TenderCare Pediatrics

Patient History

Child's Name _____ Birth Date _____ Today's Date _____

Reason for today's visit _____

How did you hear about us? _____

Family Medical History

List the blood relative next to the item if present in the family; *for example, grandfather, mother, aunt, etc.*:

Aids _____
Alcoholism _____
Anemia/Blood Disorder _____
Arthritis _____
Asthma _____
Attention Deficit Disorder _____
Birth Defects _____
Cancer _____
Colitis _____
Cystic Fibrosis _____
Early Deafness _____
Diabetes _____
Epilepsy/Seizures _____
Heart Disease _____
Hepatitis _____
High Blood Pressure _____
High Cholesterol _____
Mental Retardation _____
Migraines _____
Muscular Dystrophy _____
Tuberculosis _____
Other _____

Family Profile

Are parents: ❑ married ❑ separated ❑ divorced ❑ living together ❑ Other _____

Father's age _____ Highest level of education _____

Mother's age _____ Highest level of education _____

Siblings and ages _____

Pregnancy & Birth

Mother's age at birth _____ Illnesses and/or medications during pregnancy _____

Use of tobacco, alcohol or street drugs during pregnancy _____

Was your baby? ❑ early ❑ on time ❑ late Was the delivery? ❑ vaginal ❑ C-section

Complications at the birth and/or the first week of life _____

Child's Past Medical History

Allergic reactions to medications and type of reaction _____

Food or medication intolerance _____

Any hospitalizations and date _____

Major medical problems your child has _____

Medications your child takes on a regular basis _____

Operations your child has had and the date _____

Serious injuries your child has had _____

Child Development & Behavior

Feeding Patterns ❑ breast ❑ bottle Special diet needs _____

Any gastrointestinal reflux or gas problem encountered? _____

Age at which child: reached for objects _____ rolled over _____ crawled _____ pulled-up _____

walked _____ used sentences _____ toilet trained _____

Problems with behavior or getting along with others _____

Name of school & grade _____

Learning difficulties or problems in school _____

Favorite hobbies/sports/social activities _____

TenderCare Pediatrics

Patient Info

Demographics, Emergency & Insurance Information

Child's Name _____ Birth Date_____ Today's Date _____

Parents

Mother: _____Birth Date _____SS # _____

Address/City/State/Zip: _____

Phone: Home _____ Cell _____ Work_____

Email: _____

Father: _____Birth Date _____SS # _____

Address/City/State/Zip: _____

Phone: Home _____ Cell _____ Work_____

Email: _____

Sibling(s) (name & age): _____

_____

Emergency Contact *(if parents cannot be reached)*

Name: _____Relation to Patient_____

Address/City/State/Zip: _____

Phone: Home _____ Cell _____ Work_____

Pharmacy

Name _____ Location _____ Phone _____

Insurance Information

Primary:

Name of Plan_____ ID# _____ Group # _____

Name of Subscriber _____ DOB _____ SS #_____

Employer _____

Secondary:

Name of Plan_____ ID# _____ Group # _____

Name of Subscriber _____ DOB _____ SS #_____

Employer _____

TenderCare Pediatrics

Financial Agreement & Service Policies

Child's Name _____ Today's date_____

Insured Patients

Your medical insurance is a contract between you and your insurance company. We will help you if we participate with your insurance and will handle your claims according to our contract with the company. We cannot become directly involved in disputes between you and your insurance company regarding deductibles, co-payments, covered and non-covered services or usual and customary services.

Insurance Authorization and Assignment

I hereby authorize Lisa Caso, DO to furnish information to insurance carriers concerning my illness and treatments; and I hereby assign to the doctor all payment for medical services rendered by Tender Care Pediatrics. I understand that I am financially responsible for all charges whether or not covered by insurance. I am aware that my bills may be submitted electronically.

Responsible Party's Signature _____ Date _____

Insured's Signature _____ Date _____

A photocopy of this Authorization and Assignment shall be considered as valid as the original.

No Insurance

We understand there are times when people may not have insurance. When this occurs, the cost of the visit and/or procedures and diagnostics will be discussed with you before services are rendered. Then a discounted payment plan will be established.

Payment

We request that office visits be paid at the time of service by the caregiver bringing the child to be seen. This is required in order to control our cost of billing rather than be forced to raise our fees. Additionally, repeated episodes of missed appointments, or "no shows", will have a fee charged to the account and there is a service charge for returned checks.

Billing Errors or Questions

If you think your bill is incorrect or you need more information about a transaction, you may telephone our office to discuss it. We ask that a written inquiry regarding the dispute follow the telephone conversation to assure your rights.

Multiple Visits & Sick Appointments

In the case that more than one child is seen at a time, separate charges will be determined and processed for each child. This charge will include both of the co-payments (if applicable) and any other service fees rendered for each child.

Responsible Party Signature _____ **Date** _____

TenderCare Pediatrics

Individual Patient's Authorization

Child's Name _____ Birth Date_____ Today's Date _____

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

I give my authorization, voluntarily, to use or disclose all of my child's health records to any or all medical personnel for any kind of medical purpose. This includes Tender Care Pediatrics' permission to talk to any other medical personnel about my child's health and/or for any other doctor to contact this office about my child.

Also, I give permission for the staff at Tender Care Pediatrics to leave messages on my answering machine that pertains to my child's health. This authorization will end when my child turns 21 years of age.

I give authorization for any other family member to bring my child to this office and allow the staff at Tender Care Pediatrics to treat her/him.

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

I understand that under most circumstances a healthcare provider may not place conditions on treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my child's protected health information for research purposes may be a condition of my child's treatment if he/she is undergoing research-related treatment. Also, I may be required to sign an authorization if my child's treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. Under some circumstances, an insurance provider may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the insurance provider to make enrollment and eligibility determinations.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____ **Date** _____

You have a right to have a copy of this form after you sign it.

TenderCare Pediatrics
Financial Agreement & Service Policies

AGREEMENT TO PAY:

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (50%), all attorney fees and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the constitution of the State of Pennsylvania. Bills are expected to be paid within 30 days. A $20 service charge (unpaid balance fee) will be applied to any unpaid balance on the second billing statement. Forty-five days after that, a **50% collection agency fee** will be applied and your account will be forwarded to our collection agency.

I, the undersigned, accept the fee charged for missed appointments, re-billing fees, service charges for unpaid bills and agree to pay said fee if such be necessary. I waive, now and forever, my right of exemption under the laws of the constitution of the State of Pennsylvania. I understand that all balances are due at the time of service. This includes co-pays or any service not covered by my insurance. If a bill needs to be generated secondary to lack of payment, a $20 service charge will be added. Missed appointments will be subject to a $50 charge with the second missed appointment. If a double well visit is missed a $100 fee will be charged. A missed triple appointment accrues a $150 fee. **48 hour cancellation notice is required.** A $50 deposit, per child, will be required if the account has had multiple unpaid balance fees or if the account goes to collections. This deposit must be paid prior to future appointments being given, and will be kept on file to avoid possible collection efforts in the future. I understand that it will not be used to pay future bills, these bills are my responsibility in order to keep the account current.

I, the undersigned, authorize Lisa Caso, D.O. to furnish information to insurance carriers concerning my medical treatments. I hereby assign to the doctor all payment for medical services rendered by TenderCare Pediatrics. I understand that I am financially responsible for all charges whether or not covered by insurance. I am aware that my bills may be submitted electronically.

I agree, in order for TenderCare Pediatrics to service my account or to collect monies I may owe, that they or their agents may contact me by telephone at any telephone number associated with my account, including cellular phones, which may result in charges to me. We may also contact you by sending text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use automatic dialing devices, as applicable.

I/we have read this disclosure and agree that TenderCare Pediatrics, it's employees and/or agents may contact me/us as described above.

_____ _____

Signature Date