NEA BAPTIST CLINIC | Pediatrics

PATIENT INFORMATION

PATIENT INFORMATION (THE PERSON SEEING THE PHYSICIAN):

NAME _____ (LAST) _____ (FIRST) _____ (M.I.) _____ email address

ADDRESS _____ CITY _____ COUNTY _____ STATE _____ ZIP _____

SSN _____ DATE OF BIRTH _____

☐ Male ☐ Female Race _____ Primary Language _____ Ethnicity _____

PHARMACY _____ **Is the patient a student? Y / N** **Fulltime? Y / N**

GUARANTOR/GUARDIAN INFORMATION (PERSON RESPONSIBLE FOR THE BILL):

MOTHER NAME _____ (LAST) _____ (FIRST) _____ (M.I.) _____ email address

ADDRESS _____ (STREET, ROUTE) CITY _____ COUNTY _____ STATE _____ ZIP _____

PHONE (___) _____ CELL PHONE (___) _____ SSN _____ DOB _____

EMPLOYER _____ PHONE (___) _____

FATHER NAME _____ (LAST) _____ (FIRST) _____ (M.I.) _____ email address

ADDRESS _____ (STREET, ROUTE) CITY _____ COUNTY _____ STATE _____ ZIP _____

PHONE (___) _____ CELL PHONE (___) _____ SSN _____ DOB _____

EMPLOYER _____ PHONE (___) _____

PARENT OR GUARDIAN _____ RELATIONSHIP _____

May we call you at work? Y / N **May we leave a message on your answering machine? Y / N**

EMERGENCY CONTACT (SOMEONE NOT LIVING IN THE HOME):

NAME _____ (LAST) _____ (FIRST) _____ (M.I.)

PHONE (___) _____ RELATIONSHIP TO PATIENT _____

PRIMARY INSURED (THE PERSON WHO CARRIES THE INSURANCE):

NAME _____ (LAST) _____ (FIRST) _____ (M.I.)

ADDRESS _____ (STREET, ROUTE)

CITY _____ STATE _____ ZIP _____

PHONE (___) _____

SSN _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other _____

EMPLOYER _____

PHONE (___) _____

INSURANCE INFORMATION

PRIMARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME _____

PHONE (___) _____

ADDRESS _____ (STREET, ROUTE & BOX #)

CITY _____ STATE _____ ZIP _____

IS THIS WORKERS COMP RELATED? Y / N

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

HOSPITAL REQUIRED _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

DOES PRIMARY INSURANCE REQUIRE A REFERRAL? Y / N

SECONDARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME _____

PHONE (___) _____

ADDRESS _____ (STREET, ROUTE & BOX #)

CITY _____ STATE _____ ZIP _____

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

HOSPITAL REQUIRED _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

DOES SECONDARY INSURANCE REQUIRE A REFERRAL? Y / N

INSURED NAME _____

RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other _____

SSN _____ DOB _____

EMPLOYER _____

PHONE (___) _____

ASSIGNMENT OF BENEFITS AND RELEASE OF RELATED MEDICAL RECORDS I hereby assign, transfer, and set over to NEA Baptist Clinic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ Signature (Parent or Guardian, if patient is a minor) _____ Date

CONSENT TO TREAT I permit my physicians and their employees involved in my care to provide treatment, testing, or care in ways they judge beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment. I also understand that I have the right to withdraw my consent. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my treatment, testing, or care.

_____ Signature (Parent or Guardian, if patient is a minor) _____ Date

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NEA BAPTIST CLINIC

Authorizations & Consents

Date_____ DOB_____ MRN_____

Patient Name_____
First Middle Initial Last

Communications Regarding My Account

Initial Here _____ I agree that the facility, NEA Baptist Clinic, or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility, may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

General Consent to Treatment and Test

Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team. I understand that a clinical summary of today's visit is available upon request within 72 hours.

Release of Information

Initial Here _____ I authorize NEA Baptist Clinic to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I authorize payment directly to NEA Baptist Clinic for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by NEA Baptist Clinic and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

_____ Date_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT

OFFICE USE ONLY - SCAN DOCUMENT UNDER AMB_AUTH AND CONSENTS

NEA BAPTIST CLINIC

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

Patient Name: _____
First Middle Initial Last

DOB:_____ MRN:_____ SSN:_____

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

_____ _____
Date Patient/Legal Representative Signature

_____
State Capacity, if Legal Representative

For internal use only

Lack of Patient Acknowledgment:

Date	**Reason**	**Staff Signature**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

With whom may we share information about your health? Please list below.

Note: In order for NEA to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number **2. Patient's date of birth** **3. Patient's zip code**

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name_____ Relationship to Patient_____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:_____ Date: _____

If legal representative, explain the capacity: _____

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NEA Baptist Pediatrics

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Please place a check mark under any family member (as related to your child) that has a known history of one of the following disorders:

Patient's name	Father	Mother	Brother	Sister	Grandfather	Grandmother	Uncle	Aunt
ADD/ADHD								
Allergies								
Asthma								
Eczema								
Anxiety/Depression/Bipolar disorder								
Developmental disorder								
Genetic disorder								
Seizure disorder								
Congenital heart defect								
Heart disease before the age of 50								
Heart arrhythmia (irregular rhythm)								
Sudden unexplained death before age 50								
Arthritis before age 30								
Diabetes (childhood onset or insulin dependent)								
Immune deficiency								
Thyroid problem								
Inflammatory bowel disease								
Kidney disease or required dialysis treatment								
Hearing loss as a child								
Please list any other significant family history you feel we should know about:								

NEA Baptist Pediatrics

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Patient's Name:	__ M __ F	DOB:

Is your child allergic to anything?	What type of reaction did this cause?

Please list any medications, vitamins, or supplements that you give your child on a regular basis and the dosage, if known.

Medication:	Dosage:

Which pharmacy do you prefer to have prescriptions filled at?

Does your child have any chronic medical problems? (such as allergies, asthma, eczema, reflux, etc.)

Has your child ever been hospitalized overnight? If so, at what age and for what reason?

Age	Reason	Comments

Has your child ever had any surgeries? If so, what type (including ear tubes, having tonsils removed, etc.) and at what age?

Age	Surgery	Hospital

Social History

Is your child exposed to any tobacco smoke?

Please list the name and relations of all members of your household. If the child shares time among separate homes, please list those members as well:

Does your child attend daycare or school? If so, where? What grade in school?