JUST US KIDS PEDIATRICS

NEWBORN HISTORY FORM

DATE: _____

PATIENT NAME: _____ D.O.B _____

BIRTH HISTORY

WAS YOUR BABY FULL TERM? _____ PRE-TERM? _____ ADOPTED? _____

IF PRE-TERM, HOW MANY WEEKS? _____ IF ADOPTED, AT WHAT AGE? _____

TYPE OF DELIVERY: VAGINAL _____ C- SECTION _____

PLEASE DESCRIBE ANY PROBLEMS AFTER BIRTH: _____

WERE THERE ANY PROBLEMS DURING PREGNANCY? _____

WAS YOUR BABY EXPOSED TO TOBACCO, ALCOHOL OR DRUGS DURING PREGNANCY? _____

DID YOUR BABY PASS THE HEARING SCREEN IN THE HOSPITAL? YES _____ NO _____

DID YOUR BABY HAVE THE METABOLIC SCREEN(PKU) DONE? YES _____ NO _____

WAS YOUR BABY BREECH ANYTIME DURING THE LAST MONTH OF PREGNANCY? YES_____ NO ____

FAMILY HISTORY

DO ANY FAMILY MEMBERS HAVE ANY OF THE FOLLOWING:

Condition	Mother	Father	Sibling	Grandparent
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Prolonged QT	☐	☐	☐	☐
Early Heart Attack (under 50)	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding or clotting disorder	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Development/genetic Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐
Ear Tubes	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐

Condition	Mother	Father	Sibling	Grandparent
Liver Disease	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Drug/Alcohol Abuse	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐
Lazy eye	☐	☐	☐	☐
Hip Dysplasia	☐	☐	☐	☐

SOCIAL HISTORY

WHO LIVES IN THE HOUSEHOLD? _____

WILL THERE BE ANY SMOKERS AROUND THE CHILD? Yes _____ No _____

IF THERE ARE GUNS IN THE HOUSE, ARE THEY LOCKED/SECURED? Yes _____ No _____

WILL YOUR CHILD BE IN DAYCARE? Yes _____ No _____

RISK ASSESSMENT 2-5 DAYS

CONCERNS ABOUT HOW CHILD SEES	YES	NO	CONCERNS
SLEEPS ON BACK	YES	NO	CONCERNS
SLEEPS IN CRIB	YES	NO	CONCERNS
DOES BABY EAT WELL	YES	NO	CONCERNS
HAS 6-8 WET DIAPERS PER DAY	YES	NO	CONCERNS
REGULAR CAR SEAT USE	YES	NO	CONCERNS
CAR SEAT REAR FACING	YES	NO	CONCERNS
HOME & CAR ARE SMOKE-FREE	YES	NO	CONCERNS
KNOWN HOW TO TAKE RECTAL TEMP	YES	NO	CONCERNS
BOTH PARENTS UP TO DATE ON TDAP (WHOOPING COUGH VACCINE)	YES	NO	CONCERNS
VITAMIN D SUPPLEMENT IF BREAT FEEDING	YES	NO	CONCERNS
WAS BABY BREECH DURING LAST MONTH OF PREGNANCY?	YES	NO	CONCERNS

2-5 DAYS DEVELOPMENT

FOLLOWS PARENT/CAREGIVER FACE	YES	NO	CONCERNS
CAN SUCK, SWALLOW, & BREATHE EASILY	YES	NO	CONCERNS
TURNS & CALMS TO PARENT/CAREGIVER VOICE	YES	NO	CONCERNS

JUST US KIDS PEDIATRICS

PATIENT INFORMATION:

NAME: _____
(FIRST) (MIDDLE INITIAL) (LAST)
DATE OF BIRTH: _____ SEX: ☐ FEMALE ☐ MALE
ADDRESS: _____
CITY, STATE, ZIP: _____
HOME PHONE#: _____ MOMS CELL#: _____
DADS CELL#: _____
EMAIL ADDRESS: _____
PHARMACY NAME: _____
PHARMACY ADDRESS: _____

GUARANTOR INFORMATION: (INSURANCE POLICY HOLDER)

NAME: _____
(FIRST) (MIDDLE INITIAL) (LAST)
DATE OF BIRTH: _____ SEX: ☐ FEMALE ☐ MALE
SOCIAL SECURITY NUMBER: _____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER
ADDRESS: _____
CITY, STATE, ZIP: _____

INSURANCE INFORMATION (COPY OF INSURANCE CARD REQUIRED TO FILE CLAIMS)

PRIMARY INSURANCE CARRIER NAME: _____
INSURANCE ADDRESS: _____
CITY, STATE, ZIP: _____
INSURANCE PHONE#: _____ EFFECTIVE DATE: _____
INSURANCE MEMBER ID#: _____
POLICYHOLDER RELATIONSHIP TO PATIENT: _____

YOUR SIGNATURE BELOW INDICATES YOUR CONSENT FOR TREATMENT AND RESPONSIBILITY FOR THE PAYMENT OF THE BILL.

_____ _____
GUARDIAN OR PATIENT SIGNATURE **DATE**

JUST US KIDS PEDIATRICS

FINANCIAL & BILLING POLICIES

Our providers follow the American Academy of Pediatrics guidelines in their approach to care. We are committed to providing you and your child with the best medical care available. We also want to be very clear about our expectations for reimbursement of the services you receive here. The following financial policy is provided to avoid ANY misunderstanding and provide you with an outline of our expectations.

If you are divorced, please note: the party that brings the child to the office will be responsible for the visit copay AND will also be the responsible party on record. We will not be involved in parental court cases. Copays are due at the time of service or the visit will may have to be rescheduled.

INSURANCE & BILLING

Please note that there are over 1,000 plans and it is YOUR responsibility to become familiar with your plan. If you do not understand your specific plan coverage, please call your insurance company or your HR department where you are employed. The number for the insurance is listed on the back of the card.

Just Us Kids Pediatrics will file primary insurance; however, you are ultimately responsible for your visit charges. We participate in most plans, but if we do not accept your insurance, you will be responsible for that days charges at the end of the visit. We do not file secondary private insurance. We expect payment once your primary insurance has indicated your liability.

You are expected to know if vaccines, well-checks, labs or other procedures are covered or might fall into the deductible. It is your responsibility to know if your well-check is made within the time frame allowed by your insurance company.

If your primary insurance requires a copay, you MUST make the copay at the time of service or your visit may be rescheduled. If you have missed making a copay in the past, we may ask for credit card information to be held on a secure site to be used for payment prior to making your next appointment. PLEASE REMEMBER: we are contractually obligated by your insurance company to collect your copay at the time of service. Followup visits DO require a copay.

If you have a deductible plan, please be aware we will be collecting $75 toward the individual deductible until it has been met. The balance of your charges will be billed. Payment in full is due with the receipt of the statement. We accept cash, check, MasterCard, Visa or Discover. WE DO NOT ACCEPT AMERICAN EXPRESS. Balances over 60 days will be required to pay or make financial arrangements before their next visit is scheduled. There will be a $25 fee for all returned checks.

Proof of current, valid insurance MUST be provided at the time of each service. We verify primary insurance electronically. You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill.

PAYMENT PLANS

If you are having difficulty paying your balance in full, please contact our financial department for arrangements. We must have a signed payment plan on file if in agreement.

CANCELLATION & MISSED APPOINTMENTS

All patients with a scheduled sick or well appointment will need to call within 24 hours to cancel. If a 24 hour notice is not received, the patient will be charged a $25.00 broken appointment fee. We understand that sometimes emergencies do occur, in which we will waive the $25 fee.

As a courtesy, our office will attempt to contact you to confirm your child's appointment; however, we ask that you assume responsibility for your child's appointed time. Multiple broken appointments (3 or more) without prior cancellation notice, may be subject to dismissal from the practice.

ARRIVING LATE TO APPOINTMENT

Because of our physician schedule, we may ask that you reschedule the appointment if you arrive 15 minutes or more after the appropriate time.

AFTER HOUR CALLS

Because our practice is charged per call for after-hour calls to the Children's Healthcare of Atlanta advice line, we request that you contact your free insurance advice line listed on your card first. You will be charged a $15 fee for any after-hours calls returned by Children's Healthcare of Atlanta or the provider. Since our physicians do not call in medications, we will charge $15 for each prescription requested.

By signing below, the adult who signs a minor child into our practice accepts full responsibility for payment. We will communicate about treatment and payment with the parent that is present. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FOR EACH VISIT PLEASE BRING:

1. Current insurance card
2. Drivers license
3. Copay for the days visit (cash, check, MasterCard, Visa, & Discover)
4. Deductible that may be due at the time of visit
5. Cash, check or credit card for paying balance from previous visits

Our financial and billing department is available if you have any questions, concerns, or difficulty paying your bill. Please do not hesitate to speak with us with any problems!

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of Just Us Kids Pediatrics and is bound by the terms and conditions set forth therein. You also understand that failing to sign this agreement may result in discharge from the practice.

Please list all patient names & dates of birth:

1. _____

2. _____

3. _____

4. _____

5. _____

_____ _____

Signature of Parent or Responsible Party Date

JUST US KIDS PEDIATRICS
Notice of Privacy Practice

As part of my health care, Just Us Kids Pediatrics originates and maintains paper and/or electronic records describing patients health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. This information serves as:

- A basis for planning patient care and treatment
- A means of communication among the many health professionals who contribute to patient care
- A source of information for applying my diagnose and surgical/treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Consent to Disclosure of Patients Protected Health Information

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I understand and have been provided with the practice Note of Privacy Practice before signing this document.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand that by failing to sign or revoking this consent, the practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I fully understand and accept the terms of this consent.

Guarantor Recognition of Fiscal Responsibility

I understand that I am responsible at the time services are rendered. I also understand that even though the office, out of courtesy, may verify my benefits, this is not a guarantee of payment. All benefits and eligibility are subject to change without notice. The benefits we verify are only a general summarization and are not intended to be used as an authorization of services provided. In the event my insurance does not cover all charges, I agree to pay the balance due in a timely manner. I am also responsible to notify the office of insurance changes.

Signature: _____ Date: _____

(Patient, Parent, Legal Guardian)

If signed by representative, state relationship to patient:_____