JEANNE M. SCHAEFER, M.D., PLLC
FIRST CHOICE PEDIATRICS

Patient Information

Last Name _____ First Name _____ Middle I _____

Nickname: _____ Date of Birth: _____ Sex: M / F

Social Security #: _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White

Guarantor / Parent Information

Last Name _____ First Name _____ Middle I _____

Street Address _____ City _____ State _____ Zip _____

Social Security #: _____ Date of Birth: _____ Sex: M / F

Marital Status: S / M / W / D / SEP Email: _____ Preferred Method of Contact: Home / Cell / Work

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Place of Employment: _____ Job Title: _____

Insurance Information *** We will also need to make a copy of your insurance card(s)**

Primary Insurance: _____ Insured: _____ Social Security #: _____

Date of Birth: _____ Insured's Relationship to Patient: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Insured: _____ Social Security #: _____

Date of Birth: _____ Insured's Relationship to Patient: _____

Policy #: _____ Group #: _____

Emergency Contact Information

Emergency Contact (someone in different household): _____

Relationship: _____ Phone Number: ( ) _____ Work / Home / Cell

I verify the above information is correct and complete to the best of my knowledge. I also authorize Jeanne M. Schaefer, MD, PLLC to file claims and for the release of medical records to the insurance company for claims purpose. The records authorized for release may include information which may indicate the presence of a venereal or other communicable disease. This includes, but is not limited to, Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature: _____ Date: _____

First Choice Pediatrics
Patient's Health History
Newborn to 12 month

Patient Name: _____ Date of Birth: _____

Previous Physician: _____ How did you hear about us? _____

Pregnancy:

Maternal illnesses or problems during pregnancy? _____
Any medications taken? _____
Smoke cigarettes? _____ Drink alcohol? _____ Use recreational drugs? _____

Birth History:

Birth Weight: _____ Place of Birth: _____ Obstetrician: _____

Vaginal delivery or C-section? _____ Gestational age: _____wks

NICU admit? _____ If yes, why? _____ How long? _____

If breast fed, how long? _____ If bottle fed, what formula? _____
Was Hep B given in hospital? _____

Medical History:

Surgeries: _____

Allergies or reactions to medications: _____

Current Medications: _____

_____

***PLEASE GIVE THE NURSE A COPY OF THE PATIENT'S IMMUNIZATION RECORD.**

Family:

Please list those who currently live in the home, their age, and relationship.

_____

_____

Other:

Please provide any other medical history that you think might be helpful.

_____

_____

_____

First Choice Pediatrics

Family Health Screening

Please circle any of the **child's** family members if they have or had any of the medical conditions listed below.

MEDICAL CONDITIONS

Heart Attack	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma
Asthma	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma
High Cholesterol	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma
Diabetes	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma
Smoke Cigarettes	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma
Other	Father	Mother	Sister	Brother	P.Grandpa	P.Grandma	M.Grandpa	M.Grandma

FIRST CHOICE PEDIATRICS

Identification Verification

Federal law requires patients/guarantors to validate their identity before services are provided. Section 114 of the Fair and Accurate Credit Transaction (FACT) Act of 2003, mandates implementation of a Red Flag Program that is consistent with the policies and procedures issued under section 326 of the USA PATRIOT Act, 31 U.S.C. 5318(1), requiring verification of the identity of persons opening new accounts. In order to be in compliance with the Federal regulations, please provide your photo identification and the policy holder's social security number when required by your insurer. This information will be maintained in a secure location and used only for identity validation. If you are unable to provide a photo ID, your account will be flagged for possible identity theft.

◯ Guarantor was unable to provide photo ID

◯ Guarantor refused photo ID to be copied.

◯ Guarantor was unable to provide social security number of policy holder as required by insurer.

◯ Guarantor was able to provide photo ID

◯ Guarantor was able to provide social security number of policy holder as required by insurer.

ID was viewed and verified by:_____ (employee signature)

Print Patients Name:_____

Patient/Guarantor Signature:_____Date:_____

FIRST CHOICE PEDIATRICS

AUTHORIZATION FOR TREATMENT OF A MINOR

I/We parent(s) or legal guardian, do hereby give permission for medical treatment of:

_____

Signature: _____ Date: _____

The following person(s) is/are authorized to bring the above named minor to the physician's office for medical treatment.

	NAME	PHONE NUMBER	RELATIONSHIP
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____

FIRST CHOICE PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ Signature of Parent/Guardian

_____ Date

_____Address of Parent / Guardian

_____ Phone Day/Evening numbers

FOR OFFICE USE ONLY

An attempt was made to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgement could not be obtained because:

⬭ An emergency situation prevented First Choice Pediatrics from obtaining acknowledgement

⬭ The Patient declined to sign the acknowledgement

⬭ Other (Please Specify)

_____

_____

Patient name _____

Patient DOB _____

Staff Member _____

Date _____

FIRST CHOICE PEDIATRICS

FINANCIAL POLICY AND AGREEMENT

First Choice Pediatrics staff is committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please review this document, and sign at the bottom, after you've familiarized yourself with this Financial Policy.

Patients with Insurance: We are a participating provider with a number of insurance plans. Please bring your insurance card with you to your appointment. All co-payments will be collected upon check in. If your health insurance company does not cover 100% of the services rendered, you will be responsible for any balance due to deductible, co-insurance, termed coverage, or non-covered services. Non-covered services could include, but are not limited to: fluoride, developmental testing, wart removal, strep & flu tests, etc. (Consult your individual plan regarding your specific coverage) You will receive a monthly statement from our office with an accounting of the amount your insurance has paid and the amount owed. Any balance remaining is due within thirty (30) days of receipt of the statement. You will receive up to three statements for the same DOS at no charge. If you do not pay within that time period, a $10 per month statement fee will be assessed each month going forward, to cover the time and cost involved to collect the balance. We work closely with a credit reporting collection agency and will turn accounts over to them as we feel necessary. It is your responsibility to keep our office up to date with current insurance, phone and address information.

Patients without Insurance: If you are uninsured/self-pay at the time of your appointment, you will receive a discount for our services, as long as you do not have an outstanding account balance with us. Because we offer a discount, we ask you pay when services are rendered. Failure to do so will cause us to bill you for the full cost of services provided.

Separated/Divorced Families: In a situation where parents are separated or divorced, the parent authorizing treatment and bringing the child to the appointment is responsible for payment. This includes co-pays as well as any outstanding balance. These will be collected at the time of service. If there is a legal agreement stating the parties are to split charges incurred, or if the party not bringing the child is financially responsible, we will still collect the full amounts due from the parent authorizing treatment. **It is the authorizing parent's responsibility to collect from the other parent if necessary.** First Choice pediatrics will not act as a mediator in collecting payments. However, we will gladly provide you with a copy of your receipt to verify your payment.

FAILURE TO CANCEL A SCHEDULED APPOINTMENT WILL RESULT IN A $25 NO SHOW FEE.

I have read and understand the above Financial Policies of First Choice Pediatrics.

Signature:_____ Date:_____