CORNERSTONE PEDIATRICS – PATIENT HISTORY

701 Will Halsey Way, Madison, AL 35758

□Denny □Johnson □Lawley □Manners □Miller □Reynolds □Tatum

PLEASE FILL ALL INFORMATION. INCOMPLETE FORMS CAN'T BE PROCESSED.

HAVE ANY OF YOUR CHILDREN BEEN PATIENT's OF CORNERSTONE'S IN THE PAST? ___YES ___ NO

Patient Name_____ Date of Birth_____ Sex_____

Race_____ Ethnicity: Latino/Hispanic Other School _____ Grade_____

Marital Status: (Parents of child) ☐Married ☐Divorced ☐Separated ☐Never Married ☐Widowed

Primary Address of Child_____Zip Code_____

Dad's Name_____ DOB_____ SSN_____

Mom's Name_____DOB_____ SSN_____

Dad's Email_____ Mom's Email_____

Step Dad's Name_____ DOB_____ SSN_____

Step Mom's Name_____DOB_____ SSN_____

Child resides with_____

Other address if parents not in same household:_____
Whose address is this_____

Please list phone numbers in order you prefer us call you for appointment reminders. (mom cell 1st, home 2nd, dad cell 3rd, work, etc.)

#1._____☐ mom cell ☐ home ☐ dad cell ☐ _____ #2._____☐ mom cell ☐ home ☐ dad cell ☐ _____

#3._____☐ mom cell ☐ home ☐ dad cell ☐ _____ #4._____☐ mom cell ☐ home ☐ dad cell ☐ _____

Dad's Employer_____ Work Phone_____
Mom's Employer_____ Work Phone_____

Emergency Contact other than parents_____ Phone_____

PREFERRED PHARMACY (name and location)_____

INSURANCE INFORMATION:

Primary Insurance Co_____ Insured's Name_____ DOB___ Group No._____Contract No._____

Secondary Insurance Co_____Insured's Name_____ DOB___ Group No._____Contract No._____

I hereby authorized payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____
Signature Date

PARENT/LEGAL GUARDIAN MUST BE PRESENT AT INITIAL VISIT

HEALTH HISTORY

BIRTH HISTORY

Full Term___ Premature____ Vag___ C-Sec___ Birth Weight_____ Length_____
APGAR Score_____ Blood Type_____ Circumcision: Yes No NA

GENERAL INFORMATION

Current Medicines:_____
Allergies to Medicines: YES or NO If yes, please list:_____
Hospitalizations:_____
Surgeries:_____
Asthma/Bronchitis:_____ Bronchiolitis:_____
Chicken Pox:_____ Ear Infections:_____
Meningitis:_____Pneumonia:_____ UTIs:_____
Tonsillitis/Pharyngitis:_____ Other:_____

NUTRITION INFORMATION

Breastfed_____ Formula_____ Vitamin Supplement_____ Type_____
Soft Foods Added_____Stools_____Appetite_____

DEVELOPMENT HISTORY

Held up Head	Stood Aided	Smiled	Stood Alone
Sat Aided	Walked	Sat Alone	Said Words
Said Sentences	First Teeth	Crept	Toilet Trained
Reached for objects			

FAMILY HISTORY

Mother's Age_____ Race_____ Occupation_____
Father's Age_____ Race_____ Occupation_____

Siblings of child	Age	Sex	Health Status	Patient of Cornerstone?
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____

Do family members (mother, father, siblings, aunts, uncles, grandparents to child) have:

Asthma	Cancer
Diabetes	Heart Disease
High Blood Pressure	Kidney Disease
Mental Illness	Seziures
Sickle Cell Disease	Tuberculosis
Other	

ADDITIONAL PERSON FOR RELEASE OF INFORMATION

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Purpose: To ensure authorization that releases Cornerstone Pediatrics to speak with additional persons regarding patient care.

I, _____, parent/guardian of the above listed children, authorize the following individuals to be able to discuss my child(ren's) care and/or appointments at Cornerstone Pediatrics with the physicians, clinical staff, as well as the front office staff.

_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship

X_____ _____

Signature of Parent/Guardian Date

IMMUNIZATION SCHEDULE

Newborn	**Newborn Screen**
2 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus***
4 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus***
6 Months	**DtaP, IPV, Hepatitis B, HIB, Pneumococcal, Rotavirus***
12 Months	**MMR, Varicella, Pneumococcal, Hepatitis A***
15 Months	**DTaP, HIB**
18 Months	**Hepatitis A***
4 Year	**DTaP, MMR, Varicella, IPV**
9 Years & Up	**HPV***
11 Years & Up	**Tdap, Meningococcal***
16 Years & Up	**Meningitis B***

It is the policy of all Cornerstone Pediatrics physicians that your child(ren) receive all immunizations required by the AAP. **THIS IS A NON-NEGOTIOABLE POLICY OF THE PHYSICIANS OF CORNERSTONE PEDIATRICS.** Also, it is our policy that you keep all scheduled well check appointments yearly until 18 years of age.

The following immunizations are not required but recommended by the physicians of Cornerstone Pediatrics:

* Hepatitis A
* HPV
* Meningitis B
* Meningococcal
* Rotavirus

If you miss three (3) consecutively scheduled well check appointments, refuse to comply with required immunizations, or excessively abuse scheduled appointments, your child(ren) will be considered for dismissal from this practice for non-compliance.

I acknowledge receipt of the immunization policy of Cornerstone Pediatrics, and by registering my child as a patient of Cornerstone Pediatrics, I agree to comply with the required immunizations.

_____ _____

Parent/Guardian Signature Date Signed

Medical Records Policy

In order to assume care for your child, it is very important that we receive **ALL** previous medical records in our facility. Attached is a Medical Records Request. One request will need to be filled out for **EACH PHYSICIAN** your child has seen in the past. Every attempt will be made by our office to obtain the records. If there is missing information, you will be responsible for ensuring our office receives the missing information. If after 30 days, records are not received, it will then be your responsibility to obtain these records. We greatly appreciate your assistance in helping us provide the best possible medical care for your child.

_____ _____

Parent Acknowledgement Date

NON–COVERED SERVICES STATEMENT & CONSENT FOR TREATMENT

As your child's provider, I want to provide my patient with the best care possible. There are services I feel are necessary for the treatment of your child's condition and maintenance of good health that may not be covered by your health benefits contract. Should your insurance not cover these services, you are expected to pay for those services in full.

Let me reassure you that I will order only the tests and treatments that I feel are necessary for your child's treatment and care. If you have any questions about whether a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for the services outlined below that are not covered by my contract as indicated by my signature for each date below.

POSSIBLE NON-COVERED SERVICES INCLUDES BUT NOT LIMITED TO THE FOLLOWING:
If your visit is for a check-up and there is an illness, co-pays/co-insurance/deductibles may apply
After Hour charges may apply
Walk in/Emergency charges may apply
Preventive Care
Developmental Screening Forms (ASQ-MCHAT) & ADD/ADHD Questionnaire Forms
Hearing/Vision Screening
External labs and imaging (billed by an outside provider, not Cornerstone Pediatrics)
In-house labs
Vaccines
Medical & Orthopedic Supplies
Other: _____

CONSENT FOR TREATMENT: I, the undersigned, consent to the care and treatment by the attending physician, his/her associates, or assistants.

Please **PRINT** all patients within the same household covered by this non-covered service:

_____	_____	_____
Child name/DOB	Child name/DOB	Child name/DOB
_____	_____	_____
Child name/DOB	Child name/DOB	Child name/DOB

Signature: _____ Date: _____
Parent / Guardian (Financially responsible party)

Cornerstone Pediatrics - Financial Policy

We are committed to providing you with the best possible medical care. You can help by eliminating the need for us to bill for co-pays. Due to increased co-pays, high deductible plans, participating insurance requirements, and compliance issues, we find it necessary to update our financial policy.

PAYMENT:

1) All co-payments, co-insurance, and deductibles are due and payable at the time of service, regardless of who brings the child in for the appointment. Babysitters, grandparents, divorced parents, etc. must be prepared to pay at the time of service. Cornerstone Pediatrics accepts cash, checks, and credit/debit cards.
2) There is a $30 charge for returned checks. After receiving two returned checks, Cornerstone Pediatrics will only accept cash or credit card payments from you.
3) If you need financial assistance or have questions, please contact the Billing Department or Office Manager.
4) If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with Cornerstone Pediatrics, your outstanding balance will be sent to a collection agency and your child(ren) will be dismissed from this practice for non-compliance.
5) Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written within 30 days of your verbal or written request.
6) Anytime a physician is involved in medical decision making an office visit must be charged and co-pay, deductible and/or co-insurance collected if there is one due with your health insurance policy whether the appointment was scheduled or not.

INSURANCE:

1) Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card to each visit
   - Know your co-pay and be prepared to pay your co-pay at each visit
   - Know your insurance benefits (well child, immunization coverage, etc.)
   - Specific coverage issues should be directed to your insurance company's member services department
   - If you are enrolled in a managed care insurance plan, you must receive a referral from our office before seeing a specialist. NO retroactive referrals will be given.
2) If you have insurance that we do not participate with our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3) Cornerstone Pediatrics files secondary insurance as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

MISSED APPOINTMENTS:

1) It is the policy of all Cornerstone Pediatrics physicians that your child(ren) receive all immunizations required by law and that you keep all scheduled well check appointments until the age of 18.
2) If you miss three (3) consecutively scheduled well check appointments or excessively abuse scheduled appointments, your child(ren) will be considered for dismissal from this practice for non-compliance.
3) A $55 reschedule fee may apply for well child checkups rescheduled on the same day. There may be a $55 no show fee if an appointment is not kept.

FORMS/LETTERS/BLUE CARDS/PRESCRIPTIONS:

1) Your child must have been seen for a physical in the past year for us to sign a physical/daycare/sports/camp form. Whether your insurance company will pay for the visit or not, a complete physical is still required in the past 365 days. There will be a charge for any forms not brought to the yearly checkup that require a physician signature. Form fees are as follows: 48-hour turnaround time - $10, 24-hour turnaround time - $20.
2) FMLA paperwork ranges from $20 - $50 and requires a minimum of 1 week for completion.
3) Immunization Records not obtained at the well child checkup are $5.
4) There is a $30 charge for calls made to our physicians after hours.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the billing department or Office Manager. I have read and understand Cornerstone Pediatrics Financial Policy. I agree to assign insurance benefits to Cornerstone Pediatrics whenever necessary. In the event of non-payment or default, I am responsible for all costs of collections, including, but not limited to, collection agency fees, court costs, and reasonable attorney fees. Cornerstone Pediatrics reserves the right to change or amend this financial policy at any time and at its discretion.

_____

Signature of Patient or Responsible Party Print Name Date

Child's Name_____ Date of Birth_____

Cornerstone Pediatrics, P.C.

Consent for Treatment and the Use and Disclosure of Protected Health Information

This is a consent form. It asks you to permit Cornerstone Pediatrics to treat, use and disclose information about your health. That information is called Protected Health Information. It is any information we receive or create that identifies (or could identify) you, deals with your physical or mental health, any health care we provide you and/or payment for such health care.

By signing this form, you are consenting to treatment and to our use and disclosure of your protected health information in order to carry out treatment, payment or health care operations.

We have a "Notice of Privacy Practices." The notice describes in detail how we might use or disclose protected health information. The notice also discusses your rights and our duties with respect to protected health information. You have the right to review the notice before signing this consent.

You also have the right to revoke this consent, in writing except where we have previously taken action in reliance on your prior consent.

_____ _____
Signature of Patient or Legal Guardian Print Name of Legal Guardian

_____ _____
Patient's Name Date Signed

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of Cornerstone Pediatrics' Notice of Privacy Practices.
(please print patient name)

_____ _____
Signature of Patient or Legal Guardian Date Signed

IF YOU WOULD LIKE A COPY OF THE PRIVACY PRACTICES, PLEASE CHECK HERE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (specify)

_____

CORNERSTONE PEDIATRICS, P.C.
701 Will Halsey Way, Madison, AL 35758

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient's Name (print):_____

Birthdate:_____ Phone (home):_____ (work):_____

Address:_____

City:_____ State:_____ Zip:_____

I, the undersigned, authorize and request **Cornerstone Pediatrics, P.C.** to **obtain from:**

Physician/Parent/Patient:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Please release the following information from the medical records for care/treatment:

XXXX Complete Record _____ Lab Results _____ Immunizations _____ Progress Notes _____ X-Ray Results _____ Other_____

I specifically authorize the release of protected information regarding: ____Drugs/Alcohol ____HIV

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Cornerstone Pediatrics, P.C., 701 Will Halsey Way, Madison, AL 35758.

_____

Patient or Authorized Representative Date

_____

If not patient, relationship to patient

I understand that by signing this release, I will no longer have a relationship with Cornerstone Pediatrics and cannot expect any appointments to be made.

This authorization expires 90 days from date signed.

Please fax records to 256-461-7168 or mail them to the address above. If you have any questions, please call us at 256-461-7440.

Reason for Release of Records:

___ Transferring to another provider locally

Reason transferring:_____

_____

___ Moving out of town

___ Insurance Purposes

___ Other_____

We suggest that you keep a personal copy of any records you provide this office or this office provides you.