grace
PEDIATRICS
BRANDY GHEESLING MD
807 A OAKHURST DR. | EVANS, GA 30809
706 - 426 - 7706 | FAX: 706 - 426 - 7728 | DRGHEESLING@HOTMAIL.COM

New Patient Medical Questionare

Please answer the following questions. Your answers are for our records and are strictly confidential.

Date: _____ Forms Completed by: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Race: _____

Birth History

Birth Weight: _____

Delivery *(Vaginal or Cesarean)*: _____

Feedings *(Breast or Bottle)*: _____

Baby Born *(Term or Premature)*: _____

IF Premature, how many weeks of gestation? : _____

Did the baby have any problems after birth? *(infection, breathing problems, time in NICU)* Yes or No: _____

IF Yes, please explain: _____

Did the mother have any illness or problem during pregnancy? Yes or No: _____

IF Yes, please explain: _____

During the pregnancy did the mother:

Smoke: Yes or No: _____

Drink Alcohol: Yes or No: _____

Use Drugs: Yes or No: _____ *(IF Yes, what and when?)*: _____

Take Medication: Yes or No: _____

Past Medical History

Does your child have any serious illness or medical condition? Yes or No: _____

IF Yes, please explain: _____

Has your child had any serious injuries or accidents? Yes or No: _____

IF Yes, please explain: _____

Has your child ever been hospitalized? Yes or No: _____

IF Yes, please explain: _____

Has your child ever had surgery? Yes or No: _____

IF Yes, please explain: _____

Is your child allergic to any food or medication? Yes or No: _____

IF Yes, please explain: _____

Problems and Illnesses

Has your child had any of the following? *(Mark with an "X" all that apply)*

___ ADHD
___ Allergies
___ Anemia
___ Anxiety Disorder
___ Asthma
___ Autism
___ Bedwetting *(after age 5)*
___ Bladder or Kidney Problems
___ Blood Diseases
___ Broken Bones
___ Bronchitis
___ Cancer
___ Chicken Pox
___ Congenital Anomalies
___ Constipation
___ Depression
___ Development or Behavioral Disorders
___ Diabetes
___ Ear or Hearing Problems
___ Fatigue
___ Head Injury / Concussion
___ Headaches
___ Heart Problems / Murmur
___ Mental Illness
___ Muscle, Joint, or Bone Problems
___ Nosebleeds
___ Pneumonia
___ Seizures / Epilepsy
___ Skin Problems
___ Speech Problems
___ Thyroid or Other Endocrine Problems
___ Vision or Eye Problems

For Girls Only

Has she started her menstrual cycle? Yes or No: _____

IF Yes, at what age did her menstrual cycle start?: _____

Are there any problems with her menstrual cycle? Yes or No: _____

IF Yes, please explain: _____

Current Medication

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Developmental History

Do you have any concerns about your child's development? Yes or No: _____

IF Yes, please explain: _____

Are you concerned about your child's attention span? Yes or No: _____

IF Yes, please explain: _____

Academic History

If your child is in school:

School Name and Grade: _____

How is his / her behavior in school?: _____

Has he / she failed or repeated a grade in school?: _____

How is he / she doing in academic subjects?: _____

Family History

Has anyone in your family died suddenly under the age of 50? Yes or No: _____

IF Yes, please explain: _____

Have any relatives had or currently have any of the following? *(Mark with an "X" all that apply)*

___ Allergies
___ Anemia
___ Anxiety Disorder
___ Asthma
___ Blood Coagulation Disorders
___ Cancer
___ Depression
___ Development Disorders
___ Diabetes
___ Disorder of the Thyroid Gland
___ Heart Disease
___ High Cholesterol
___ High Blood Pressure
___ Immunodeficiency Disorder
___ Kidney Disease
___ Liver Disease
___ Mental Disorder
___ Migraines
___ Seizures
___ Substance Abuse
___ Tuberculosis

Family History

Who does the child live with?: _____

The child's biological mother and father are *(Married, Divorced, Single, Unmarried, Widowed)*: _____

Please list child's siblings names: _____

Does any of the child's family members or caregivers smoke? Yes or No: _____

Is your child in Daycare? Yes or No: _____

IF Yes, please list the name of the daycare: _____

Are there any pets in the home? Yes or No: _____

IF Yes, what kind?: _____

Are there smoke / carbon monoxide detectors in the home? Yes or No: _____

Does your child use seat belt / car seats routinely? Yes or No: _____

Does your child use sunscreen and insect repellent routinely? Yes or No: _____

Are there guns present in the home? Yes or No: _____

List any hobbies and or activities that your child participates in:

_____

_____

_____

What is the name of the pharmacy that your child uses?: _____

What is the name of the lab that your insurance would like for us to use?: _____

What is the Hospital that you would use?: _____

How did you find out about us?: _____

_____ _____

Signature of Parent or Guardian **Date**

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Patient Information

Name: _____

Date of Birth: _____ Age: _____ Sex: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip Code: _____

Siblings (Name and DOB): _____

Responsible Party Information

Choose one *(Mother, Step-Mother, Guardian)*: _____

Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-mail: _____

Choose one *(Father, Step-Father, Guardian)*: _____

Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____

Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-mail: _____

Insurance Information

Primary Insurance

Company: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Secondary Insurance

Company: _____

Policy Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

I understand and agree that it is my responsiblity to pay in full in a timely manner any and all amounts that the insurance company does not cover or pay for.

_____ _____

Signature of Parent or Guardian **Date**

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Permission to Discuss Protected Health Information

Emergency Contact

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Person(s) Grace Pediatrics may communicate with regarding your child's condition or course of treatment or has authorization to bring your child in for medical treatment in your absence. If none, write none.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I acknowledge by signing below that these are people that Grace Pediatrics may discuss my child's health with.

_____ _____

Signature of Parent or Guardian **Date**

Person(s) Grace Pediatrics may **NOT** communicate with regarding your child's condition or course of treatment or has authorization to bring your child in for medical treatment in your absence. If none, write none.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I acknowledge by signing below that these are people that Grace Pediatrics may NOT discuss my child's health with.

_____ _____

Signature of Parent or Guardian **Date**

Patient Eligibility Screening Record

Vaccines for Children Program

This provider participates in the Vaccines for Children Program (VFC). If you meet the requirements of this program, we can provide your children's immunizations at a reduced fee. In order to determine eligibilty, we must know if your child has insurance that pays for immunizations.

Name: *(Last Name, First Name, MI)* _____ DOB: _____

Parent / Guardian: *(Last Name, First Name, MI)* _____

INELIGIBLE FOR STATE - SUPPLIED VACCINE *(Mark with an "X" if available)*

___ The child has insurance that pays for immunizations. *(Fully - Insured / Private Pay)*

ELIGIBLE FOR STATE - SUPPLIED VACCINE

This Child qualifies for vaccination with state - supplied vaccine because: *(Mark only one with an "X")*

___ The child is enrolled in Medicaid
___ The child is American Indian or Alaskan Native
___ The child does not have health insurance. *(Not Insured)*
___ The child has insurance that does not pay for vaccines. *(Underinsured)*
___ The child is enrolled in PeachCare for Kids

Note To Providers:

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who recieves immunizations with vaccines supplied by state programs. **While verification of responses is not required. It is necessary to retain this or a similar record for each child recieving vaccines.**

	VFC ELIGIBILITY* (Check only one category)					**NOT ELIGIBLE**
DATE SCREENED	PEACHCARE FOR KIDS	MEDICAID ENROLLED	UNINSURED	AMERICAN INDIAN OR ALASKA NATIVE	UNDER-INSURED	INSURANCE COVERS VACCINATIONS

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Financial Policies

We have outlined some common financial / insurance issues for your convenience. If you need more information, please ask to speak with our Office Manager

Insurance

You are financially responsible for the cost of your child's care. While you may have insurance coverage, the determination as to wheter or not your insurance company will cover any of our services is up to them. We ask that you present all insurance cards to the receptionist at every visit. If you have a co-payment due at the time of service your insurance company requires us to collect it at the time of your child's visit. This is due from the parent / guardian who brings the child in to be seen.

We depend on you to give us the correct insurance information so that we may file your claim as appropriate. It is your responsibility to know and inform us if your insurance company requires a specific hospital, laboratory, or radiology facility.

If your insurance company will not cover the services your child needs, or if you have no insurance, payment in full is expected at the time of your child's visit.

We file your insurance claims as courtesy to you. Even though a claim to your insurance company may have been filed, you will recieve a statement reflecting your current balance. Unpaid balances become PAST DUE 30 days after the balance becomes your responsiblity. After 120 days, we will use an outside collection agency to assist us in the collection of past due balances.

If you have a financial situation which causes your child's expenses to be a burnden on you, please contact our billing office to discuss your circumstances.

Divorce and Seperation Issues:

It is very important that, in the case of divorce or seperation, that we be notified as to who has primary responsiblity, including financial responsiblity, for the care of the child. The person with primary responsiblity is responsible for the payment of all charges not paid for by insurance and paid in a timely manner. Grace Pediatrics will not get involved in how these charges are allocated, if applicable, among parents or guardians.

Services

- Immunization records will be prepared within 48 hours and are at no charge to you.
- Request for medical records are usually completed within 5 business days and have a charge of $30.00, or as allowed by law.
- We require that you give us 48 hours to get ADHD prescriptions ready.
- All forms that need to be filled out by Grace Pediatrics will be completed in 48 hours and are at no charge to you provided that your child has a well visit in the past 12 months or as noted in the chart.
- Sports Physicals are $30.00 and will not be filled by insurance.

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and or dependents. I furhter expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for my dependents and that I am bound by this signature as through the undersigned had personally signed the particular claim.

I, _____ hereby authorize the insurance company of record for any particular date to pay and hereby assign directly to Grace Pediatrics, PC all benefits, if any, otherwise payable to me for services as describe on the attached forms. I understand that I am financially responsible for all charges incurred. I furhter acknowledge that any insurance benefits when received by and paid to Grace Pediatrics, PC will be credited to my account in accordance with the above assignment

_____ _____

Signature of Parent or Guardian **Date**

Medicaid Primary / Secondary Insurance Notice

Grace Pediatrics will gladly file your Medicaid, Peachcare, Wellcare, or Amerigroup insurance as your primary insurer. If you have any insurance policy with any commercial carrier, that insurance by law, must be filed as primary insurer and any government insurance (ex: Tricare, such as listed above) must be filed as the secondary insurer.

If you obtain other primary insurance while your children are patients with Grace Pediatrics, it is your responsibilty to inform us so that we may file in accordance with the law to the appropriate primary carrier. If you do not inform us of the new primary insurance, the government insurers will ultimately require Grace Pediatrics to reimburse them. In that case, your insurer may not pay for the visit and we will transfer the balance of those visits to your account and you will be responsible for any charges incurred.

Authorization

I hereby give my consent for the examination and treatment of the above named patient including immunizations and injection when indicated and properly authorized. I certify that I am the legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment.

_____ _____

Signature of Parent or Guardian **Date**

I acknowledge by signing below that I have read and accepted Grace Pediatrics Finacnial and Office Policies

_____ _____

Signature of Parent or Guardian **Date**

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Notice of Privacy Practices

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.

How we may use and disclose medical information about you: The following categories describe different ways that we use and disclose medical information. For category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed.

For payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For treatment: We may use medical information about you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For health care operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

Who will follow this notice: This notice describes our practice's policies and procedures an that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

Policy regarding the protection of personal information: We create a record of the care and services you receive at the practice. We need this record in order to provide you quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure the medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include; appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosures to, or for; disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and other; public health risks; and workers compensation.

Notice of Individual Rights

YOU HAVE THE FOLLOWING RIGHTS REGARDING MEDICAL INFORMATION WE MAINTAIN ABOUT YOU.

Right to an accounting of disclosures: You have the right to request and "accounting disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to inspect and copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to paper copy of this notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to request confidential information: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone involved in your care or the payment for your care, an example being a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Changes to this notice: We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

Complaints: If you believe your privacy rights have been violated, you may file a complaint wit the practice or with the Secretary of the Department of Health and Human services. To file a complaint with the practice, contact the Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses of medical information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have read and accepted Grace Pediatrics Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Signature of Parent or Guardian **Date**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Grace Pediatrics, PC
807 A Oakhurst Dr.
Evans, GA 30809

This request and authorization applies to: *(Mark with an "X")*

____ Healthcare information relating to the following treatment, condition, or dates

____ All healthcare information

____ Other:

_____
_____
_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphyilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

____ Yes ____ No I authorize the release of my STD results, HIV / AIDS testing, wheter negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

____ Yes ____ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____
Signature of Parent or Guardian **Date**