Rhodes Pediatric Clinic Date: _____

Patient's Name: _____ (_____) **DR: Rhodes /Marzullo/Adams**
Last First Middle Preferred
Date of Birth: _____ **Sex: M or F** **SS#** ____-____-____ **Race:** _____ **Lang:** _____

Person patient lives with: _____ **Relationship:** _____

Parents Marital Status: ___ **Married** __ **Divorced** __**Separated** __**Unmarried** __**Widowed** **Custody: joint or sole**

Mother/Guardian's Information

Full Name: _____ (Maiden): _____
Birthday: _____
Address: _____
City, State, Zip: _____
Cell Phone #: _____
Employer: _____
Occupation: _____
Email: _____

Father/Guardian's Information

Full Name: _____
Birthday: _____
Address: _____
City, State, Zip: _____
Cell Phone #: _____
Employer: _____
Occupation: _____
Email: _____

PERSON RESPONSIBLE FOR BILL: _____ Permission to TEXT appt. reminders: ___yes ___ no **(initial)**

Are there other siblings under our care? Y N

Name: _____ DOB: _____ Name: _____ DOB: _____
Name: _____ DOB: _____ Name: _____ DOB: _____

Emergency Contact: Contact other than parent: _____ Phone: _____
Relationship to Patient: _____

Preferred Pharmacy: _____ Phone: _____

CONSENT: I consent to medical treatment necessary for the above patient.

_____ _____ _____
Signature of Parent/ Legal Guardian Relationship Date

Insurance Information:

PRIMARY INS.: _____ Subscriber/ ID #: _____ Group #: _____ Employer: _____
Insured name: _____ Relationship to pt: _____ Policy holder Soc. Sec. #: _____

2ND INS.: _____ Subscriber/ ID #: _____ Group #: _____ Employer: _____
Insured Name: _____ Relationship to pt.: _____ Policy holder Soc. Sec #: _____

I understand that payment in full is expected at the time of service. However, in the event Rhodes Pediatric Clinic files claims on my behalf, I authorize all benefits to be paid directly to Rhodes Pediatric Clinic. I authorize Rhodes Pediatric Clinic and or the rendering physician(s) to release all information required by my insurance company to file for medical benefits.

Parent/Guardian _____ **Date:** _____

Acknowledgement of Receipt of Notice of Health Information Privacy Practices

I, (parent name) _____, *acknowledge receipt of Notice of Health Information Privacy Practices.* By: _____ Date: _____

Rhodes Pediatric Clinic Financial Agreement and Consent

We are committed to providing your family with the best possible pediatric care. Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

BILLING YOUR INSURANCE:

- Please present your current health insurance card at each office visit.
- Our office will bill validated **Primary Insurance** as a courtesy. You must pay for any patient responsibility.
- If you have **No Insurance** then payment in full is required at the time of service.
- Know your insurance and **REMEMBER: Non-covered services such as vaccines can be VERY EXPENSIVE**.

PAYMENT FOR SERVICES:

- Co-pays, co-insurances, and deductibles must be paid at the time of service. _____**please initial**
- We accept cash, checks, money orders, Visa®, MasterCard®, Discover, American Express and debit cards.

RETURNED CHECKS:

- **The charge for a non-sufficient funds (NSF) check is $45.** You must pay in full for the NSF check and NSF fee within 10 days of notice. If payment is not received by the due date, we reserve the right to proceed with legal representation. It is a felony to knowingly write a bad check. For the next 12 months, cash or equivalent payment at the time of service is required.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days we reserve the option to refer the account to an outside collection agency. **If your account is sent to an outside collection agency, there will be a 40% surcharge added to your balance.** Rhodes Pediatric Clinic reserves the right to reschedule or deny future appointments for delinquent accounts. If your account is sent to a collection agency you may be asked to find another provider.

LATE ARRIVALS, CANCELLATIONS AND NO SHOWS:

Please arrive 10 minutes prior to your scheduled appointment to allow for check-in and any paperwork.

- We require a **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, a 2-hour notice is required. **If you arrive 15 minutes late to your appointment, you have missed your appointment; therefore, a late cancellation fee will be charged, whether you are seen then or not.**
- Failure to give proper notice for cancellation or reschedule will result in:
  - A $25.00 charge for missed vaccine appointments or late cancellations, per child
  - A $25.00 charge for the first missed appointment, per child
  - A $50.00 charge for the second missed appointment, per child
  - A $75.00 charge for the third missed appointment, per child.
  - Your family could be subject to dismissal for a third or subsequent missed appointment.
- **Please initial that you understand the fees above.**_____

* I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay Rhodes Pediatric Clinic directly. A copy of this authorization can be considered an original for insurance purposes.
* I do hereby consent to and authorize the performance of all examinations, treatments, and medical services by Rhodes Pediatric Clinic and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Child(ren)

Child/Children's Names and Date(s) of Birth: _____ _____

_____ _____

Updated 12.1.16

Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late?_____
If early, how many weeks gestation? _____
Did mother have any illness or problems with her pregnancy? ☐ Y ☐ N
Explain _____

During pregnancy, did mother:
Smoke ☐ Y ☐ N Drink alcohol ☐ Y ☐ N
Use drugs or medications ☐ Y ☐ N
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?
If Cesarean, why? _____
Did your baby have any problems right after birth? ☐ Y ☐ N
Explain _____

Was initial feeding ☐ Breast Milk? ☐ Formula?
Did your baby go home with mother from the hospital? ☐ Y ☐ N
Explain _____

Current and Past History

Is your child currently on any medication?	☐ Y ☐ N	Explain _____
Does your child have any serious or chronic illnesses?	☐ Y ☐ N	Explain _____
Has your child had serious injuries or accidents?	☐ Y ☐ N	Explain _____
Has your child had any surgery?	☐ Y ☐ N	Explain _____
Has your child ever been hospitalized?	☐ Y ☐ N	Explain _____
Is your child allergic to any medicine or drugs?	☐ Y ☐ N	Explain _____
Has your child had any reactions to immunizations?	☐ Y ☐ N	Explain _____
Does Your Child Have, or Ever Had:		
Asthma, recurrent cough, bronchitis, or pneumonia	☐ Y ☐ N	Explain _____
Nasal allergies or eczema	☐ Y ☐ N	Explain _____
Frequent ear infections or sore throats	☐ Y ☐ N	Explain _____
Problems with ears or hearing	☐ Y ☐ N	Explain _____
Problems with eyes, vision, or teeth	☐ Y ☐ N	Explain _____
Frequent headaches or other neurologic problems	☐ Y ☐ N	Explain _____
Frequent abdominal pain	☐ Y ☐ N	Explain _____
Constipation requiring doctor visits	☐ Y ☐ N	Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old)	☐ Y ☐ N	Explain _____
Any heart problem or heart murmur	☐ Y ☐ N	Explain _____
Anemia or bleeding problem	☐ Y ☐ N	Explain _____
Thyroid or other endocrine problem	☐ Y ☐ N	Explain _____
Diabetes	☐ Y ☐ N	Explain _____
ADHD	☐ Y ☐ N	Explain _____
Mental health issues (anxiety, depression)	☐ Y ☐ N	Explain _____
Use of alcohol or drugs	☐ Y ☐ N	Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, Speech Therapy? ☐ Y ☐ N Explain _____

Is your child in special or resource classes in school? ☐ Y ☐ N Explain _____

Do you have any other issues or concerns not listed above? _____

Do you have a problem immunizing your child? _____Yes _____No

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? ☐ Y ☐ N Pets in household? ☐ Y ☐ N

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

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

_____

_____

Initial Review (initials/date):

Parents of minors to fill out

RHODES PEDIATRIC CLINIC

CONSENT OF PARENTS/GUARDIANS OF MINOR PATIENTS TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name: _____
Last First Middle

Home Address: _____

_____

Home Telephone: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF RHODES PEDIATRIC CLINIC (the "PRACTICE") NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY CHILD'S GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance). I also authorize the Practice to disclose my child's medical information to insurers and providers outside of the Practice when necessary so that these providers may treat my child; seek payment for that treatment, and for the purpose of their health care operations. I also authorize the Practice to disclose my child's medical information on my home answering machine or voicemail.

The following family members/friends have my permission to accompany my child to his/her medical appointment: (please list only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

_____

_____

_____

ASSIGNMENT OF INSURANCE BENEFITS:
By my signature below, I authorize medical benefits to be paid to Rhodes Pediatrics on my child's behalf for any service provided by the medical and clinical staff of the practice. I understand that I am responsible for all charges not covered by insurance for this service date as well as all future service dates.

ASSIGNMENT OF RECEIPT OF PRACTICE'S NOTICE OF THE BILLING POLICY:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of the Billing Policy.

_____ _____ _____
Signature of parent/guardian/personal representative of minor child | Description of Authority | Date