Wee Tots Pediatrics, P.A.

PATIENT INFORMATION

Name of Minor/Child ____
Last Name First Name Initial

Sex __M__F Age ______ Birthdate ______________ Nickname ______________ SS# ______________

Home Address ____
Street City State Zip Code

Home Phone # ______________ Mom Cell # ______________ Dad Cell# ______________

List all Siblings: Name ______________________ Birthdate ______________
Name ______________________ Birthdate ______________
Name ______________________ Birthdate ______________
Name ______________________ Birthdate ______________

Father/Guardian Name ______________________ Mother/Guardian Name ______________________

SS# ______________ Birthdate ______________ SS# ______________ Birthdate ______________

Employer ______________________ Employer ______________________

Employer Phone# ______________________ Employer Phone# ______________________

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name ______________________ Relationship ______________ Phone# ______________

Name ______________________ Relationship ______________ Phone# ______________

APPOINTMENT OF AGENT

(For our patients less than 18yrs old)

I, ______________________ hereby appoint the following person(s) listed below of lawful age
(Name of Parent/Guardian and relationship to child)
as my agent and representative for the purpose of authorizing and consenting to medical care and treatment of
______________________ for any illness that may occur while such person is in the care or
(Name of patient)
custody of the agent, while I am away on vacation or otherwise not immediately available to give such consent.

Name of Appointed Person(s)

1. ______________________ Relationship ______________________

2. ______________________ Relationship ______________________

3. ______________________ Relationship ______________________

4. ______________________ Relationship ______________________

5. ______________________ Relationship ______________________

FAMILY HISTORY

Has any member of the family or close relative had: (Please **Circle** "Yes" or "No")

Arthritis	YES NO	Hemophilia-Bleeder	YES NO
Asthma or Hay Fever	YES NO	High blood pressure	YES NO
Cancer	YES NO	Kidney Disease	YES NO
Chemical dependency	YES NO	Mental Disorders	YES NO
Convulsions or Epilepsy	YES NO	Migraines	YES NO
Diabetes	YES NO	Tuberculosis	YES NO
Heart Disease	YES NO	Other____________________	

BIRTH HISTORY

Hospital______________________________ Obstetrician______________________________

Type of Delivery__________________________ Complications____________________________

Birth Weight__________ Birth Length__________ Discharge Weight____________

Did baby have any problems at or immediately after birth?______________________________

List age: Cooed or laughed_____ Sat_____ First Word_____ Held Head Up____ Walked_____ Toilet Trained_____

HEALTH HISTORY

Previous Physician__________________________ City/State____________________ Phone____________

Date of last Physical Exam________________________________ Results__________________________

Is Child under care of Physician now? YES NO Medications____________________________

Receiving any medications or drugs? YES NO ____________________________________

Has your child ever been Hospitalized? YES NO Allergies______________________________

Date: Reason: Hospital: ____________________________________

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

(Please circle all that are applicable)

A.I.D.S/H.I.V.	Chicken Pox	Heart Problems	Rheumatic Fever
Anemia	Constipation	Hepatitis	Sinus problems
Asthma	Convulsions	Kidney Disease	Speech problems
Bed Wetting	Diabetes	Lead Poisoning	Thyroid Disease
Birth Defects	Drug/Alcohol abuse	Liver Disease	Tuberculosis
Bladder problem	Ear Infections	Measles	Urinary Diseases
Bleeding, excessive	Epilepsy	Mononucleosis	Vision problems
Cancer	Fainting	Mumps	Worms
Cerebral Palsy	Hearing Problems	Pneumonia	Other__________

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I certify that my child is covered by Insurance/Medicaid/Chip with______________________________ and assign directly to the Practice of Wee Tots Pediatrics, all insurance benefits, if any, otherwise payable to for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________________________

(Signature of Parent/Guardian) (Date)

WEE TOTS PEDIATRICS OFFICE POLICY

We are committed in providing our patients with the best possible care. Your clear understanding of our policies is important to our professional relationship.

PLEASE INITIAL:

________ **ALL** patients/parents are required to **COMPLETE IN FULL** a Patient Information Form before being seen by the Provider.

________ **MINORS**-A PARENT or LEGAL guardian Must be present at the FIRST VISIT AS WELL AS EACH time for future visits, unless parent/legal guardian has a SIGNED permission statement after the first visit for services to be rendered. The person who has been assigned to bring the child is required to have his/her LEGAL identification. Legal Guardian must present the proper legal paperwork, and a copy must be kept in the patient's chart.

________ **LATE APPOINTMENTS/WALK IN'S**-If **5 minutes** late for your scheduled appointment, your appointment will be rescheduled at the next available opening date. Walk In's=Our scheduled patients will be seen **FIRST.** Any walk-ins will be seen at the first opening appointment. **Please note**: The office staff(after triaged by a nurse) will notify any of the Providers of any EMERGENCY situation and the Provider will assess the case and will decide whether the child needs to be seen in this practice or needs to be sent to the HOSPITAL EMERGENCY ROOM.

________ **NEW PATIENTS**-ALL PATIENTS MUST present their current Insurance Card or if the child is under Medicaid the **"Current"** Monthly Medicaid **Form** will be required **BEFORE rendering any services.** Patients will be **rescheduled** if such forms are not presented at the time of the visit, or will be given the choice to pay in full for the services rendered as if there is no insurance.

________ **PAYMENTS** – ANY copayment from insurances, Private Pay payments(Patients with no health insurance) are **DUE BEFORE ANY SERVICES ARE RENDERED.** Any additional payment for treatments while the patient is being seen will also be due at the time services are rendered. This office does NOT provide Payment arrangements.

________ **COLLECTIONS/BALANCES**- Any unpaid balances must be paid before services are rendered.

________ **INSURANCE CLAIMS** –will be filed as a courtesy, however, we will not become involved in any disputes that you may have with your insurance carrier.

________ **IMMUNIZATION REQUESTS**-There is a **$10.00 charge** for a new shot record or to fill out an empty shot record card. The patient's chart will be noted every time you request one(All Medical records & forms to be filled out have fees). Please make sure that you bring the Shot Record every time you come in for a Well Child Appointment. PLEASE NOTE: THERE IS A FEE FOR ALL MEDICAL RECORDS/FORMS/LETTERS.

________ **CONFLICTS** – Any problems or conflicts between staff and parents/guardians must be brought to the attention of the Office Manager. Please Note: The providers follow all of these policies to their extent and do not get involved in office conflicts.

________ **CANCELING APPOINTMENTS** – Must be made 1 to 2 hours before the scheduled time of the appointment, otherwise it will be considered as a **"NO SHOW"**

________ **NO SHOWS** – Patients will be "Dismissed from Office" after **3 NO SHOW** appointments.

________ **EXAMINING ROOMS** –Due to HIPPA Regulations All Parents/Patiens MUST remain INSIDE the Examination Room, otherwise your appointment will be canceled or you will be asked to leave.

________ **OFFICE VISITS** – Only the Mother and/or Father or Guardian of the patient with an appointment will be allowed in the Examining Room/Back Office. Any other adult(s) who accompany the Guardian will be asked to wait in the Front Waiting Room.

________ **NSF/CHECKS** –All checks are electronically processed through Merchant Connect. Checks can not be accepted if they are electronically declined. Any fees for NSF checks will be handled directly through Merchant Connect.

________ **PARKING LOT** – Do **NOT** throw dirty diapers or trash in the parking lot.

________ **WEATHER POLICY** – Wee Tots Pediatrics follows the AISD weather policy (on school days)-i.e.:If AISD is closed or delayed then our office will be closed/delayed.

________ **REFILLS/APPOINTMENTS AFTER OFFICE HOURS** – ON CALL PROVIDER – The On Call Provider (after office hours) is there to help give advice as to what type of aid your children need, based on their symptoms, to give supportive care until patient is seen the next day or refer to a children's hospital and NOT for Refills on medications NOR to make/cancel appointments. Medications will be called in at the discretion of the Provider On Call, but in NO circumstance the Providers are subject to call in medications. ****Refills, Making/Canceling Appointments are to be made during normal business hours Monday through Friday from 8am to 5pm NOT on Saturdays nor Sundays.**

PLEASE INITIAL:

________FOOD/DRINKS – No food or drinks are allowed in building.

________DISMISSALS FROM PRACTICE – The following information will be considered as reasons of dismissal from Wee Tots Pediatrics, P.A.:

- **RUDE BEHAVIOR**
- **FOUL LANGUAGE**
- **DISCOURTEOUS/VIOLENT BEHAVIOR**
- **NON-COMPLIANCE WITH PHYSICIAN/PHYSICIAN'S ASSISTANT/NURSE PRACTICIONERS ORDERS**
- **CHANGE OF PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTIONER TO ANOTHER OFFICE OTHER THAN WEE TOTS PEDIATRICS, P.A.**
- **HAVING DIFFERENT PHILOSOPHIES WITH PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTIONER.**
- **NON-COMPLIANCE WITH OFFICE POLICIES.**
- **LACK OF CONFIDENCE IN THE PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTICIONER.**
- **WHEN A PATIENT REACHES 12 YEARS OF AGE.**
- **ANY DISCORDANCE IN PHILOSOPHY BETWEEN PATIENT'S MEDICAL CARE AND PARENT DESIRES.**
- **WITHHOLDING/ALTERING THE MEDICAL CONDITION OF A PATIENT'S HEALTH FROM EMPLOYEE'S WHEN MAKING APPOINTMENTS.**
- **HAVING FOOD OR DRINKS IN BUILDING AFTER BEING WARNED ONCE NOT TO BRING THEM IN.**

***IN THE EVENT OF A DISMISSAL FROM THE PRACTICE, ALL MEDICAL RECORDS WILL BE SENT TO NEW PHYSICIAN AFTER A MEDICAL RECORDS RELEASE FORM IS COMPLETED AND SIGNED BY A PARENT OR GUARDIAN.

The undersigned, having read and expressed understanding of this, hereby agree and will abide by ALL the Office Policies.

________________________________ ________________________________

Parent/Legal Guardian Signature Date

CONSENT FOR TREATMENT

Wee Tots Pediatrics, P.A. provides primary health care including the diagnosis and treatment of illness or injuries. A Physician and/or a Physician Assistant and/or Nurse Practitioner provide services at the office. The Physician Assistant/Nurse Practitioner is not a Physician, but does function under the supervision of a Physician either directly or via protocols established by a Physician. As a patient, you have the right to request to be seen only by a Physician.

The under signed, having read and expressed understanding of this document by the signature below, does hereby agree to be medically attended and treated by Wee Tots Pediatric Associates.

______________________________ ______________________________

(Signature of Parent/Guardian) (Date)

IMPORTANT NOTICE REGARDING SHOT RECORDS

I ACKNOWLEDGE, SHOULD I **NOT** BRING THE PATIENT'S **SHOT RECORD(S)** TO THE WELL CHECK VISIT OR FOLLOW UP SHOT VISIT, ***MY APPOINTMENT WILL BE RESCHEDULED*** FOR THE **NEXT** AVAILABLE DATE. THE UNDER SIGNED, HAVING READ AND EXPRESSED UNDERSTANDING OF THIS, HEREBY AGREE.

______________________________ ______________________________

(Signature of Parent/Guardian) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Wee Tots Pediatrics, P.A. reserves the right to modify the Privacy Practices outlined in the notice. I have read a copy of the Notice of Privacy Practices for Wee Tots Pediatrics, P.A.

Name of Patient:______________________________

Date:______________________________

Signature of Parent/Guardian:______________________________

Relationship to Patient:______________________________

PARENT ACKNOWLEDGMENT

I ______________________________ understand that a Licensed Practitioner from Wee Tots Pediatrics, P.A. has ordered SERVICES (Labs, Xrays, Referrals, etc.) to be performed on my child. These Services **may or may NOT be a covered** service under my Insurance/Medicaid Coverage. **I understand that I AM responsible for payment for the items/services requested from the Physicians/Practitioners/P.A's.**

I also understand that I AM responsible to make the payment directly to the company where the services are/will be rendered. I understand that those services/items are/will be provided from a different entity/company NOT affiliated to WEE TOTS PEDIATRICS, P.A.

Parent/Guardian Signature ______________________________ Date: ______________

WITNESS: ______________________________

RECONOCIMIENTO DE LOS PADRES

Yo ______________________________ entiendo que uno de los Médicos/Asistentes Médico/Enfermera Especialista ha ordenado Servicios (Laboratorios, Rayos X, Referencias, etc.) Estos Servicios puede ser que Mi Seguro Medico/Medicaid cubra o **NO cubra los servicios o las provisiones suso dichas.**
Yo comprendo que YO SOY la persona responsable por los servicios/ordenes que han sido solicitados por parte de Los Doctores/Asistentes Médicos/Enfermera Especialista.

También comprendo que YO SOY la persona responsable de hacer ese pago directamente a la compañía donde los servicios serán/son proporcionados. Comprendo que los servicios son proporcionados por otra compañía que NO está afiliada a WEE TOTS PEDIATRICS, P.A.

Firma del Padre/Madre ______________________________ Fecha: ______________

TESTIGO: ______________________________

Patient: ______________ **D/O/B:** ______________ **MM#** ______________

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Name of Appointed Person(s)

1. ______________________________ Relationship ______________________________
2. ______________________________ Relationship ______________________________
3. ______________________________ Relationship ______________________________
4. ______________________________ Relationship ______________________________
5. ______________________________ Relationship ______________________________