Pediatric Professionals
310 NE Tudor Rd., Lee's Summit, MO 64086
816-347-0303

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Please Print

Child #1_____Sex_____DOB_____ Child #2_____Sex_____DOB_____

Child #3_____Sex_____DOB_____ Child #4_____Sex_____DOB_____

Child #5_____Sex_____DOB_____ Child #6_____Sex_____DOB_____

Address_____City_____State_____Zip_____

Primary Phone_____Alternate Phone_____

Verified_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Parent/Legal Guardian Information

Mother_____Date of Birth_____ □single □married □divorced

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Social Security No._____

Father_____Date of Birth_____ □single □married □divorced

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____

Employer_____Work Phone_____

Social Security No._____

Emergency Contact

Name_____Home Phone_____

Address_____Alt Phone_____

Primary Insurance

Insurance Company and Address_____

Name of Policy Holder_____

ID No._____Group Name/No._____

Secondary Insurance

Insurance Company and Address_____

Name of Policy Holder_____

ID No._____Group Name/No._____

Verified_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

SIGNATURE_____DATE_____

NAME_____BIRTH DATE_____SEX MALE ☐ FEMALE ☐

BIRTH HISTORY

Birth Weight_____Type of delivery □Vaginal □Cesarean If cesarean, why?_____
Was the baby born □full term □early If early, how many weeks gestation _____
Did the baby have problems right after birth? □No □Yes. Explain _____
Did the mother have problems with pregnancy? □No □Yes. Explain _____
Drugs or medications used during pregnancy □None □Yes: what_____

PAST HISTORY

Does your child have any serious illness or medical problem? □No □Yes, Explain_____

_____
Has your child had any serious injuries or accidents? □No □Yes, Explain _____
Has your child had any surgeries □No □Yes, Explain_____
Has your child ever been hospitalized overnight? □No □Yes, Explain_____

_____
Is your child allergic to any medications? □No □Yes, What_____
Does your child take any medications every day □No □Yes, Please list_____

_____

FAMILY HISTORY

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

Name	Relationship to child	Birth date	Health Problems

Please enter name, age and residence of any siblings not listed_____

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

_____
Is there a history in the family of the following: If yes, state relationship to child

Allergies □Yes _____ Asthma□Yes _____
Anxiety/Depression □Yes_____ ADHD □Yes_____
Other mental disorder □Yes_____ Genetic disorder □Yes _____
Migraine □Yes_____ Seizures □Yes _____
Heart problem □Yes_____ Diabetes □Yes _____
High blood pressure □Yes_____ Blood disorder □Yes_____

Does anyone smoke in the home? If yes who_____

Completed by_____Date_____

PEDIATRIC PROFESSIONALS
310 NE TUDOR RD., LEE'S SUMMIT, MO 6486
816-347-0303 FAX 816-347-0610

FINANCIALPOLICY

Thank you for selecting Pediatric Professionals as your child's health care facility. It is our hope that providing you with an outline of our financial policy will eliminate any future misunderstandings.

A parent or legal guardian must complete our "Patient Information Form" before child/children are seen. If there is a change in address, telephone number, family status, insurance, etc. please notify us, so that we can update the change in our computer and patient's chart.

All co-pays are due at the time of service. If co-pay is not paid you may be asked to reschedule your child's appointment. If insurance information is not provided, you will be responsible for child/children's fees at the time of service. Refunds are only made after your insurance company makes a payment.

All balances are the parent/guardian's responsibility. We will do our best to file claims in a timely and professional manner. If there are any questions or concerns reguarding our billing and collection practices, please ask. Thank you for allowing us to serve you.

CONSENTPOLICY

I give these family members permission to consent for any or all medical appointments, including immunizations, or any necessary medical treatment including lab work for my son/daughter. I also give Pediatric Professionals permission to release necessary documented information regarding my child to these persons.

1._____

2._____

3._____

I have read and understand Pediatric Professionals financial policy and parental consent form.
Parent/Legal
Guardian_____Date_____

PEDIATRIC PROFESSIONALS

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

(Please Check One)

☐ I, _____, have received a copy of Pediatric Professionals Notice of Privacy Practices.

☐ I, _____, do not want a copy of Pediatric Professionals Notice of Privacy Practices.

Signature of Patient or Guardian _____Date_____

StatementofFinancialResponsibility

I authorize all insurance payments to be made to the provider, Pediatric Professionals. I understand that I am financially responsible for all charges not covered by my insurance carrier and that it is my responsibility to insure the provider is given the correct insurance information **at the time of service**. Any delay in providing the correct insurance information or providing your insurance company with yearly coordination of benefits information will cause claims to be denied, and they will become member responsibility for payment.

Notice: Medicaid, BCBS Blue Advantage Plus and Family Health Partners are secondary to your primary insurance. Please provide the correct information.

Should the insurance company deny my claim, I agree that I will be liable for payment. Signed:

_____Date:_____

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

I understand the Health Insurance Portability and Accountability Act of 1994 (HIPPAA), I have certain patient rights regarding my protected health information.

I understand that Pediatric Professionals may use or disclose my protected health information, treatment, payment, or health care operations - which means for providing health care for me, the patient; handling bills and payment; and taking care of other health care operations.

Pediatric Professionals has a detailed document called the *Notice of Privacy Practices*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the Notice before signing this agreement. If I ask, Pediatric Professionals will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Pediatric Professionals to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Pediatric Professionals has taken action relying on this consent.

_____ _____

Signature (Patient or Legal Guardian) Date

_____ _____

Printed Patient Name DOB

_____

Relationship to Patient