PATIENT INFORMATION

Welcome to Northeast Pediatric Associates, P.A. Please provide the following information.

Patient Name:	Date of Birth:	Gender:
Home Address:	City:	Zip code:

(Circle one: Cell, Home, Work, Other) Primary Phone:	(Circle one: Cell, Home, Work, Other) Secondary Phone:	(Circle one: Cell, Home, Work, Other) Emergency Phone:

Sibling Names & Dates of Birth _____ _____ _____ _____	Contact Name: _____ Method of Contact: ☐ Mailing Address ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer Not to Answer Preferred Language: ☐ English ☐ Spanish ☐ Other: _____	Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Prefer Not to Answer	Were you referred to our clinic? ☐ Yes ☐ No If yes, who shall we thank for the referral: _____

PARENT(S) & *RESPONSIBLE PARTY INFORMATION (Bring a copy of court/legal documentation for custodial/guardian orders).
***RESPONSIBLE PARTY** is the individual who agrees to accept financial responsibility for all services performed. May not necessarily be the insurance card holder.

☐ Mother	☐ Step Mother	☐ Foster Mother	☐ Other:	☐ Responsible Party	☐ Father	☐ Step Father	☐ Foster Father	☐ Other:	☐ Responsible Party

Name:	Name:
Date of Birth:	Date of Birth:
SSN:	SSN:
Employer:	Employer:
Occupation:	Occupation:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Patient Name:
Date of Birth:

CONSENT FOR TREATMENT

As the parent or legal guardian of the child, designated above as the patient, I hereby authorize Northeast Pediatric Associates, P.A. physicians, mid-level practitioners, and/or their medical representatives to perform the required medical treatment considered advisable for the patient. I realize that no guarantees can be made as to the eventual outcome of the medical treatment advised or performed. However, I may expect the medical treatment advised or performed by Northeast Pediatric Associates, P.A. physicians, **non-physician practitioners, and/or their medical representatives to be reasonably sound by accepted medical standards. Also, as a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your phone number, you consent to receiving such calls at this number.

**Non-physician practitioners are either Nurse Practitioners or Physician Assistants, licensed by the state to diagnose and treat illnesses, injuries, disease or other medical conditions. They typically hold a master's degree with advanced education in Pediatrics. These practitioners work together with the patient's primary care physician, providing preventative care, well child examinations, physicals, immunizations, and developmental screenings.

We ask that a parent/guardian be present for your child(ren)'s initial appointment and well child visits. We must be able to obtain pertinent family background and medical history that is necessary for the treatment of your child(ren). **It is the policy of Northeast Pediatric Associates, P.A. that you must authorize family members and others who make appointments and accompany your child(ren) to their appointments. Therefore, the following other individuals (other than parents) are authorized to act in your place with respect to any medical matters after your initial appointment.** Please note that as we have no control over these individuals, any private health information disclosed under this authorization is no longer protected by the Privacy Rule.

Name	Phone Number	Relationship
1.		
2.		
3.		
4.		

PARENTAL CONSENT IN CASES OF DIVORCE

(If you have a court order, please present us with a copy for your child(ren)'s file)

According to Texas Statutes – Family Code §153.073(a), unless limited by a court order, a parent appointed as a "conservator" (managing or possessory) of a child has at all times the following rights:

- Right of access to medical, dental, psychological, and education records of the child
- Right to consult with a physician, dentist, or psychologist of the child
- Right to be designated on the child's records as a person to be notified in case of an emergency
- Right to consent to medical, dental, and surgical treatment during an emergency involving an immediate danger to the health and safety of the child

_____
Print Name Parent/Guardian

_____
Signature of Parent/Guardian

_____
Relationship to Patient

_____
Date

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request the payment of authorized Medicaid/other insurance company benefits be made either to me or on my behalf to Northeast Pediatric Associates, P.A., for any services provided by that party who accepts assignment/physician. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. In Medicaid/ other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid/ other insurance company as the full charge, and the patient/guardian is responsible only for the deductible, coinsurance, and non-covered services.

PRIMARY INSURANCE	SECONDARY INSURANCE (If Applicable)
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Relationship to Patient:	Relationship to Patient:
Insurance Co. Name:	Insurance Co. Name:
ID#:	ID#:
Group #:	Group #:
Phone #:	Phone #:
Claims Address:	Claims Address:

IMMUNIZATION POLICY

Northeast Pediatric Associates, P.A. provides the highest quality of evidence-based medical care to our patients. This includes our adherence to the vaccine schedule recommended by the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the Advisory Committee on Immunization Practices (ACIP). Northeast Pediatric Associates, P.A. serves as an advocate for our patients, while making every effort to respect the wishes of our parents. Should a family member desire to alter the vaccine schedule or withhold recommended vaccines, Northeast Pediatrics believes this decision not only puts your child at risk of serious preventable diseases, but also contributes to the health risk of others, including our youngest patients who may be in the office. **Please be advised that if you desire an "alternate" vaccine schedule, or if you intend to refuse vaccines, you do so against the advice of Northeast Pediatrics, the AAP, the AAFP, and the ACIP. Due to the aforementioned reasons, Northeast Pediatrics respectfully declines to accept you into our practice.**

_____

Print Name of Parent/Legal Guardian

_____

Signature of Parent/Legal Guardian

_____

Date

INSURANCE WAIVER AGREEMENT

Please complete this waiver ONLY if you have a newborn, have recently enrolled in a new insurance plan, or for any other reason that might cause any delays or non-payments from your insurance carrier.

Patient Name:
Date of Birth:
Date of Service:

I, _____, understand that in the opinion of Northeast Pediatric Associates, P.A., the services
(PRINT NAME OF PARENT/LEGAL GUARDIAN)
that I have requested to be provided to my child on the above date of service may not be covered by my insurance carrier
_____.
(INSURANCE CARRIER NAME)

REASON FOR THIS WAIVER:

Northeast Pediatric Associates, P.A., is unable to verify coverage due to the following:

☐ **NEWBORN**: Patient has not been added to the policy. (The member has 30 days from birth to add the newborn to the policy.)
☐ **NEW ENROLLMENT STATUS (NON-NEWBORN)**: Policy holder must contact us within 7-10 business days to confirm policy is active.
☐ **OTHER ELIGIBILTY ISSUE**: Please verify below.

I understand that I am responsible for payment of services that I request and receive if these services are not covered by my insurance.

_____
Print Name of Parent/Legal Guardian

_____
Signature of Parent/Legal Guardian

_____
Date

FINANCIAL POLICY
(New Patient)

It is the policy of this office to help keep healthcare costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. **Your signature indicates your understanding and agreement.**

Patient/Guardian responsibility:

- Bring your child's insurance card to **every** office visit
- Notify us of any demographic changes (i.e., insurance, address, phone number, etc.)
- Copay and deductibles are due at time of service, or if you do not have insurance be prepared to pay visit in full
- Confirm with insurance Northeast Pediatric Associates is a provider for your policy
- Verify coverage limitations prior to appointment

Patient/Guardian financial responsibility:

- **$15 late fee will be added to account if copays are not paid at time of service.**
- $35* fee for any checks returned for insufficient funds.
- $10* fee for printout of any ledgers (i.e., account history, payment history, etc.) is due prior to receiving the ledger.
- $25 fee for after hour or weekend visits.
- $35 walk-in fee.
- $7 fee to fill out any health forms (i.e., school, camp, sports, daycare, etc.).
- $25 fee for FMLA form.
- $10 per letter for medical necessity letters.
- $5 administrative fee for rushed requests on letters, forms, or any other documents.
- Monthly statements are mailed out for balances, which are due within 14 days of the statement date. If any disputes, concerns, or questions contact the billing department immediately.
- **$50 fee for all missed/no shows or if the appointment is not canceled within 24-hour notice. At the third incident, a $75 charge will be incurred and the practice may choose to dismiss you as a patient.**
- If your child requires follow-up care with his/her primary care physician after an automobile accident, the visit is considered out-of-network because we are not contracted with auto insurance companies. The visit(s) must be paid in full at the time of service.
- To request/transfer records there is a $25 fee for the first 20 pages, and 50¢ for each additional page, in addition to mailing, shipping, or delivery fees. There is a $15 fee for executing affidavits.
- **If we refer your past due account to a collection agency, you agree to pay all collection costs which are incurred.** Northeast Pediatric Associates will no longer provide medical care to patients whose account have been referred to collection agencies and will be reported to the Credit Bureau.
- **Any consultation/treatment for an illness received outside the scope of a well child visit may be subject to a copay/deductible which you are responsible for. (i.e. treatment of an ear infection, pneumonia, or strep throat)**

I have read the above financial policy and I agree to the terms and conditions contained herein

Child's Name	Date of Birth

_____ _____ _____

Print Name of Parent/Guardian | Signature of Parent/Guardian | Date

* These fees are subject to change at any time

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I hereby acknowledge my receipt of Northeast Pediatric Associates P.A.'s Notice of Privacy Practices which explains how my child's medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Child's Name	Date of Birth

_____ _____

Print Name of Parent/Legal Guardian Signature of Parent/Legal Guardian

_____

Date

Acknowledgement NOT obtained because:

- ☐ Patient/legal representative declined to accept Notice of Privacy Practices
- ☐ Patient received Notice of Privacy Practices, but refused to sign Acknowledgement form
- ☐ Other (briefly describe)

_____

_____

_____ _____

Print Employee Name Sign Employee Name

_____

Date

PATIENT PORTAL SIGN-UP FORM

Utilizing the Patient Portal will allow you to access your child(ren)'s medical records on your time.

***Once the patient is 17 years old, the patient will have to fill out this form for themselves to be able to view their medical records. ***

This includes:

- Most recent physical date
- Allergy list
- Secure messaging
- Upcoming appointments
- Immunization record

You can download your child's immunization record directly from Northeast Pediatric Associates' portal at **http://mykidschart.com/npa**

Please select Yes below.

☐ Yes, I want to be sent an invitation to join the NPA Patient Portal. I understand that it can take up to 4 days to receive my invitation to join the Patient Portal from NPA.

Patient Name: **Date of Birth:**

Email Address:
Parent/Legal Guardian Name:
Relationship to Patient(s):
Signature of Parent/Legal Guardian:
Email address if patient is 17 or older:
Patient Name if 17 or older:
Patient Signature if 17 or older:
Date:

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

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