Caldwell Pediatrics and Wellness Center

We grow healthy children, Naturally!

Office Policies

1. Caldwell Pediatrics does **NOT** operate as a walk-in clinic.
2. Patients arriving 15 minutes **AFTER** their appointment will be **RESCHEDULED**.
3. Insurance cards, payment, and photo ID are required **AT THE TIME OF VISIT**.
4. Patients/parents/guardians are required to be **OFF cell phones** while at the registration window.

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Suite 106
Hopewell, VA 23860
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Fax: 804-520-2259
admin@caldwellpediatrics.com

REGISTRATION FORM

Date: _____

PATIENT INFORMATION

Patient Name: _____

Address: _____ Suite/Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work #: _____ Cell #: _____

May leave message at: □ Home □ Work □ Cell Email address (age 18 and up): _____

Gender: □ F □ M DOB: ___/___/_____ Preferred Language: _____ Hospital Born: _____

Race/Ethnicity: □ American Indian □ Black/African American □ Hispanic/Latino □ Native Hawaiian □ White □ Asian

□ Other _____

Pharmacy Name and Address: _____ Phone #: _____

Siblings & DOB: _____

RESPONSIBLE PARTY INFORMATION

Mother's Name or Guardian: _____ Social Security or DL#: _____

DOB: ___/___/_____ Address: _____ City/State: _____/_ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Mother's Employer: _____ Employer's Address: _____

Father's Name or Guardian: _____ Social Security or DL#: _____

DOB: ___/___/_____ Address: _____ City/State: _____/_ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Father's Employer: _____ Employer's Address: _____

Email Address for Electronic Communications- Mother: _____ Father: _____

EMERGENCY CONTACT (other than parent)

Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____/_____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

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INSURANCE INFORMATION

Insurance Company:_____Policy #: _____

Group #:_____Insured's Name:_____DOB:_____

Secondary Insurance:_____Policy #: _____

Group #:_____Insured's Name:_____DOB: _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

Our Notice of Privacy Practices (available upon arrival to our office) provides information about how we may use and disclose protected health information (PHI) about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have received a copy of Caldwell Pediatrics and Wellness Center' Notice of Privacy Practices. I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____

Patient or Parent/ Legal Guardian Signature Date

DISCLOSURES OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS

Disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. We will only disclose information relevant to current treatment.

I authorize Caldwell Pediatrics and Wellness Center to disclose my health care information to:

_____

Name Phone Number Relationship

_____

Name Phone Number Relationship

_____ _____

Patient or Parent/ Legal Guardian Signature **Date**

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FINANCIAL POLICY AND RELEASE

Regarding Insurance: You are responsible for checking with your carrier to see if services at our office will be covered. All copayments must be made at the time of service. It is your responsibility to notify us of any changes in your policy information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your medical plan. You will be responsible for these balances. Additionally, it is your responsibility to obtain and track referrals for your visits.

Release: I hereby authorize direct payment of insurance benefits that are otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or other persons to whom disclosure is necessary to establish or collect a fee for services provided.

Returned Checks and Collection Fees: There will be a $25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, we reserve the right to call your bank to verify funds for any future checks that are presented for payment. In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees whether or not the attorney files suit. Additionally, you will be assessed a finance charge of 1.5% per month on balances over thirty (30) days past due, which is an APR of 18%.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the minimum rate of $25 per missed appointment. Please help us serve you better by keeping your scheduled appointments.

I have read, understand and agree to this Financial Policy:

_____

Patient Name (print)

_____ _____ _____

Patient or Parent/ Legal Guardian Signature **Print Name** **Date**

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Permission to Treat

I_____authorize Caldwell Pediatrics and Wellness

Print name(s) of legal guardian(s)

Center and its personnel to deliver medical services to my child(ren):

_____ _____

_____ _____

_____ _____

Print child's and date of birth

I/We authorize the following people to bring my child in for treatment:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship: _____

_____ _____

Signature of Legal Guardian Date

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Patient History

Name:_____

Acc. Number: _____

Birth date:_____Age_____

Form completed by: _____

Date completed: _____

HOUSEHOLD:

Please list all those living in the child's home:

NAME	RELATIONSHIP TO CHILD	BIRTHDATE	HEALTH PROBLEMS

Are there any siblings not listed? If so, please list their names and ages and where they live: _____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____.

If one or both parents are not living in the home, how often does he/she see the parent/s not in the home?

_____.

BIRTH HISTORY:

Birth weight:_____Method of delivery:_____vaginal_____cesarean

If by cesarean section, why:_____.

Was the baby born term:_____early:_____if early, how many weeks:_____.

Did your baby have any problems right after birth?_____Yes_____No

If yes, explain problems:_____.

Did mother have any illness or problems with her pregnancy:_____Yes_____No

If yes, explain:_____.

How was baby fed initially? breast_____bottle_____

During pregnancy, did mother smoke:_____Yes_____No

Drink alcohol_____Yes_____No / Use drugs or medications:_____Yes_____No

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If yes, what medications or drugs were used:

_____

Was the baby discharged home with the mother:_____Yes_____No

If no, explain_____.

GENERAL:

Do you consider your child to be in good health?_____Yes_____No Explain _____

Does your child have any serious illness or medical conditions:?_____Yes_____No Explain _____

Has your child had serious injuries or accidents?_____Yes_____No Explain _____

Has your child had any surgery?_____Yes_____No Explain _____

Has your child ever been hospitalized?_____Yes_____No Explain _____

Is your child allergic to any medicines or drugs?_____Yes_____No Explain_____

DEVELOPMENT:

Are you concerned about your child's physical development?_____Yes_____No Explain_____

Are you concerned about your child's mental or emotional development?____Yes____No Explain_____

Are you concerned about your child's attention span?_____Yes_____No Explain_____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

FAMILY HISTORY:

Have any members of the family had the following:

Deafness	Yes_____No_____Who_____
Nasal allergies	Yes_____No_____Who_____
Asthma	Yes_____No_____Who_____
Tuberculosis	Yes_____No_____Who_____
Heart disease (before 50 years old)	Yes_____No_____Who_____
High blood pressure (before 50 y.o.)	Yes_____No_____Who_____
High cholesterol	Yes_____No_____Who_____
Anemia	Yes_____No_____Who_____
Bleeding disorder	Yes_____No_____Who_____
Liver disease	Yes_____No_____Who_____

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Kidney disease Yes

____No____Who_____

Diabetes (before 50 y.o.) Yes____No____Who_____

Bed-wetting (after 10 y.o.) Yes____No____Who_____

Epilepsy or convulsions Yes____No____Who_____

Alcohol abuse? Yes____No____Who_____

Drug abuse? Yes____No____Who_____

Mental illness? Yes____No____Who_____

Mental retardation? Yes____No____Who_____

Immune problems, HIV or AIDS? Yes____No____Who_____

Additional family history or comments: _____

_____.

_____.

PATIENT HISTORY:

Does your child have, or has he/she ever had:

Chickenpox: Yes___No____When_____

Frequent ear infections: Yes___No____Explain_____

Problems with ears or hearing: Yes___No____Explain_____

Nasal allergies: Yes___No____Explain_____

Problems with eyes or vision: Yes_No_Explain_____

Asthma, bronchitis, bronchiolitis, pneumonia: Yes__No__Explain_____

Any heart problem or heart murmur: Yes___No____Explain_____

Anemia or bleeding problems: Yes___No____Explain_____

Blood transfusions: Yes___No____Explain_____

Frequent abdominal pain: Yes___No____Explain_____

Constipation requiring doctor visits: Yes___No____Explain_____

Bladder or kidney infections: Yes___No____Explain_____

Bed-wetting (after 5 y.o.): Yes__No__Explain_____

(For girls) has she started menstrual period? Yes__No__When_____

(For girls) are there problems with period? Yes__No__Explain_____

Any chronic or recurrent skin problems (Acne, eczema, etc)? Yes_No_Explain_____

Frequent headaches: Yes___No____Explain_____

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Convulsions or other neurologic problems: Yes___No_____

Explain_____

Diabetes: Yes___No_____Explain_____

Thyroid or other endocrine problems: Yes___No_____Explain_____

Any other significant problem: Yes___No_____Explain_____

Use of alcohol or drugs: Yes___No_____Explain_____

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Records Release

I Hereby Authorize You to Release My Child's Records to the Following:

TO: **[All fields required]**

Dr. _____

_____

(Street Address) (City) (State) (Zip Code)

_____ _____

(Telephone Number) (Fax Number)

FROM: **[All fields required]**

Dr. _____

_____

(Street Address) (City) (State) (Zip Code)

_____ _____

(Telephone Number) (Fax Number)

Extent of information to be released:

Complete Health Records _____

Office Notes_____from_____to_____

Immunizations Only _____

Lab Only _____

X-Ray Only _____

Other _____

Please include any Medical information concerning diagnosis and records of treatment or examination rendered.

Please note there may be a per page charge.

Child's Name:_____Date of Birth: _____

Child's Name:_____Date of Birth: _____

Child's Name:_____Date of Birth: _____

Name of Legal Guardian: _____

_____

(Street Address) (City) (State) (Zip Code)

□ **I would like to pay an additional cost to have my child's medical records mailed certified mail which includes a tracking number. This cost will be determined by the weight of the package being mailed.**

□ **I would not like to pay the additional cost to have my child's medical records mailed certified mail, and I understand Caldwell Pediatrics and Wellness Center is not responsible for any medical records that the USPS fails to deliver timely or loses.**

Parent's Signature:_____Date: _____

Telephone Number: _____