PEDIATRIC associates

Date _____

3516 12th Ave NE * Olympia, WA 98506 * 360-456-1600

PATIENTS INFORMATION:

First name MI Last name Date of birth M/F

Street/PO Box City State Zip Home phone number

Other Children (seen as patients):

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

First Name MI Last name Date of birth M/F

Parent or Guardian information: *(Living in same household as patient)*

Relationship to patient: _____

First Name MI Last Name Date of Birth SS#

Street/PO Box City State Zip

Home number Work number Cell number

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐ Yes ☐ No

Parent or Guardian information (other contact):

Relationship to patient: _____

_____

First Name MI Last Name Date of Birth SS#

_____

Street/PO Box City State Zip

_____

Home number Work number Cell number

IS THE ABOVE ADDRESS THE CORRECT ONE FOR STATEMENT BILLING? ☐ Yes ☐ No

INSURANCE INFORMATION:

Primary Insurance:

_____

Name of Plan Subscriber ID# Group# Effective date

_____

Subscribers name Date of Birth Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

Secondary Insurance:

_____

Name of Plan Subscriber ID# Group# Effective date

_____

Subscribers name Date of Birth Employer

Subscriber's relationship to patient: ☐ Mother ☐ Father ☐ Self ☐ Other (explain):_____

Emergency Contact Information: (*Relative/friend outside of the household)*

_____

First name Last name Contact number Relationship to patient

Contact information will remain in place until changed in writing by you

Authorization for treatment of a minor:

I, _____, the parent/legal guardian of _____, hereby authorize the physicians of Pediatric Associates to provide medical care to the above name minor child.

_____

Signature Date Relationship to patient

Financial responsibility, Release of Information and Assignment of Benefits:

I hereby authorize release of information necessary to file a claim with my insurance company, and assign benefits otherwise payable to me to the doctor or group indicates on the claim. I understand I am financially responsible for any balance not covered by my insurance company. A copy of this signature if just as valid as the original.

_____

Signature Date Relationship to patient

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PARENTAL ADVANCE CONSENT TO TREAT MINORS

Authorization for Pediatric Associates:

I hereby authorize and consent to routine and emergency medical treatment for my child by qualified medical personnel at Pediatric Associates. I authorize and consent to emergency medical treatment when deemed necessary or advisable to safeguard my child's immediate health, and I cannot be reached within a reasonable time by reason of absence for the community or otherwise. I waive my right to informed consent to such treatment with the understanding what every attempt to contact me has been made.

_____

Signature Printed name Relationship to patient Date

Other Authorization:

This is to certify that the person(s) **(not parents)** listed below has my permission to authorize necessary medical care for my child, in the event that I am unable to accompany my child to their doctor's appointment. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

_____

Name Relationship to patient Phone number

_____

Name Relationship to patient Phone number

Does the above named person(s) have permission to speak with Pediatric Associates over the phone regarding your child's health care information? Yes ☐ No ☐

_____

Signature Printed name Relationship to patient Date

_____

Patient Name Date of Birth

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NOTICE OF PRIVACY PRACTICES

Pediatric Associates has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Cindy Strandberg at (360) 456-1600 ext 104 to obtain a current copy of the Notice of Privacy Practices of to ask questions.

By my signature below I acknowledge receipt of the Notice of Privacy Practice given to me by a representative of Pediatric Associates.

_____

Signature Printed name Relationship to patient Date

For Office Use Only

Office staff complete below:

I have attempted to obtain the parents signature on this form, but was not able to obtain for the reason(s) listed below:

Reasons:_____

_____

_____

Date_____ Staff member's signature_____

_____

Patient Name Date of Birth

PEDIATRICS ASSOCIATES

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

Definition of a *"No-Show"* Appointment

Pediatric Associates defines a "No-show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a *"No-Show"* Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is denying appointments to other patients in need of care
- Disrupts patient flow and affects other families

How to Avoid Getting a *"No-Show"*

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

Pediatric Associates will attempt to contact you two business days before your scheduled appointment to confirm your visit. **Please remember confirmation calls are a courtesy, ultimately it is your responsibility to know your appointment date and time. **

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of *"No-Show"* Appointments

If you miss 3 or more appointments within a year you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider
2. Only emergency medical treatment will be offered within the first 30 days of dismissal

I have read and understand the Pediatric Associates "No-Show" Policy as described above.

_____ _____

Patient Signature Date

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HEALTH QUESTIONNAIRE

Please complete the following questions. Skip any that you can't answer or do not apply to your child.

Past Medical History **(check all that apply)**

Is your child on any medications? _____Yes _____No

If yes please list medications

_____

_____

_____

_____

Any allergies to medications or foods? _____Yes _____No

If yes please list allergies including reaction type:

_____

_____

Does your child have any chronic medical problems (asthma, allergies, diabetes, seizures etc.)

_____Yes _____No

If yes please list

_____

_____

Has your child ever been hospitalized? _____Yes _____No

If yes please explain

_____

_____

Any past injuries or broken bones? _____Yes _____No

If yes please explain

_____

_____

_____

Patient Name Date of Birth

Health questionnaire cont.

Is your child up to date on immunizations? _____Yes _____No

Any previous reactions to immunizations? _____Yes _____No

If yes please explain:_____

_____

Social history

Is your child in daycare? _____Yes _____No

Does anyone in your home smoke? _____Yes _____No

Do you have pets at the home? _____Yes _____No

If so what kind? _____

Who lives at home with your child?_____

_____

Family history

Does anyone in the immediate family (parents, siblings, maternal grandparents, paternal grandparents) have any of the following medical issues: (please circle)

ADHD	Depression	Anxiety	High blood pressure	
Learning Disability	Autism	Developmental Delay	Anemia	Cancer
Kidney Disease	Liver Disease	Diabetes	Allergies	Asthma
Hay fever	Seizure	Heart Disease at early age? (Under age 55)		
Substance abuse				

<u>If you circled yes to any of the above please list the family member's relationship to your child: (example: hay fever – maternal grandmother)</u>

_____

_____

_____