Pine Lake Health, LLC & Waverly Health Care

PEDIATRIC HEALTH HISTORY

PATIENT INFORMATION

Full Name: (include middle initial)	Today's 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

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	___	___

Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St. Lincoln, NE 68506

CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD WITHOUT PARENT / LEGAL GUARDIAN PRESENT

Minor's Name: _____ DOB: _____

By law in Nebraska, any child under the age of 19 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (if none, state 'none' or 'na')

_____

☐Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 and older**.

This consent shall be in effect for: ☐ Date_____**(only)**

☐ Indefinitely, until revoked by written communication

AUTHORIZATION:

I (parent/legal guardian name) _____request and authorize Pine Lake Health, LLC and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Pine Lake Health, LLC and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment, minor burns, minor suturing of lacerations) and prescribing new medications.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____

Parent or Legal Guardian (please print) **Relationship**

_____

Parent or Legal Guardian Signature **Date**

Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St. Lincoln, NE 68506

HIPAA RELEASE OF 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

2611 S. 70th St. Lincoln, NE 68506

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. could range from $50-$300 per occurrence depending on the complexity of the requested paperwork plus the patient visit. Copying of medical records is charged $.50 cents per page. Copying of medical records (PDF) to CD is charged at $30 per patient.

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 & Waverly Health Care

2611 S. 70th St, Lincoln NE 68506 | Phone: (402) 423-4200 | Fax: (402) 423-4201 | Email: info@pinelakehealth.com

Authorization for the Release of Medical Information / Medical Records

Patient Name: _____ Date of Birth: ____/_____/_____
Last First MI

TO or FROM (circle one) :	**TO:**
_____ **(Name of facility or Medical Provider)**	**Pine Lake Health / Waverly Health Care**
_____ **(Address)**	2611 S. 70th St, Lincoln NE 68506 OR 13220 Callum Dr. Suite 4, Waverly NE 68462 (**do not send records to the Waverly address**)
_____ **(Address)**	**Fax: 402-423-4201**
_____ **(Phone & Fax)**	(*Please DO NOT fax more than 10 pages! Records over 10 pages, please send via secure email or place on CD & mail to our address*)

Please send the following health information:

____ Entire Medical Records ____ Inclusive Dates Only ___/___/_____-___/___/_____

____ Immunization Records ____School Physicals ____ Mental Health Records

____ Other; if applicable, the following health information related to testing, diagnosis, and or treatment for:

_____ HIV/AIDS virus _____sexually transmitted disease _____mental health _____ drug and/or alcohol abuse.

Information to omit: State and Federal law protect the following information as directed by you, the patient.

____ Mental Health records ____HIV/AIDS records ____Substance abuse (Drugs/Alcohol) records

____Other:_____

If leaving practice, please provide us with the following (check all that apply):

____Referral to/from another medical office ____Moving/Moved ____Legal Purposes
____Insurance Purposes ____Personal ____Other:_____
____Transfer to new physician; reason_____

The date of this authorization is _____ / _____ / _____ and shall remain in effect until _____ /_____ / _____
(if no ending date is given, it shall remain in effect for one year from the date of authorization).

Conditions: We may not condition your right to receive health care services from us upon your signing of this authorization if you are leaving our practice. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further use and disclosures: When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such situation, your disclosed health information may no longer be protected by federal and state laws.

Revocation: You have the right to revoke this authorization at any time by notifying the providing organization in writing.
When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Reimbursement: Pine Lake Health, LLC reserves the right to recover the cost involved in producing the requested health information. You or the party to receive disclosures, named able, may be charges $20.00 plus 50 cents per page for handling and coping this information.

I authorize the use and disclosure of the medical records and health care information indicated above:

Print Name: _____ Date: ____/ ____ / _____

Patient Signature: _____

Relationship to patient: self or _____