Alice Pediatric Clinic
Children's Healthcare

Patient Name:_____

DOB:_____

Date:_____

Allergies: (Include Drug, Reaction, and Age of Onset):

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____
Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: Vaginal C-Section
Duration of Labor: If C-Section why?_____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
Infant Feeding : Breast Bottle Both Formula Name? _____

Comments: Newborn Hearing Screening: Pass Fail , Other Comments: _____
_____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD_____	Yes	No	Allergic Rhinitis _____	Yes	No
Anemia _____	Yes	No	Asthma _____	Yes	No
Congenital Heart Disease_____	Yes	No	Constipation _____	Yes	No
Developmental delay _____	Yes	No	Diabetes _____	Yes	No
Eczema _____	Yes	No	Food Allergies _____	Yes	No
GE Reflux _____	Yes	No	Mental Illness _____	Yes	No
Murmur _____	Yes	No	Prematurity _____	Yes	No
Recurrent Otitis (ear infections) ___	Yes	No	Recurrent Strep Throat _____	Yes	No
Seizures _____	Yes	No	Substance Abuse _____	Yes	No
UTI _____	Yes	No	Vision Problems _____	Yes	No
Vesicoureteral Reflux _____	Yes	No	Wheezing _____	Yes	No

Other Medical History:

_____

_____

Surgical History: (Check Appropriate Box)

			Date	Surgeon
Adenoidectomy (adenoids removal)	Yes	No		
Appendectomy (appendix removal)	Yes	No		
Ear Tubes _____	Yes	No		
Fundoplication _____	Yes	No		
Gastrostomy Tube Placement ____	Yes	No		
Heart Surgery_____	Yes	No		
Hernia Repair_____	Yes	No		
Orthopedic Surgery _____	Yes	No		
Tonsillectomy _____	Yes	No		
Urologic Surgery _____	Yes	No		
VP Shunt_____	Yes	No		

Other Surgical History:

_____

_____

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Patient Name:_____

DOB:_____

Date:_____

Family History: (Check all boxes that apply)

Relationship to CHILD		Name	A:Alive	D:Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		A	D																		
	Father		A	D																		
Sibs	Sister		A	D																		
	Brother		A	D																		
Aunts/ Uncles	*M Aunt		A	D																		
	*M Uncle		A	D																		
	*P Aunt		A	D																		
	*P Uncle		A	D																		
Grand-parents	*MGM		A	D																		
	*MGF		A	D																		
	*PGM		A	D																		
	*PGF		A	D																		

Comments (including other family medical problems):_____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to CHILD	Name																				
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		

Home Environment:

Number of People at Home: _____
Lives with biological parents: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others:_____
Daycare (hours/day): _____
Time at Relatives (hours/day): _____
Pets: Yes No

Parent's Status:

Parent's Marital Status (circle): Married Divorced Single Other_____

Mother's Occupation: _____
Father's Occupation: _____

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Date Completed
Primary Care Provider

Patient Registration Form (Please fill in all fields completely)

Patient Information

Child's Full Legal Name (Last, First, Middle)	Date of Birth	Sex	S.S #
Other Children in family:			
Child's Mailing Address (City, State, Zip Code)	Telephone#where child lives	Parent's Work # ☐Mom ☐Dad	Parent's Email Address: ☐ Mom ☐ Dad

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian and other Pacific Islander ☐ White

Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Patient's Primary Language: English ____ Spanish ____ Other _____

Parent's/Legal Guardian's Primary Language: English ____ Spanish ____ Other _____

Does the parent/legal guardian require an interpreter? Yes ☐ No

If there is insurance for child/children, please present the insurance card to the check-in staff.

Emergency Contacts

Mother's Name (Last, First, Middle)	S.S #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Father's Name (Last, First, Middle)	S.S #	Work #	Cell #
Home Address (City, State, Zip Code) (if different from above)			
Additional Contact (Last, First, Middle)	Home #	Work #	Cell # (Relationship to Patient)
Home Address (City, State, Zip Code)			
			Birth Hospital

Guarantor Information (Person financially responsible)

Name	Relationship to Patient		Emancipated Minor? ☐ Yes ☐ No
Street Address (If different from patient)	City	State	Zip
Date of Birth	Home #	Work #	Cell #
Employer Name	City	State	Zip

Insurance Information (if insurance is provided, please complete the information below)

Insurance Name	Claims Address	Telephone #
Subscriber ID #	Group #	Patient Relationship to Subscriber:
Subscriber's Name		DOB:
Subscriber Address (if different than guarantor)		Subscriber Employer

Alice Pediatric Clinic
Children's Healthcare

Consent to Treat

Written Acknowledgement of Receipt of ALICE PEDIATRIC CLINIC Notice of Privacy Practices

_____
(Please initial)

I acknowledge receiving ALICE PEDIATRIC CLINIC (APC) Notice of Privacy Practices (The Notice). The Notice explains how APC may use and disclose your protected health information for treatment, payment and healthcare operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

If you have questions about the Notice, Please contact the APC Privacy Office. You may find their contact information located in the Notice.

General Consent to Treat

_____
(Please initial)

I am the parent/guardian of _____ (name of patient). 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 Alice Pediatric Clinc and their 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 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

_____
(Please initial)

In agreement with federal and state law, I agree to allow ALICE PEDIATRIC CLINIC to deliver the necessary care to this child in order to provide continuity of care and treatment. ALICE PEDIATRIC CLINIC and/or the patient's provider may obtain from any source and examine and 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, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain 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.

_____
(Please initial)

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Electronic Prescriptions (E-Prescribing)

_____
(Please initial)

I voluntarily authorize ALICE PEDIATRIC CLINIC to allow E-Prescribing for the patient's mail order prescription, 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.

Name of Patient:_____

Signature of Parent/Guardian:_____

Date:_____

Thank you for choosing ALICE PEDIATRIC CLINIC

3/2015

Alice Pediatric Clinic
Children's Healthcare

Delegation of Consent

Name of Patient _____

Patient's Date of Birth _____

I hearby authorize (when I am unavailable to give consent) to the following individual(s):

_____ Name of person	_____ Relationship to child/ Phone Number
_____ Name of person	_____ Relationship to child/ Phone Number
_____ Name of person	_____ Relationship to child/ Phone Number
_____ Name of person	_____ Relationship to child/ Phone Number

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Signature of Parent/Guardian/Patient (if 18 years or older) _____

Relationship to Patient _____

Date _____

Witness _____

Thank you for choosing ALICE PEDIATRIC CLINIC
9/2015

Alice Pediatric Clinic
Children's Healthcare

2015

APC FINANCIAL POLICY

WE at Alice Pediatric Clinic (APC) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your APC financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and APC with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
APC does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do _____ do not _____ currently have Medicaid\ Chips insurance (Please Initial Response)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with a APC physician, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current card at each visit.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to APC or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- . The practic has an AFTER HOUR fee of $50.00. After hour fee will be charged if the patient is seen after 5:00 P.M weekdays or seen on the weekend.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Parent/Guardian Signature: _____

Date:_____ Print Name_____ Date of Birth _____

Relationship to Patient:_____ Birth:_____ S.S#_____

PATIENT(S) NAME: _____ Date of Birth: _____

Acknowledgement of Privacy Practices

Written Acknowledgement of Receipt of Alice Pediatric Clinic Notice of Privacy Practices
By signing below, you acknowledge receiving the Alice Pediatric Clinic (APC) Notice of Privacy Practices (Notice). The Notice explains how APC may use and disclose your protected health information for treatment, payment and healthcare operations purposes. Protected health information means your personal health information found in your medical and billing records.

APC reserves the right to change the Notice from time to time. A copy of the current Notice or a summary of the current Notice will be posted at patient service locations throughout APC and on our website at ALICEPEDIATRIC.COM. The effective date of the Notice will appear on the first page of the Notice or summary. In addition, each time you register to any APC for treatment or healthcare services , APC will have available for you, at your request, a copy of the current Notice in effect.

Your signature below only acknowledges that you have received the Notice.
If you have any questions about the Notice, please contact the APC Medical Record Office. Contact information is located in the Notice.

Printed Name of Patient _____

Patient's Date of Birth _____

Printed Name of Patient's Parent/Guardian _____

Relationship of Patient's Representative _____

Signature of Patient or Patient's Parent/Guardian _____

Date _____

Thank you for choosing Alice Pediatric Clinic
March 2015