www.luvkidspediatrics.com

Patient Intake Form

Child's Name: _____ Today's Date: _____

Child's DOB: _____ Sex: _____ Address: _____

Mother's Name: _____ Occupation: _____

Mother's Email Address: _____

Genetic Parent? Y / N if no, explain: _____

Phone (Cell): _____ (Work): _____

Father's Name: _____ Occupation: _____

Father's Email Address: _____

Genetic Parent? Y / N if no, explain: _____

Phone (Cell)_____ (Work): _____

Primary Language Spoken in the home: _____

How did you hear about Luv Kids Pediatrics?

_____

Does your child have a nickname? _____

_____

EMERGENCY CONTACT INFORMATION (other than parents):

Name: _____ Relationship to Child: _____

Phone Number: _____

Name: _____ Relationship to Child: _____

Phone Number: _____

Primary Insurance: _____Member ID: _____

Subscriber on Policy: _____Subscriber DOB: _____

Policy Holder: _____

Secondary Insurance: _____ Member ID: _____

Subscriber on Policy: _____Subscriber DOB: _____

Policy Holder: _____

If parents are divorced or separated please fill out this section:

Who has custody? _____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

_____

Pharmacy Information:

What pharmacy do you routinely use so we may process prescription and prescription refills?

Name: _____ Phone Number: _____

Address: _____ City: _____ Zip Code: _____

Authorization to Treat Minor

I, _____hereby authorize the following person(s) to bring my child(ren) in for medical treatment.

I also allow them to make any medical decisions that are in the best interest of my child.

I understand that this person is required to bring a picture ID with them to the visit along with my child's insurance card(s) and any co-payment that are due at the time of visit. Without a picture ID the child will NOT be seen. Failure to present insurance card(s) and any co-payments due may result in the child not being scheduled.

I can be reached at _____ for any questions and/or concerns.

Person(s) authorized to bring the child to medical appointments:

1)Name: _____ Relationship: _____
2)Name: _____ Relationship: _____
3)Name: _____ Relationship: _____

_____ _____
Parent/Guardian (printed) **Parent/Guardian (signature)**

This authorization will remain active unless a written statement is received by the parent/guardian to revoke an authorized person.

OFFICE POLICIES & PROCEDURES

Effective January 1, 2021 the following policies have been implemented:

1. At the time of check-in at EVERY visit, you will be required to provide your insurance card and identification (DL, state ID, military ID or any legal ID). All insurances will be verified upon arrival. All deductibles, co-pays, and/or coinsurance amounts will be due at the time of service. Please verify that patient's insurance is active prior to your appointment.
2. If you are a new patient, please come to your appointment at least 15-20 minutes before the scheduled appointment time to complete the registration process.
3. Any routine call backs, prescriptions, or documents left for the physician will be completed within 48 hours.
4. At the time of service, if your account reflects and outstanding balance, you will be asked to pay the balance in FULL before you can check in.
5. If you do not have your insurance card at every office visit you will be considered as self-pay for that date of service.
6. There is a $25.00 service fee for any returned checks. In addition, ALL expenses incurred to recover outstanding balances will be payable immediately (including but not limited to collection agency fees and legal fees).
7. There will be a $20.00 no call no show fee for appointments (see appointment policy).

MEDICAL RECORDS RELEASE POLICY AND PROCEDURES

1. A medical records release must be filled out or requested by the parent or legal guardian of the patient prior to the copying of any medical records. Please request or fill out one release per patient.
2. If you are transferring to another physician you may complete a medical records request for your child's records to be forwarded to your new provider this will be charged to you at the time of service. Please allow 30 business days for this transfer to be completed.
3. All shot records will be copied one-time as a courtesy for your personal use. All additional copies will have been charged to you at the time of service. Please allow 2 business days for this process to be completed.
4. All daycare/school and sports physicals or similar forms will be provided upon your request and will be charged to you at the time you are requesting. Duplicate copies of these forms will be available within 2 business days and will be an additional charge to you at the time of service.

I have read and understand the ***OFFICE POLICIES & PROCEDURES*** and ***MEDICAL RECORDS RELEASE POLICY AND PROCEDURES.***

_____ _____
Printed Name of parent/legal representative **Date**

_____ _____
Signature of parent/legal representative **Date**

Appointments:

Your scheduled appointment time has been reserved specifically for your child. As a courtesy, Luv Kids Pediatrics will confirm all appointments one or two business days prior to the appointment. However, it is your responsibility to remember and keep scheduled appointments and knowing if your child's insurance is active for each visit. We kindly ask that you give a 24-hour notice if you need to cancel your appointment. In the event there is less than 24 hours' notice, please call as soon as possible so that the appointment time may be given to another patient. There is a $20 fee for no call, or no show, missed appointment, just call to give notice of cancelation. The child's insurance or Medicaid DO NOT COVER THIS FEE. We understand that unexpected delays and emergencies occur. If you know that you will be late more than 10 minutes for your appointment, please call the office to notify the staff. They will attempt to schedule you as soon as possible that same morning or afternoon when other patients have been seen first. Meaning if you had a morning appointment you would possibly be able to be seen before lunch, and if you had an afternoon appointment you would possible be able to be seen prior to closing. Otherwise, your child may need to reschedule at next available day and time. We must be courteous of other appointments who are on time. Parent(s), legal guardian(s), foster parent(s) of the child must be noted in chart to be brought to the clinic and give consent for patient needs. No sibling of a child can bring and consent to treatment unless they are their legal guardian and have shown proper documentation. A child cannot come to the clinic alone or be dropped off unsupervised unless they are 18.

During Covid-19 only one caregiver per child is allowed in the clinic.

Please arrive 15-20 minutes earlier to appointment time for new patients.

We respect all patients and their needs, for questions or concerns regarding appointments please do not hesitate to ask, Luv Kids Pediatrics, Rose M. Campbell, APRN, C-PNP.

I have read and agree to the Luv Kids Pediatrics Appointment policy:

Signature_____Date_____

Printed_____Relationship_____

FINANCIAL RESPONSIBILITY

I, _____ am financially responsible for the above patient(s). I hereby agree to be financially responsible for any outstanding payments including co pays or procedures or out of pocket costs the day of the visit.

PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F

Previous Physician	Request for Records Transfer Complete Y N	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name
Step-Mother's Full Name (If Applicable)	Step-Father's Full Name (If Applicable)
Custodial Provider's Full Name (If different from above)	Relationship to Patient

Birth History

Birth Weight _____ Preg#_____ Mom's age_____ Was the birth □ Vaginal ? □ Cesarean? □ Early? □ Late?

If birth was early, how many weeks early? _____ If Cesarean, why? _____

Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain _____

Did baby have any problems right after birth? □ Yes □ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

□ Smoke Cigarettes (amount)_____ □ Drink Alcohol (amount) _____

□ Use "street" drugs (type)_____ □ Use Prescription Drugs (type)_____

Was initial feeding □ Breast Milk? □ Formula?

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 surgeries?	□ Y	□ N	Explain_____
Has your child ever been hospitalized?	□ Y	□ N	Explain_____
Is your child allergic to any medications?	□ Y	□ N	Explain_____
Has your child ever reacted to immunizations?	□ Y	□ N	Explain_____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Explain_____
Nasal allergies or eczema	□ Y	□ N	Explain_____
Frequent ear infections or sore throat	□ 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 problems or bedwetting	□ Y	□ N	Explain_____
Any heart problems/murmur	□ Y	□ N	Explain_____
Anemia or bleeding problem	□ Y	□ N	Explain_____
Thyroid or other gland problem	□ Y	□ N	Explain_____
Diabetes	□ Y	□ N	Explain_____
ADD/ADHD	□ Y	□ N	Explain_____
Mental Health Issues	□ Y	□ N	Explain_____
Use of drugs or alcohol	□ Y	□ N	Explain_____

Household Information

Please List All Those Living in the Child's Home		
Name	**Relationship to Child**	**DOB**

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

_____

_____

Child Care:_____

Smokers in household? □ Y □ N

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

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Who_____	Comments_____
Allergies	□ Y	□ N	Who_____	Comments_____
Asthma	□ Y	□ N	Who_____	Comments_____
Birth Defects	□ Y	□ N	Who_____	Comments_____
Blood Disorders	□ Y	□ N	Who_____	Comments_____
Bone Disorders	□ Y	□ N	Who_____	Comments_____
Cancer	□ Y	□ N	Who_____	Comments_____
Diabetes	□ Y	□ N	Who_____	Comments_____
Endocrine Disease	□ Y	□ N	Who_____	Comments_____
Ear/Nose/Throat Disorders	□ Y	□ N	Who_____	Comments_____
Eye Disorders	□ Y	□ N	Who_____	Comments_____
Gastrointestinal Disorders	□ Y	□ N	Who_____	Comments_____
Heart Disease	□ Y	□ N	Who_____	Comments_____
High Blood Pressure	□ Y	□ N	Who_____	Comments_____
High Cholesterol	□ Y	□ N	Who_____	Comments_____
Immune Disorders	□ Y	□ N	Who_____	Comments_____
Joint Problems	□ Y	□ N	Who_____	Comments_____
Kidney Disease	□ Y	□ N	Who_____	Comments_____
Liver Disease	□ Y	□ N	Who_____	Comments_____
Lung Disease	□ Y	□ N	Who_____	Comments_____
Migraine Headaches	□ Y	□ N	Who_____	Comments_____
Metabolic Disorders	□ Y	□ N	Who_____	Comments_____
Obesity	□ Y	□ N	Who_____	Comments_____
Seizure Disorders	□ Y	□ N	Who_____	Comments_____
Skin Disorders	□ Y	□ N	Who_____	Comments_____
Stroke History	□ Y	□ N	Who_____	Comments_____
Thyroid Disorders	□ Y	□ N	Who_____	Comments_____
Mental Health History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____

Covid-19 Screening

How was screening obtained? Phone: __ In person: __ Telehealth: __

1. Do you have Fever, Cough, Sore Throat, Chills, or Shortness or Breath, Vomitting, or Diarrhea?

____Yes _____ No

2. Have you had loss of smell or taste?

____Yes _____No

3. Have you had contact with a person who is suspected to have or confirmed to have Coronavirus/COVID-19 in the past 2 weeks?

____Yes _____ No

4. Have you had contact with any person with unexplained flulike symptoms in the past 2 weeks?

____Yes _____ No

5. In the past 2 weeks, have you been to any high risk areas, travelled internationally, or within the U.S?

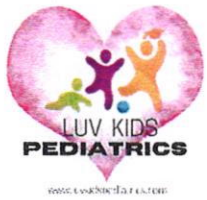
____Yes _____ No

If you answered yes to any of these questions, please provide an explanation:

_____

Signature: _____ Relationship to patient: _____ Date: _____

Luv Kids Pediatrics witness: _____ Date: _____



AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: Doctor's Name: _____

Address: _____

Phone: _____ Fax: _____

Please send ALL medical records on my children:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

To the following office:

Name of Practice: _____

Address of Practice: _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name and Address:

_____

_____

Cell phone: _____ Home phone: _____

HIPAA LAW RIGHT TO PRIVACY CONSENT

Patients Name: _____ Date of Birth:_____

Guardian Name: _____ Relationship to Patient: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Direct Messaging is a system utilized to only allow providers access to your child's medical information when they may need to be referred to other subspecialty providers. This along with privacy screens, protected emails, and cellular HIPPA compliant phone technology you can be assured that your Childs information is always kept confidential.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that Luv Kids Pediatrics

- The practice will protect health information may be disclosed or used for treatment, payment, or healthcare operations.

- The practice reserves the right to change the privacy policy as allowed by law.
- The practice as the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Relationship to patient: _____ Date: _____

Luv Kids Pediatrics Witness: _____ Date: _____