PINE LAKE HEALTH LLC

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 Person whom is financially responsible for the patient)

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, Pine Lake Health, LLC, when he/she accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Pine Lake Health, LLC, to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) Date

Pediatric Health History

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 (cont.)

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 (cont.)

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

B*oys*		
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	___	___

PINE LAKE HEALTH LLC

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 Pine Lake Health, LLC 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 Pine Lake Health LLC 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 Pine Lake Health LLC.

Furthermore, I acknowledge that I am financially responsible for any and all medical examinations and treatments provided to my Child at Pine Lake Health LLC. I hereby assign and authorize payment directly to Pine Lake Health LLC any and all third party payor benefits otherwise payable to me. I hereby agree that Pine Lake Health 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 Pine Lake Health LLC to furnish the insurance company(ies) with any information desired concerning said medical care and treatment. I understand that I am financially responsible to Pine Lake Health LLC 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.

_____

Patient Authorized Signature

_____

Relationship to Patient Date

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)*

Email: _____

Authorization to Communicate Personal Health Information:

Pine Lake Health, LLC may communicate information to the following people regarding my/my child's 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 _____

PINE LAKE HEALTH LLC

CREDIT CARD POLICY

I understand it is the financial policy of Pine Lake Health, LLC to secure an imprint of my credit card at the time of my initial visit.

If, after a claim has been submitted to my insurance carrier:
(1) the claim is denied for any reason; OR,
(2) the charges are not paid, or only partially paid, by my insurance carrier;

Pine Lake Health, LLC will charge my credit card for the entire amount owed for treatment or services provided to me or my dependent.

I understand that in the event my credit card has been charged for medical treatment or services, and my insurance carrier subsequently makes payment to Pine Lake Health, LLC for those charges, the office will issue a credit to my credit card in the amount received from my insurance carrier.

CREDIT CARD: VISA MASTERCARD DISCOVER

Credit Card Number: | | | | | | | | | | | | | | | |

Expiration Date: _____ 3 Digit Security Code: | | |

Name of Card Holder:_____ Signature of Card Holder: _____

Name of Patient: _____ Telephone No: _____

Address: _____

_____

I hereby authorize Pine Lake Health, LLC (a Nebraska company) and its designated employees to charge my credit card the full amount of all charges made for medical treatment and services provided by Pine Lake Health, LLC and the amount charged to my credit card will be reflected on my credit card statement.

The charge will be based on the medical treatment rendered to me (or, my dependent) and the usual and customary charges made by Pine Lake Health, LLC for such treatment and service.

If my credit card company denies payment, I will pay the entire amount within 30 (thirty) days.
I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Pine Lake Health, LLC and agree that if the office places my account with an agency or attorney for collection, Pine Lake Health, LLC shall be paid by me for all of its costs and expenses in collecting monies owed to them to the extent allowed by applicable law.
Those expenses include, but shall not be limited to, attorney's fees, court costs and other expenses incurred with collection of my account by an agency or attorney.

This authorization shall remain effective unless expressly revoked by me in writing, delivered to the office of Pine Lake Health, LLC.
.

_____ _____ _____
SIGNATURE of Patient/ Responsible Party PRINTED DATE

If you would like to receive an email notification when your credit card has been charged please provide us with your email address.

_____@_____