PEDIATRIC CARE ASSOCIATES CHECK-IN FORM

(1)Child's Name: Last_____ First_____ Please call patient: _____
Date of Birth _____ Patient's sex: ☐Male ☐Female

(2)Child's Name: Last_____ First_____ Please call patient: _____
Date of Birth _____ Patient's sex: ☐Male ☐Female

(3)Child's Name:Last_____ First_____ Please call patient: _____
Date of Birth _____ Patient's sex: ☐Male ☐Female

Primary Home Address: _____
City, State, Zip_____

Mother's Cell _____
Father's Cell _____
Secondary Home Address (if applicable)
Guardian Name _____Relationship_____
Street _____
City, State, Zip_____
Secondary home phone: _____

Mother's Name Last_____ First_____ DOB _____
Father's Name Last_____ First_____ DOB _____
Other Guardian Last_____ First_____ DOB_____Relationship_____

INSURANCE INFORMATION
Primary Insurance Company: _____Who holds the insurance? Name _____
Patient's relationship to insured _____ Birth date _____
Address: (If different than above)_____
Employer: _____ Phone # _____

Secondary Insurance Company _____ Subscriber Name _____
Employer: _____ Phone # _____
Patient's relationship to insured _____ Subscriber Birth date _____

ADDITIONAL INFORMATION
Primary Email _____
Mother Work # _____ Father Work # _____
Patient Cell (If over age 15 years) _____ Patient Email_____

Patient Race: (Required by US government for medical practices using EMR):
☐ American Indian or Alaska Native ☐Asian ☐Native Hawaiian ☐African American/Black ☐Caucasian/White
☐Hispanic ☐Other Race ☐Other Pacific Islander ☐Choose not to declare
Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Choose not to declare

PHARMANCY INFORMATION
Pharmacy of Choice: Name _____ City _____ Street _____

How did you learn about our practice? ☐Family/Friend ☐Insurance Company ☐Hospital resource
☐Physician ☐Internet source—Which one?_____ ☐Other:_____

Pediatric Care Associates, S.C.

Infants, Children, Teenagers

Robert A. Boton, M.D. **Michelle Reinstein, M.D.** **Catherine Fitzpatrick, M.D.**
Ryan McCoy, M.D. **Preeti P. Mirchandani, D.O.** **Mary Mortlock, PNP, IBCLC Maria Vallort, CPNP**

Patient Financial Responsibility Form

Thank you for choosing Pediatric Care Associates, SC ("PCA") as your healthcare provider. We are honored by your choice and are committed to providing you with highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and all major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of PCA. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours advance notice.
    - Charge for extensive phone consultations and/or after-hours phone call requiring diagnosis, treatment, or prescriptions.
    - Charge for copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Any costs associated with collection of patient balances.
    - Charge for new prescriptions provided over the phone to treat a new condition during regular office hours.
    - Added charges may apply if during a routine well physical exam, additional evaluation and treatment is required to manage a medical problem or condition. This may be subject to additional co-pays or deductibles that may have not been part of the routine well exam.

Patient Authorizations

- By my signature below, I herby authorize PCA and the physicians, staff and hospitals associated with PCA to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to PCA and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize PCA personnel to communicate by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____

Signature of Patient or Guardian Date

_____

Name of Patient Relationship

(Version 3-7-19)

RECEIPT OF NOTICE PRIVACY PRACTICES FORM

I, _____, hereby give my consent to Pediatric Care Associates, S.C. to obtain, use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of: _____.
(Patient's Name)

I hereby give my consent to Pediatric Care Associates, S.C. to obtain any current or previous medical information or records pertaining to the patient(s) stated above from another healthcare facility.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may obtain, use and disclose my confidential information.

I understand that the physician has reserved a right to change his privacy practices that are described in the Notice. I also understand a copy of any revised Notice will be provided to me or made available at my request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed:_____ Date:_____

_____
Relationship to patient

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MISSED APPOINTMENT POLICY INFORMED CONSENT

Pediatric Care Associates has a missed appointment fee. Missed appointments constitute any appointment for which a patient does not show up. Pediatric Care Associates will waive the missed appointment fee if the patient cancels their appointment prior to 24 hours before the scheduled appointment time.

Missed appointment place a burden on our pediatric practice by creating wasted physician time, wasted work by the staff in preparing the chart for an office visit, and taking away appointment times that can be used by other patients.

I have read this missed appointment policy and agree to its terms in regards to my children's appointments at Pediatric Care Associates.

_____ _____
Signed Date

_____
Relationship to patient

MEMO TO OUR PATIENTS REGARDING ROUTINE WELL EXAMS

(Version 12-18-20)

Patient Last Name: _____ Patient First Name: _____

Patient Birth Date: _____

Routine well exams are also known as 'school physical, routine preventative care visits, Pre-participation exams, routine well exams, sports physicals or routine physicals'. These visits are the most important visits at a pediatrician's office because they allow us to monitor many critical aspects of health, including our patient's overall growth, nutritional status, physical well-being, developmental status and psychological well-being. They also allow us to screen for potential health problems, psychological issues and other medical problems that may not get diagnosed in a timely manner without the routine physical. Current coding and insurance reimbursement guidelines dictate how much time is typical for the routine physical, and what components are considered part of the routine physical. The routine physical is primarily for ***preventative care***. This refers to issues related to general nutrition and growth, development, immunizations, routine well child laboratory screening, and general screening for potential medical problems.

In our pediatric practice, there are several other types of office visits that go beyond the scope of the typical routine physical, including (1) ***diagnostic care*** visits, also called a ***sick care*** visit, (2) ***consultative care*** visits and (3) ***procedural care*** visits. Examples of ***diagnostic care*** visits may include issues such as ear infections, headaches, stomach aches or orthopedic problems. Examples of ***consultative care*** visits may include issues relating to school based problems, depression or anxiety. Examples of ***procedural care*** visits may include treatment of warts, earwax or removal of sutures. During the routine well exam, specific problems are often discovered by the provider or brought up by the patient or their caregivers. These can be things that go beyond the typical preventative care visit as described above and require additional history, evaluation, examination, decision making and treatment.

During your routine well exam, if an additional diagnostic, consultative or procedural care problem is identified and addressed beyond the usual preventative care services then there will be an evaluation and management (EM) code added to the visit which is sent to the insurance carrier. This may require a co-pay or an additional out-of-pocket expense based on your insurance plan that may not be part of the routine well exam coverage. This represents standard coding and billing practices. We certainly want our patients and families to discuss their issues and concerns with the provider at the time of their routine physical, as proper and timely evaluation and treatment of any medical concern is our highest priority. Typically, the provider may ask that you schedule a separate visit in order to provide the time necessary to adequately address these concerns. Other times, the provider may address these non-preventative care issues at the same time as the well exam but it will entail the additional EM code as mentioned above.

I have read these policies as described above and have been given a copy of this memo:

Parent/Patient/Caregiver Signature: _____

Today's Date: _____

Pediatric Care Associates Vaccine Policy

(Policy date 8-1-18)

The healthcare providers at Pediatric Care Associates (PCA) believe very strongly that immunizations against infectious illnesses is critical in preventing diseases in children and adults. Historically, these pathogens have caused tremendous disease, resulting in devastating medical and financial burdens. There is irrefutable evidence that vaccines are effective at eliminating these diseases or greatly reducing the impact these diseases can have on an individual patient and society as a whole. These vaccines also prevent serious complications from the diseases. As a result of vaccination, many life threatening diseases are now very rare and unlikely to cause serious illness or complications in our society. There is also strong evidence that when vaccines are stopped or missed, then these conditions begin to circulate, spread and cause significant disease.

Typical adverse effects of vaccinations are mild, including some soreness, redness or swelling at the injection site. Less common side effects can be mild fever or achiness for 1-2 days. Other more severe reactions, such as allergic reactions, are very uncommon. Lastly, major serious adverse effects are extremely rare, about 1 per 1 million in some cases or less frequent than that. Serious adverse effects are virtually non-existent and should not affect any decision to vaccinate. The benefits of vaccination are so large and significant, they clearly outweigh any potential negative adverse effects. Vaccines are one of the most studied, safest, and valuable achievements to come from modern medicine.

For these reasons, PCA has enacted a policy that we will no longer accept new patient families that will not agree to vaccinate their children. We will continue to encourage our families to vaccinate according to the recommendations of the American Academy of Pediatrics immunization schedule, as well as the recommendations from the Advisory Committee on Immunization Practices (ACIP). These organizations review the relevant, up-to-date research in order to provide the best recommendations for individuals and the population as a whole.

For those individuals who choose to vaccinate on an alternative schedule, or who get behind due to other reasons, PCA will require that all vaccines normally given prior to age 4 years be completed by the end of the age frame for the next routine well examination. For example, if four month well visit routine vaccines are missed or delayed then we will require that those four month vaccines are completed by the time of the six month well exam. This may require additional visits to the office for vaccines. For vaccines normally given at age 4 years or later, we will require that the vaccines be completed within 2 years of the usual age of administration.

Some vaccines, including those that are not required for school entry in the State of Illinois, will be exempt from the mandatory vaccine policy at PCA. However, the physicians strongly endorse all of the vaccines recommended by the American Academy of Pediatrics, and will continue to discuss the reasons why these vaccines are essential for the well-being of our children.

For those who do not wish to abide by these policies, then we kindly ask that you seek pediatric care elsewhere.

I have read the Pediatric Care Associates vaccine policy as described above and agree to its terms and conditions for my child.

_____ _____

Name of Signed Guardian Signature

_____ _____

Relationship to Patient Name of Patient

_____

Date

FAMILY MEDICAL HISTORY

PATIENT LAST NAME: _____

FIRST NAME: _____ **BIRTHDATE:** _____ **SEX:** _____

FIRST NAME: _____ **BIRTHDATE:** _____ **SEX:** _____

FIRST NAME: _____ **BIRTHDATE:** _____ **SEX:** _____

	CHECK ALL ITEMS THAT APPLY	High Cholesterol	High Blood Pressure	Early Heart Disease (Under age 55)	Kidney Disease	Cognitive Impairment	Learning Disability	Autism	Attention Deficit Disorder	Drug or Substance Abuse	Thyroid Disorder	Diabetes Juvenile	Diabetes Adult Onset	Eye Disease	Gastrointestinal Disease	Ulcers	Hepatitis	Hearing Disorder	Depression	Anxiety Disorder	Allergies Drugs	Allergies Environmental	Allergies Foods	Asthma	Skin Disorder	Cancers Adult Onset	Cancers Childhood Onset	Seizure Disorder	Bone or Joint Disease	Other:
Family Member	**Name**																													
Mother																														
Father																														
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Mat GM																														
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Other:																														

Please provide details: