Print clearly using black ink only

Patient Name____ **Date of Birth**___________________

Social History

Mother's Name_______________________________ Father's Name____________________ ____________
Sibling(s):
1.___________________________________age____ 3.________________________________age____
2.___________________________________age____ 4.________________________________age____
5.___________________________________age____ 6.________________________________age____
Stepparent(s)_________________________________ ____
Who does the child live with: ____

Birth History

Birth Hospital_____________________________ Birth City_________________________State_________
Mother's age at time of delivery ____________ Number of pregnancies you have had: ________ Live Births:_________
Abortions/Miscarriages ________ How many living children: _________
Complications during *<u>this</u>* pregnancy or delivery? (circle) NONE Hypertension Diabetes
Clotting Pre-mature birth Drug Use IUGR Gonorrhea Chlamydia Group B strep
Other____

Feeding: ☐Breast feeding ☐ Formula (name)_____________ **Delivery:** Vaginal C-section Forcep Vacuum
Bilirubin (level at birth) ______ **APGARS** 1st_______ 2nd_______ **Birth weight** _____ lbs. _____oz. **Length** ______
Date of Discharge____________ Weight (at discharge)____________ **Was your baby in the NICU**: Yes No
Reason:____ How long?_____________________

Patient History

Please list **ALL** your child's medical hospitalizations/diagnoses/surgeries, the dates of diagnosis, ***and*** treatment:

Diagnosis/Surgery/Hospitalization	Date	Treatment
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Other:____
Does your child take ANY medications? ○ YES ○ NO
IF yes, list all medications:

Medication	Strength	How often?

List ALL allergies (medication, food, seasonal):

____

____

****Please see other side to complete form**

Patient Name____ **Date of Birth**__________________

Family History

Does the child's ***primary family members*** have any of the following diseases/disorders (please circle):
(Includes mother, father, sibling, maternal grandparents, paternal grandparents)

Medical Condition	Yes	No	WHO in the family has this condition/Comments
Asthma			
Anemia/low iron			
Cancer (Specify type)			
Celiac Disease			
Crohn's Disease			
Diabetes			
Type I			
Type II			
Eczema			
Eye problems (strabismus, macular degeneration, cataracts)			
Headaches (type)			
Hearing loss			
Heart Disease			
Hemophilia			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease (Specify type)			
Mental Disorders:			
Anxiety			
Depression			
Bi-polar disorder			
Schizophrenia			
Muscular Dystrophy			
Neurofibromatosis			
Rheumatoid arthritis			
Seizures/Epilepsy			
Scoliosis			
Sickle Cell Anemia (trait or disease)			
Thalassemia			
Thyroid problems			
Tuberculosis			
Ulcers and/or GERD			

Are there smokers in the household? YES NO IF YES, who? ____

IS there a history of abuse? YES NO Explain:____

____

____

Printed Name of Responsible Party

____ ___________________________________

Signature of Responsible Party **Today's Date**

Patient's Name ____Date of Birth__________________

OFFICE POLICIES

1. **CHECK IN**
   - **a.** All patients are required to be signed in prior to receiving any services
   - **b.** All patients must present their insurance card and copay at every visit
   - **c.** Payment is due at the time of service
   - **d.** It is the sole responsibility of the patient's parent or legal guardian to provide us with all insurance information and ensure it is accurate.
   - **e.** If no insurance information is given or it is not updated at the time of service the patient's parent/legal guardian will be billed for services.
   - **f.** Any amount NOT covered by insurance will be billed to the parent/legal guardian.
   - **g.** ONLY the child whose appointment was made for may be seen. If other children need to be seen you need to make an appointment for them. This helps us with long wait times.

   ** Please initial that you have read and understand these policies ___________(initial)

2. **FORMS OF PAYMENT**
   - **a.** We accept cash, checks, Master Card, Visa, and Discover
   - **b.** Checks need to be made to Wee Care Pediatrics. All returned checks will be subject to a $35.00 NSF fee in addition to any bank fees imposed.
   - **c.** For self-pay families, we do offer payment plans.
   - **d.** All bills must be paid within 90 days of service.

   ** Please initial that you have read and understand these policies ___________(initial)

3. **NO-SHOW AND CANCELLATIONS:**
   - **a.** You must cancel your child's appointment within 24 hours or it will be considered a NO-CALL, NO-SHOW and you may be charged a fee of $50 for the missed appointment.
   - **b.** **After THREE total no-call, no-show's your family may be discharged from the practice. (To include ALL children seen at Wee Care Pediatrics)**

     ***IF** the first appointment scheduled results in a no-call, no-show it is an **automatic discharge**.
   - **c.** We do our best to give you a reminder call for your appointment, but we are NOT responsible if you forget your appointment.

   ** Please initial that you have read and understand these policies ___________(initial)

4. **LATE ARRIVALS**
   - **a.** If you are going to be late, please contact our office as soon as possible.
   - **b.** We do allow a 5-minute window for late arrivals
   - **c.** IF you are later than 5 minutes, it will be at the discretion of the provider to approve the visit or you will need to reschedule your appointment.

   ** Please initial that you have read and understand these policies ___________(initial)

5. **LAB WORK**
   - **a.** ALL lab work will be referred to an outside lab facility that are within the network of your insurance. We have a list of contracted labs, however it is ultimately your responsibility to know who is in network with your insurance.
   - **b.** We are not responsible for any bills you receive from the lab.

   ** Please initial that you have read and understand these policies ___________(initial)

____ ____________________

Signature of Responsible Party Date

WEE CARE PEDIATRICS

Print clearly in black ink only

Patient Name______________________________________Date of Birth_______________

PATIENT CONSENT FORM

I hereby give consent for Dr. Margot A. Crossley and her staff/representative to use and disclose Protected Health Information (PHI) about me or my child to carry out treatment, payment, and healthcare operation (TPO).

I have the right to review Dr. Margot A. Crossley's Notice of Privacy Practices prior to signing this patient consent form. Wee Care Pediatrics reserves the right to revise its Notice of Privacy Practices at any time.

By signing this patient consent form, Dr. Crossley's office may call my home or other numbers which I provide and leave a message on my voicemail or in person pertaining to any item that assist the office in carrying out TPO, such as appointment reminder, insurance items and any call regarding to my child's clinical care to include lab and test results.

Wee Care Pediatrics may conduct, plan and direct my child's treatment and follow-up among multiple healthcare providers who may be involved in treatment directly or indirectly, obtain payment from third parties and conduct normal healthcare operations such as quality assessments and physicians certifications.

My signature on this from gives consent to Wee Care Pediatrics to use and disclose my PHI to complete treatment, payment, and healthcare operations.

I may revoke this consent, in writing at any time. If I do not sign this patient consent form or revoke my consent, Wee Care Pediatrics may decline to treat my child.

Upon revoking this form, Wee Care Pediatrics may no longer use or disclose patient PHI for TPO. Wee Care Pediatrics may use PHI to the date of written revocation for TPO services.

____

Printed Name of Responsible Party

____ ____________________

Signature of Responsible Party Date

PATIENT REGISTRATION FORM　　　　　　　　　　　　　　　　WEE CARE PEDIATRICS

Please Print Clearly in BLACK ink

PATIENT INFORMATION:

Patient Name____
Last　　　　　　　　　　First　　　　　　　　　　MI

Date of Birth ____________________ Gender: ◯ Male ◯ Female Nickname:_______________________
(mm/dd/year)

Address ____
Street　　　　　　　　Apt #　　　　　City, State　　　　　Zip Code

Primary Phone (　　　)________________ Secondary Phone (　　　)__________________ OK to leave message Y N

Name of Father/legal guardian ____ DOB________________
Last　　　　　　　　First　　　　　　　　(mm/dd/year)

Employer____ SSN______-______-_______

Name of Mother/legal guardian____ DOB________________
Last　　　　　　　　First　　　　　　　　(mm/dd/year)

Employer____ SSN______-______-_______

Email address____@____________________________

EMERGENCY CONTACT INFORMATION:

Name of relative or friend NOT living in the home that we may contact in an emergency

Name____ Relationship (to patient)__________________
Last　　　　　　　　First

Phone (　　　)________________________ Can we speak to this person regarding your child's medical care? Y N

INSURANCE INFORMATION: (Medicaid and CHP+ are *secondary* insurances to ANY private insurance)

Primary Insurance__________________________Policy/ID #______________Group #_________________

Policy Holder________________________ Date of Birth_________________ SSN_____________________

Relationship to patient________________________________ Employer______________________________

Secondary Insurance________________________Policy/ID #______________Group #_________________

Policy Holder________________________ Date of Birth_________________ SSN_____________________

Relationship to patient________________________________ Employer______________________________

Please check here if you do NOT have insurance coverage ◯ Have you applied for government assistance? Y N

Would you like contact information as to how you may apply for assistance? Yes No, thanks

OTHER INFORMATION:

Is this child in foster care? Y N IF yes, please provide social worker's name:_______________________
Phone (　　　)__________________________ I give permission for Wee Care Pediatrics employees to contact the individual listed above in regards to _________________________________ (list child's name).

Signature ____ Date_______________________

The information above is true and up to date (please initial and date):

PATIENT REGISTRATION FORM WEE CARE PEDIATRICS

Patient Name____**Date of Birth**____________________

We are committed to providing you with the best possible medical care. If you have medical insurance , we would like to help you receive the maximum allowable benefits. In orde to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

Assignment: I request that payment of authorized insurance, Medicare and Medicaid benefits be made payable to Wee Care Pediatrics, on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

__________ **(Initial) I have read and agree to the above statement**

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed, billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amount by primary and secondary insurance. Tertiary insurance billing remains my responsibility.

__________ **(Initial) I have read and agree to the above statement**

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits of y dependents or myself. If I have health insurance coverage under an HMO, I authorize Wee Care Pediatrics o release information concerning my diagnosis and treatment to my primary care or referring physicians after each visit.

__________ **(Initial) I have read and agree to the above statement**

REQUEST FOR INFORMATION: Should I receive any request from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

__________ **(Initial) I have read and agree to the above statement**

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by my insurance company and MUST be paid at each visit. Patents with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

__________ **(Initial) I have read and agree to the above statement**

WORKER'S COMPENSATION: I will provide approval/authorization by the Worker's Compensation carrier at the initial visit of the claim. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney or the Worker's Compensation carrier will be provided to this office.

__________ **(Initial) I have read and agree to the above statement**

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for any checks returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

__________ **(Initial) I have read and agree to the above statement**

PRIVACY POLICY: I have been made aware of the privacy policy of Wee Care Pediatrics and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

__________ **(Initial) I have read and agree to the above statement**

I have read and agree to the above statements and I, the undersigned patient or patient's legal representative, am ultimately responsible for all fees.

____ ________________________

PRINTED NAME OF PATIENT OR LEGAL REPRESENTATIVE RELATION TO PATIENT

____ ________________________

SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECIEPT

I acknowledge I have received a copy of Dr. Margot A. Crossley, D.O., Notice of Privacy Practices.

Notice of Privacy Practices describe how Wee Care Pediatrics may use and disclose my/my child's protected health information, restriction of use, disclosures of my/my child's healthcare information and rights I have regarding my/my child's protected healthcare information.

Patient Name____

Signature of responsible party____

Printed name of responsible party____

Date________________________

Understanding your child's health information

Each time you visit Wee Care Pediatrics, a record of your child's visit is created. This record contains your child's name, home information, symptoms, examination, test results, diagnoses, treatment plan, and plans for future healthcare and financial information. This record is sometimes referred to as your child's medical record or medical chart. This record allows:

- Doctors, nurses and other medical health care professionals to plan your child's treatment
- Obtain payment for services we provide to you and your child
- Measure the quality of care provided to you and your child

We are committed to keeping your child's health information confidential. We will not use or give your child's health information to anyone without your written consent, except as previously stated.

A) Other uses and disclosures allowed or required by law

We may use or give your child's health information for the following purposes under limited circumstances:

- When ordered by a judge of the court
- When law enforcement requests information
- When requested by coroners and funeral directors to allow them to carry out their duties
- Organ donor agencies
- Government agencies that oversee our practice
- Government agencies that have a right to receive and collect healthcare information
- Any family members or friends that you have signed consent to allow them to bring your child in.
- Business associates of Wee Care Pediatrics such as our billing company; Code One
- For any other purpose required by law

B) Other uses and disclosures requiring you written permission

To release medical information to any other place such as day care, school, WIC, etc, we require the responsible party to sign a medical release form allowing us to send the requested information to the other party. You may revoke your authorization at any time by notifying the office in writing. If you revoke your permission, we will no longer use or disclose medical information about your child to that party. Understand that we are unable to withdraw any disclosures we have already sent with your previous consent, and that we are required by law to retain our records of the care provided by Wee Care Pediatrics to your child.

C) Your right regarding your child's medical information

Although your child's health record is the physical property of Wee Care Pediatrics, it is subject to certain legal limits. You are entitled to the use or disclosure of your child's health care information including:

- Requesting limits on uses of your child's health information
- Receiving confidential communications of your child's health information
- Inspecting and copying your child's health information
- Requesting a change to your child's health information

To exercise any of your right with Wee Care Pediatrics, please obtain the required forms from the office and submit your request in writing.

D) Questions, concerns, and changes to this notice

If you have any questions or concerns regarding any of the information in the Notice of Privacy Practices, please contact our office manager.

If you feel your rights have been violated, you may file a complaint with Wee Care Pediatrics.

We reserve the right to change our Notice of Privacy Practices at any time within the legal parameters which we are bound and will notify you of these changes by posting them in the office.

WEE CARE PEDIATRICS
MARGOT A. CROSSLEY, D.O.
DELANNE AMONETT, CPNP
CHELSEA SOUCIE, CPNP
1465 Kelly Johnson Blvd. Suite 300
Colorado Springs, CO 80920
Phone 719-266-5944 Facsimile 719-266-5947

IMMUNIZATION AGREEMENT

I acknowledge that I have read and understand the importance of immunizations as written and approved by the CDC (Center of Disease Control) and AAP (American Association of Pediatrics).

I ____, hereby give my consent for Wee Care Pediatrics to immunize my child. Shall I disagree with this practice; I understand that my registration will not be accepted.

____
Name of Patient

____
Name of Responsible Party

____
Signature of Responsible Party

____
Date