

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

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
PINE LAKE HEALTH & WAVERLY HEALTH CARE**

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 & Waverly Health 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 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.
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 _____