Northwoods Pediatric Center
(Please Print Clearly)

Patient's Name_____Date of Birth_____Sex_____

Address_____City & Zip_____

Home Phone#_____Email address_____

Mom's Information

Mom's Name_____SS#_____DOB_____

Employer_____WK#_____Cell#_____

Dad's Information

Dad's Name_____SS#_____DOB_____

Employer_____WK#_____Cell#_____

Medical Insurance Information

Aetna____ Blue Cross/Blue Shield____ Cigna____ Humana____ Memorial Hermann_____
United Healthcare___ CHIP___ Other_____

Policy Holder

Who is the policy holder? Dad____ Mom____ Child's individual policy____

Emergency Contacts

Name_____Home ph#_____Cell#_____

Nearest Relative (not living with you)

Name_____Home ph#_____Cell#_____

Authorizations

I authorize the following persons to bring my child for well/sick health care visits at Northwoods Pediatric Center, and receive lab/x-ray results in my absence:**(Must be at least 18 years old)**
1._____2._____3._____

_____-I authorize Northwoods Pediatric to leave my child's lab/x-ray results on my home/cell Phone if I cannot be reached.

_____-I **do not** authorize Northwoods Pediatric to leave my child's lab/x-ray results on my Home/ cell phone if I cannot be reached.

By signing below you authorize Northwoods Pediatric to treat the above patient and also authorize payment of medical benefits, release of correspondence and/or medical records to other medical providers involved in your child's care. I have also read and understand the Northwoods Pediatric Financial Policy.

_____ _____

Parent/Guardian's **Name** Date

_____

Parent/Guardian's **Signature**

Northwoods Pediatric Center
Pediatric Health History

Patient's Name_____ Date of Birth_____

Pregnancy Complications:	Yes	No
Pregnancy less than 9 months	____	____
High Blood Pressure	____	____
Gestational Diabetes	____	____
Medications (if yes, list)	____	____
_____		
_____		
Bleeding	____	____
Serious Illnesses	____	____
Serious Infections	____	____
Previous miscarriages	____	____
C-section (if yes, why?)	____	____
_____		
Were forceps used?	____	____

Birth History:

Place of Birth_____
Birth Weight_____
Length of Labor_____
Hearing Screen Passed Yes____ No____
Is Child Adopted? Yes____ No____

Problems:	Yes	No
Jaundice	____	____
Breathing problems	____	____
Group B strep infection	____	____

Other problems (explain)_____
_____
Breast:_____Formula:_____

Development: At what age did your child……

Smile_____ Roll over_____ Sit alone_____ Walk alone_____
1st word with meaning_____ Use 2 word sentences_____ Bladder trained_____
Bowel trained_____ Ride bike_____ Tie shoes_____

List medication child takes regularly

_____
_____
_____

Hospitalizations & Operations

_____
_____
_____

Child's Illnesses	Yes	No	Date
Chickenpox	___	___	____
RSV infection	___	___	____
Meningitis	___	___	____
Pneumonia	___	___	____
Diabetes	___	___	____
Seizures	___	___	____
Bed Wetting	___	___	____
Kidney disease	___	___	____
Sickle Cell	___	___	____
GE Reflux	___	___	____
Allergies	___	___	____
Asthma	___	___	____

Serious Illnesses?	Dates
_____	_____
_____	_____
_____	_____

Allergies to Medications
_____
_____
_____

Northwoods Pediatric Center

Thank you for choosing Northwood Pediatrics to be your healthcare provider. We are committed to providing quality healthcare for your child. **Please read carefully and initial each policy.**

_____**Vaccine Policy-** Northwoods Pediatricians firmly believe in vaccinating all children according to the standard guidelines from AAP/CDC/TDH. **No exceptions will be made in terms of deferring the vaccines, splitting the vaccine schedule, or altering the vaccine schedule. Any family requesting exceptions to this practice will be asked to transfer care to another pediatric practice.**

_____**Payment Policy-** Payment is required at the time services. For your convenience, we accept VISA, Mastercard, American Express, Discover and cash. No personal checks are accepted. Copayments must be paid at the time of service, regardless of whom brings the child to the office.

_____**Divorced/Separated Parents-** The parent who authorizes treatment or brings the child to be seen is responsible to us for payment. If a divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Northwood Pediatrics will not be able to act as a mediator in collecting our payments.

_____**Outstanding Balances-** Patients with an outstanding balance must make arrangements for payment prior to being seen by our providers. Accounts over 90 days past due will be considered seriously delinquent and referred to the credit bureau.

_____**Insurance-** We bill participating insurance companies as a courtesy to you. If you do not have insurance information with which we participate, full payment is expected at the time of service. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan and therefore ask you to be as familiar as possible with your own plan. It is your responsibility to notify us of any insurance change. If we have not received payment from your insurance plan within 30 days we will request payment in full from you directly. You are ultimately responsible for all charges.

_____**Referrals**- If you are enrolled in a managed care insurance plan, you must receive a referral from our office before seeing a specialist. **No retroactive referrals will be given**. We require at least one week notice to arrange your referral for the specialist.

_____**Lab test/ Specialist appointments-** You take full responsibility of completing laboratory and other tests, and following up with sub-specialists as recommended by the physician.

_____**Medications**- In order to provide quality healthcare for your child, our physicians do not call in medications including antibiotics over the phone, without first evaluating your child.

_____**Well exam schedule-** 1 week, 2 week, 1 month, 2 month, 4 month, 6 month, 9 month, 12 month, 15 month, 18 month, 2 year, 2 ½ year, 3 year, and yearly thereafter until 18 years of age.

_____**Audio and Video recordings/ Use of cell phones**- Strictly prohibited while inside the office.

_____**Pictures-** I give permission for my child's picture to be used in their electronic chart.

_____ _____

Child's Name Date

_____

Parent/ Guardian's Signature

General Consent to Treat

_____ I am the parent/guardian of _____(name of patient).

(Please Initial) I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests that Northwoods Pediatric Center and its designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the Doctors, Nurses, Physician Assistants, Nurse Practitioners, and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

Consent to Release and Obtain Information

_____ Northwoods Pediatric Center and/or the patient's provider may obtain from

(Please Initial) any source and examine, use, or discuss and disclose, the patient's medical record and information to treating hospital personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include but is not limited to medical history, examinations, diagnosis, treatments, any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to obtain and release information is valid until revoked. The undersigned may revoke the consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent.

Electronic Prescriptions (e-prescribing)

_____ I voluntarily authorize Northwoods Pediatric Center to allow e-prescribing for the

(Please Initial) patient's mail order prescriptions, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information, and medical dispense history as long as this child is a patient at this office or until I withdraw my consent.

_____ I have read this form or this form has been read to me in a language that I

(Please Initial) understand and I have had an opportunity to ask questions about it.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

_____ I acknowledge that Northwoods Pediatric Center provided me with a written copy

(Please Initial) of his/her Notice of Privacy Practices, and that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient's Name_____ Patients Date of Birth_____
Name of Patient's Representative_____
Relationship of Patient's Representative_____
Signature of Patient's Representative_____Date: _____

Northwoods Pediatric Center, PA

No Show/ Late Reschedule/ Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A "**no show**" is missing a scheduled appointment. A "**late cancellation**" or a "**late reschedule**" is canceling/ rescheduling an appointment without calling us to cancel/ reschedule 2 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise. We therefore offer multiple ways to communicate with our office: phone call, email, or patient web-portal.

*****Please understand that insurance companies consider this charge to be entirely the **patient's responsibility.**

A charge of $25.00 will be assessed for each "No Show" or "Late Cancellation/ Late Reschedule" of the scheduled appointment if less than 2 hours notice is given from the time of the appointment.

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name: _____Patient's Date of Birth:_____

Parent/Guardian's Signature:_____Date:_____

Northwoods Pediatric Center
Ph 281-296-7770
Fx 281-296-9777

What does a "Well Child Exam" mean or include?

Today you are scheduled for your Well Child Checkup which is also known as your routine checkup, yearly exam, or preventative visit. If this is not the case, or you need anything in addition to this, please let the receptionist know immediately.

What is a Well Child exam?
A well child exam is a visit to your pediatrician for a general health checkup.

What should I expect during my Well Child examination?
- A General exam with Weight, height, blood pressure. At certain ages vision/ hearing testing
- A private area exam in males (females only if indicated)
- Review of vaccines that are due
- Nutrition counseling/nutritional concerns
- Screening labs
- Review of growth/ development

What is NOT included in a Well Child examination?
- Discussion of any new or recurrent problems, symptoms, or concerns (medical or behavioral)
- Consults regarding any established medical problem that needs more/ special attention
- **New health care concerns or problems found at the time of the Well Child Exam (i.e. Ear infections, skin rashes, constipation, asthma, allergies, bedwetting etc.)**
- A detailed review of chronic conditions
- **Sports Physicals**
- Any questions regarding family members, friends, or acquaintances
- Refill of medications for an existing diagnosis

What happens if I have a new health problem or symptom when I come for my Well Child exam?
Well child exams do not include "problem visits", therefore if you do have a chronic condition or acute illness concern at the time of your visit, please notify us and we will check your plan to see if these two visits can be completed on the same day. If so, and if we have the availability, we will take care of both visits for you at the same time. Depending on your plan, a copay/ deductible will be collected to cover the "Non well" part of the exam.

Insurance Coverage Issues:
Please remember that we bill your insurance as a **COURTESY TO YOU**. We will do our best to determine your plans benefits, but it is your responsibility to be as familiar as possible with your plan's benefits and for any balance that your insurance assigns as "members responsibility". Some insurance will cover both a Well Child visit along with a Problem Visit on the same day, given a copay/ deductible is collected.

Patient's name_____ DOB:_____

Patient's name_____DOB:_____

Parent/Guardian signature_____Date:_____