administrative support in rendering your care. These business partners are required by contract and by law to comply with the provisions of federal privacy laws (under HIPPA) and give you the same protection of your privacy that we do.

We may also use or disclose your medical information for many other purposes. Subject to certain requirements we may give out medical information about you for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, workers compensation purposes or emergencies. We also will disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We may also contact you for appointment reminders, or tell you about or recommend treatment options, alternatives, health related benefits or services that may be of benefit to you.

In any other situation not discussed in this in this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use of disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding your medical information:

You have the right to review and obtain a copy of medical information that we use to document your care by submitting a written request. A charge may be assessed to offset the cost of making copies.

You have the right to request that we correct your records by submitting a request in writing that provides your reason for requesting the correction.

You have a right to a list of any instance where we have disclosed medical information about you, other than for treatment, payment, and health care operations or per your written request. The request must state the time period desired and can not precede the date of September 1, 2011.

You have the right to request that medical information about you be communicated in a confidential fashion. This may include sending mail to an address other than your home. Your request must specify how and where you wish to be contacted. We will honor all reasonable requests.

You have the right to be provided with a paper copy of this notice for your own use if you so desire.

Complaints:

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may file a complaint with our practice in writing with our Privacy Official.

You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights.

Under no circumstances will you be penalized or retaliated against for filling a complaint.

IMPACT PEDIATRICS
HIPPA NOTICE AND CONTACT OPTIONS

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE IMPACT PEDIATRICS NOTICE OF PRIVACY PRACTICES.

Patient Name: ______________________________ Date of Birth: ____________

Parent/Gaurdian: ______________________________

Relationship to Patient: ___________________________

Signature: ____ Date: ____________

Contact options with appointments and medical information:

_______ I may be contacted at home by phone ______________________________

_______ A voicemail message may be left at my home

_______ I may be contact by cell phone ______________________________

_______ A voicemail or text may be left on my cell phone

_______ I may be contacted at work ______________________________

_______ A voicemail may be left to contact IMPACT Pediatrics at my work. (We will not leave medical information at your work, only a message to call us)

_______ I may be contacted via email ___________________________________

_______ I may be contacted via US mail ___________________________________
Appointment reminders will be sent, labs and results if requested

What is your preferred method to contact you about your child? ________________