Stonecrest
Family Medicine

HEALTH HISTORY QUESTIONNAIRE – PEDIATRIC

Name: _____ Date: _____

Date of Birth: _____ ☐ Male ☐ Female

Birth Weight: _____ Was your child born premature: ☐ Yes ☐ No

YOUR CHILD'S MEDICAL HISTORY

Please indicate if **YOUR CHILD** has had a history of the following:

Had any serious medical illness? ☐ Yes ☐ No

Had broken bones or severe sprains? ☐ Yes ☐ No

Had a history of asthma or wheezing? ☐ Yes ☐ No

Had mental or behavioral problems? ☐ Yes ☐ No

Ever used an inhaler or nebulizer? ☐ Yes ☐ No

Had a positive tuberculosis skin test? ☐ Yes ☐ No

If yes, to any above, please explain: _____

_____

Have you or another healthcare provider ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? ☐ Yes ☐ No

If yes, please explain: _____

Girls Only: Age at first period: _____ (if applicable)

YOUR CHILD'S PERSONAL HEALTH HISTORY

Surgeries and/or hospitalizations ☐ My Child has had no surgeries or hospitalizations

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Has your child ever had a blood transfusion? ☐ Yes ☐ No

Please list other physicians your child has seen in the last 12 months

Physician _____ Reason _____

Physician _____ Reason _____

Physician _____ Reason _____

YOUR CHILD'S CURRENT MEDICATIONS

Drug _____ Dose _____ Drug _____ Dose _____

Drug _____ Dose _____ Drug _____ Dose _____

☐ Additional medications listed on the back of this form

☐ My Child takes no medications

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HEALTH HISTORY QUESTIONNAIRE – PEDIATRIC

Name: _____ Date: _____

YOUR CHILD'S IMMUNIZATIONS

Please bring a copy of your child's immunization records to your appointment

Have you ever refused an immunization for your child? ☐ Yes ☐ No

If yes, please explain: _____

YOUR CHILD'S ALLERGIES

☐ Drug Allergy Drug Name _____ Reaction _____
☐ Latex Allergy
☐ My child has no known drug allergies

YOUR CHILD'S SOCIAL HISTORY

Please list household members, relationship and age

_____

_____

Your child's parents are ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

Child-Care situation ☐ Parents ☐ Daycare ☐ School ☐ Other _____

Is violence at home a concern? ☐ Yes ☐ No Are pets in the home? ☐ Yes ☐ No

Does anyone in household smoke? ☐ Yes ☐ No Are guns in the home? ☐ Yes ☐ No

Do you have any concerns about your child? _____

YOUR CHILD'S FAMILY MEDICAL HISTORY

Only include **YOUR CHILD'S** parents, grandparents and siblings.

☐ My child is adopted and I do not know biological family history

☐ Family History Unknown	☐ Colon Cancer	☐ Migraines
☐ Alcohol Abuse	☐ Depression	☐ Osteoporosis
☐ Anemia	☐ Diabetes	☐ Other Cancer
☐ Anesthetic Complication	☐ Heart Disease	☐ Rectal Cancer
☐ Arthritis	☐ High Blood Pressure	☐ Seizures / Convulsions
☐ Asthma	☐ High Cholesterol	☐ Severe Allergy
☐ Bladder Problems	☐ Kidney Disease	☐ Stroke / CVA of the Brain
☐ Bleeding Disease	☐ Leukemia	☐ Thyroid Problems
☐ Breast Cancer	☐ Lung / Respiratory Disease	☐ NONE of the Above

By signing below, I hereby certify that, to the best of my knowledge, all the information I have furnished on this form is complete, true and accurate.

Guardian Signature: _____ Date: _____

Relationship to child: _____ Phone: _____

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Patient Information Sheet (Please Print)

Patient Full Name	Date of Birth	Social Security Number
Address (including: city, state & zip code)	Marital Status ☐ Married ☐ Single ☐ Widow ☐ Divorced	
Primary Language ☐ Not Disclosed ☐ English ☐ Spanish ☐ Other	Ethnicity ☐ Not Disclosed ☐ Hispanic ☐ Not Hispanic	Race ☐ Not Disclosed ☐ American Indian ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ Other
Home Phone	Cell Phone	Email Address May we add you to our email list? ☐ Yes / ☐ No
Work Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Other	Employer	Work Phone
Full Name of ☐ Spouse ☐ Partner ☐ Guardian	Cell Phone	Work Phone
Emergency Contact (Not in household)	Relationship	Cell / Home Phone
Responsible Party Name (if other than patient)	Relationship to Patient ☐ Spouse ☐ Parent / Guardian ☐ Power of Attorney ☐ Other	
Responsible Party's Date of Birth	Please List Other Members of Household Seen at this Practice	

Primary Insurance Information		**Secondary Insurance Information**	
Insurance Plan	Subscriber	Insurance Plan	Subscriber
Subscriber SSN	Date of Birth	Subscriber SSN	Date of Birth

- I consent Stonecrest Family Medicine to render treatment of medical care. I consent Stonecrest Family Medicine to disclose my protected health information for payment and coordination or management of my healthcare needs.
- I understand that Stonecrest Family Medicine will file primary and secondary insurance claims electronically and by signing this form I am giving permission to do so. I understand that it is my responsibility for knowledge of my individual or group insurance policy coverage or exclusions.
- **CONTRACT TO PAY FOR MEDICAL SERVICES:** I have read and I understand the Financial Policy of Stonecrest Family Medicine. I understand that I am responsible for payment of all co-pays, deductibles and non-covered and/or administrative services. I understand that I am fully responsible for payment of professional services rendered to me by Stonecrest Family Medicine.

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Stonecrest Family Medicine

01-01-2018

CREDIT / HSA / DEBIT / CARE CREDIT ON FILE AUTHORIZATION

At Stonecrest Family Medicine, PLLC, we strongly encourage you to keep your Credit / HSA / Debit or CARE Credit card on file as a convenient method of payment for the portion of services that your insurance doesn't pay, but for which you are liable. Your card information is kept confidential and secure in an off-site portal, and payments to your card are processed only after the claim has been filed and processed by your insurance, and the insurance portion of the claim has paid and posted to the account. If an email address is provided, you will receive an emailed receipt with the date of service processed noted.

I (we), the undersigned, authorize and request Stonecrest Family Medicine to charge my Credit / HSA / Debit or CARE Credit card indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that I will not receive a statement from Stonecrest Family Medicine for balances, and it is the responsibility of my insurance company to send an EOB (Explanation of Benefits) as a statement. I understand that if payment method declines, Stonecrest will reach out to secure the balance and a new form will have to be filled out.

This authorization relates to all payments not covered by my insurance company for services provided to me by Stonecrest Family Medicine. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Stonecrest Family Medicine, PLLC in writing and the account must be in good standing.

****☐ I decline to leave a card on file or enroll in Care Credit. I understand that a $10.00 Administration fee will be added on to each date of service that requires a paper statement.*

Patient Name (Print): _____ Date: _____

Patient Signature: _____

I authorize Stonecrest Family Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ **Visa** ☐ **Mastercard** ☐ **Discover** ☐ **Care Credit**

Expiration Date _____ / _____

Credit Card Number _____

Cardholder Name _____

Billing Address _____

City _____ **State**_____ **Zip** _____

Phone #:_____ **Date of Birth:**_____

Email:_____ **Your receipt will be emailed.**

Family Members attached to this account:_____

Internal Use Only: Billing ID_____ Initials:_____
Alert Added to:_____

Financial Policy

- Credit Card On File: Due to high deductibles and increasing patient responsibility, it is now mandatory to keep a credit card on file or care credit account or deposit on account. If you are unable or willing to supply this information then a **$10 Statement and Billing Fee** will be added to your account balance each visit, if a paper statement is produced. The credit cards are stored securely in a software program and we do not have access to the card numbers once entered into the system.
- Declined Credit Cards: We reserve the right to add the **$10 Statement and Billing Fee** to visits that credit card on file has declined.
- Copayments, Deductibles & Co-Insurance: These balances are due at the time of service, and appointment may be rescheduled if payment is not made. Anything remaining will be billed directly to the credit card on file. The Explanation of Benefits (EOB) from your insurance carrier is available for reconciling balances.
- Patient & Family Balances: Prior patient & family balances will be collected before you are seen. You may be asked to make payment on an account for someone in your household.
- Self-Pay: A down payment of $100.00 is required before services are rendered. Payment of all services rendered is due at checkout.
- Nurse Visit: A nurse visit will be billed when certain services are rendered by a medical assistant that do not have a specific CPT code attached. This includes blood pressure checks. A nurse visit is subject to co-payment, co-insurance and deductible liability designated by your particular insurance plan. (Injections will not be billed as a nurse visit.)
- Medical Records / Form Completion: There is a $1.00 per page or $25.00 charge for a disk of medical records after the first free copy. Completion of disability, FMLA, life insurance and other forms will be subject to a $25.00 charge. Unless specified, medical records will be issued on a disk.
- Returned Checks: There is a $50.00 charge for any returned check to our office. You will be required to pay previous balance and return check fee before future services are rendered. Failure to pay the balance and fee will result in a summons from Shelby County Attorney's office.
- Bankruptcy: If a balance is written-off due to bankruptcy, then any future visit(s) by any member of the household will require a $100.00 down payment on account before being seen.
- Collections: If your account becomes past-due and collection efforts have failed then your account may be placed with an outside collection agency. When your account is placed a 30% collection fee will be added to your outstanding balance and you may be dismissed as a patient.
- Insurance Information: Our office will charge a $20.00 fee to re-file claims with a correct insurance carrier that was not given to our practice at the time of service.
- Controlled Substance (Green Script) Refill(s): Due to requirements mandated by the State of Kentucky, a $10.00 administrative charge will be applied to every controlled substance (green script) refill(s) outside of an office visit. The charge must be paid before green script(s) will be released to patient. Also, any outstanding balances are due.
- Medication Prior Authorization Charge: Medications that require a Prior Authorization Form by your insurance company will be subject to a $20.00 administration fee. The fee must be paid before forms are filled out. Collection of the fee does not guarantee approval of the medication through your insurance company.
- No-Shows: Our practice requires a 24-hour notice to cancel an appointment or it is considered a 'No-Show.' Three 'No-Shows' may result in dismissal from the practice. Arrival to appointment time more than 15 minutes late will be counted as a 'No-Show.'

I have read and understand the Financial Policy of Stonecrest Family Medicine, PLLC. If I have any questions regarding this policy, I will contact the Stonecrest Billing Department. I agree to the terms put forth in this policy.

Patient Signature	Date	Date of Birth

HIPAA Notice of Privacy Practices

Stonecrest Family Medicine
101 Stonecrest Rd., Ste. 3
Shelbyville, KY 40065
(502) 633-5565

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Notice of Privacy Practices Acknowledgment

Stonecrest Family Medicine
101 Stonecrest Rd., Ste. 3
Shelbyville, KY 40065

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian (print) Date

Signature

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices.

Date: _____ Attempt: _____

Staff Name: _____

POS Reorder # 1606466

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Stonecrest Family Medicine, PLLC is authorized to release protected health information about the above named patient to the entities named below.

Authorized Person to Receive Information: Please check each person that is authorized to receive information.	**Description of Information to be released:** Please check what information the person on the left is able to receive.
☐ SELF ONLY (No one else is authorized to receive medical or financial information.)	
☐ VOICEMAIL Phone Number: _____	☐ General Medical ☐ Lab / X-Ray Results ☐ Financial Information
☐ SPOUSE (Provide Name) _____	☐ Medical Information ☐ Financial Information
☐ PARENT (Provide Name) _____	☐ Medical Information ☐ Financial Information
☐ Other (Provide Name) _____	☐ Medical Information ☐ Financial Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that revocation is not effective in cases where information has already been disclosed, but will be ongoing. I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. Authorization will remain in effect until revoked by patient.

_____ _____

Patient or Guarantor Signature Date