Meadowlark Pediatrics, LLC

PATIENT INFORMATION

Today's Date:

First Name	Middle Name	Last Name
Date of Birth	Gender (Circle One): FEMALE MALE	
Mailing Address City State		Zip Code
Primary Care Physician: Paula Vasek FNP Elizabeth Deprince Smith CPNP Other_____		
Primary Phone	Work Phone	Cell Phone

Other Information

Patient's Primary Language: English Spanish Arabic Other

Patient's Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline to Answer

Patient's Race: Asian Black/African American Native American/Alaskan Native Native Hawaiian/ other Pacific Islander White Other Decline to Answer

Insurance Information

Primary Insurance	Policy # :	Group # :	Copay Amount:
Policy Holder Name	Gender M F	Date of Birth	
Patient Relationship to Insured Self Spouse Parent Other:_____			
Secondary Insurance	Policy # :	Group # :	Copay Amount:
Policy Holder Name	Gender M F	Date of Birth	
Patient Relationship to Insured Self Spouse Parent Other:_____			

Parent #1 or Guardian's Information

First Name	Last Name	Use for Emergency Contact ☐
Date of Birth	Gender: MALE FEMALE	Email:
Full Address or check if same as patient ☐ :		
Home Phone	Work Phone	Relationship to Patient:

Parent #2 or Guardian's Information

First Name	Last Name	Use for Emergency Contact ☐
Date of Birth	Gender: MALE FEMALE	Email:
Full Address or check if same as patient ☐ :		
Cell Phone	Work Phone	Relationship to Patient:

Guarantor (Person who will receive statements)

Mother ☐: Father ☐: ☐ Other, please fill out information below

First Name:	Last Name:	Date of birth:	Gender: M F
Mailing Address or Check if same as patient ☐ :			
Email:		Employer	
☐ Use as emergency contact			

Signature:_____ Date:_____

MYCHART ACTIVATION

MyChart is an **online portal** connecting you with health management tools and your medical records whenever you need them. That means you have secure, easy access to lab and test results, can see upcoming appointments online and much more. If you would like to opt in, please complete the information below.

Grant Access to:		
First Name	Last Name	How would you prefer to have the activation link sent? ☐ Text ☐ Email
Date of Birth	Gender: MALE FEMALE	Email:
Full Address or check if same as patient ☐:		
Home Phone	Work Phone	Relationship to Patient:

Also grant access to:		
First Name	Last Name	How would you prefer to have the activation link sent? ☐ Text ☐ Email
Date of Birth	Gender: MALE FEMALE	Email:
Full Address or check if same as patient ☐:		
Cell Phone	Work Phone	Relationship to Patient:

MEADOWLARK PEDIATRICS, LLC PAYMENT POLICY

Thank you for choosing Meadowlark Pediatrics, LLC (MLP). We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. Insurance. MLP contracts with most major insurance companies, with Wyoming Medicaid, and with selected other qualified third-party payment sources. However, MLP does not contract with all third-party payers.

a. If you are insured by a plan MLP contracts with, you will be expected to pay your entire co-payment, an estimate of your deductible or the co-insurance portion of your charges **on the day of service**. Co-payments, co-insurance and deductibles are part of your contract with your insurer. MLP will file an insurance claim directly to your insurance company.

b. Payments collected at the time of services are *ESTIMATES* based on the information available to MLP at that time. If there is an additional balance due after your insurance has paid, then the balance will be your responsibility. Payment in full is due upon receipt of a billing statement.

c. Patients with out-of-network insurance will be treated as self-pay and should expect to pay in full for all services on the date of their appointment.

d. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage.

Initials: _____

2. Coverage changes. If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will be billed to you.

3. Payment at time of service. Patients will be required to pay in full at time of service. If patients are unable to pay at time of service, they may need to meet with our billing office regarding payment options.

4. Non-covered services. Some and perhaps all of the services received may not be covered by your insurance or not considered reasonable or necessary by your insurer. "Non-covered" may become your financial responsibility and payment in full for these services is generally due at each visit.

5. Nonpayment. If you have not made payments to your account and if there has been no attempt to contact our office with financial arrangements, it may be assigned to a collection agency after 90 days of no payment on account.

6. Payment plans. Contact one of our Billing Specialists if you need to review your financial status or make payment arrangements.

7. Payment Methods. MLP accepts payments via cash, check, Master Card, Visa, Discover Card. Payments can also be made online.

8. Late Appointments. In an effort to keep our providers schedules running on time and to reduce wait times we ask that patients arrive on time for their appointment. Patients arriving more than 10 minutes late may be asked to reschedule.

9. Missed Appointments. In order to accommodate all patients MLP may assess a missed appointment fee. Please call within 24 hours of your appointment to cancel/reschedule in order to open that time slot for other patients.

10. Returned checks (NSF). You will be charged a $35.00 processing fee for any personal check returned for nonpayment.

By signing this form, you authorize MLP to release the necessary information in order to complete and process your insurance claims. I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party: Date:

_____ _____

****PAGE IS DOUBLE SIDED PLEASE FILL OUT BOTH SIDES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health-care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

****PAGE IS DOUBLE SIDED PLEASE FILL OUT BOTH SIDES

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐ M ☐ F

Household

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

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Initial History Questionnaire

Biological Family History *(Continued from front side.)*

DK= don't know

Liver disease	□Yes	□No	□DK	Who	Comments
Kidney disease	□Yes	□No	□DK	Who	Comments
Diabetes (before 55 years old)	□Yes	□No	□DK	Who	Comments
Bed-wetting (after I O years old)	□Yes	□No	□DK	Who	Comments
Obesity	□Yes	□No	□DK	Who	Comments
Epilepsy or convulsions	□Yes	□No	□DK	Who	Comments
Alcohol abuse	□Yes	□No	□DK	Who	Comments
Drug abuse	□Yes	□No	□DK	Who	Comments
Mental illness/depression	□Yes	□No	□DK	Who	Comments
Developmental disability	□Yes	□No	□DK	Who	Comments
Immune problems, HIV, or AIDS	□Yes	□No	□DK	Who	Comments
Tobacco use	□Yes	□No	□DK	Who	Comments

Additional family history _____

Past History

DK= don"t know

Does your child have, or has your child ever had:

Chickenpox	□Yes	□No	□ DK	When _____
Frequent ear infections	□ Yes	□No	□DK	Explain _____
Problems with ears or hearing	□Yes	□No	□ DK	Explain _____
Nasal allergies	□Yes	□No	□DK	Explain _____
Problems with eyes or vision	□Yes	□No	□DK	Explain _____

Asthma. bronchitis, bronchiolitis, or pneumonia	□Yes	□No	□DK	Explain _____
Any heart problem or heart murmur	□Yes	□No	□DK	Explain _____
Anemia or bleeding problem	□Yes	□No	□DK	Explain _____
Blood transfusion	□Yes	□No	□DK	Explain _____
HIV	□Yes	□No	□DK	Explain _____
Organ transplant	□Yes	□No	□DK	Explain _____
Malignancy/ bone marrow transplant	□Yes	□No	□ DK	Explain _____
Chemotherapy	□Yes	□No	□DK	Explain _____
Frequent abdominal pain	□Yes	□No	□ DK	Explain _____
Constipation requiring doctor visits	□Yes	□No	□DK	Explain _____
Recurrent urinary tract infections and problems	□Yes	□No	□DK	Explain _____
Congenital cataracts/retinoblastoma	□Yes	□No	□DK	Explain _____
Metabolic/Genetic disorders	□Yes	□No	□ DK	Explain _____
Cancer	□Yes	□No	□DK	Explain _____
Kidney disease or urologic malformation	□Yes	□No	□DK	Explain _____
Bed-wetting (after 5 years old)	□Yes	□No	□DK	Explain _____
Sleep problems; snoring	□Yes	□No	□DK	Explain _____
Chronic or recurrent skin problems (e.g. acne, eczema)	□Yes	□No	□ DK	Explain _____
Frequent headaches	□Yes	□No	□DK	Explain _____
Convulsions or other neurologic problems	□Yes	□No	□DK	Explain _____
Obesity	□Yes	□No	□DK	Explain _____
Diabetes	□Yes	□No	□DK	Explain _____
Thyroid or ocher endocrine problems	□Yes	□No	□DK	Explain _____
High blood pressure	□Yes	□No	□DK	Explain _____
History of serious injuries /fractures /concuss io ns	□Yes	□No	□ DK	Explain _____
Use of alcohol or drugs	□Yes	□No	□DK	Explain _____
Tobacco use	□Yes	□No	□DK	Explain _____
ADHD /anxiety/mood problems/depression	□Yes	□No	□DK	Explain _____
Developmental delay	□Yes	□No	□DK	Explain _____
Dental decay	□Yes	□No	□ DK	Explain _____
History of family violence	□Yes	□No	□DK	Ex plain _____
Sexually transmitted infections	□Yes	□No	□DK	Explain _____
Pregnancy	□Yes	□No	□DK	Explain _____
(For girls) Problems with her periods	□Yes	□No	□DK	Explain _____

Has had first period □Yes □ No Age of first period _____

Any other significant problem _____