Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE _____ M

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 and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain _____

During pregnancy did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What _____ When _____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain _____

Was initial feeding ☐ Breast? ☐ Bottle?

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

General

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

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

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain _____

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

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

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

If your child is in school:

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? _____

Is he/she in special or resource classes? _____

** Please Complete other side →

HE0328

Individual circumstances may be appropriate.

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	Who _____	Comments _____
Asthma	☐ Yes	☐ No	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	Who _____	Comments _____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Mental retardation	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who _____	Comments _____

Additional family history _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When	_____
Frequent ear infections	☐ Yes	☐ No	Explain	_____
Problems with ears or hearing	☐ Yes	☐ No	Explain	_____
Nasal allergies	☐ Yes	☐ No	Explain	_____
Problems with eyes or vision	☐ Yes	☐ No	Explain	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain	_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain	_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain	_____
Blood transfusion	☐ Yes	☐ No	Explain	_____
Frequent abdominal pain	☐ Yes	☐ No	Explain	_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain	_____
Bladder or kidney infection	☐ Yes	☐ No	Explain	_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain	_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When	_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain	_____
Frequent headaches	☐ Yes	☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain	_____
Diabetes	☐ Yes	☐ No	Explain	_____

** Please Complete other side ←

TLC Pediatrics of Frisco
Credit Card on File Billing Policy

I understand that TLC Pediatrics of Frisco will maintain my credit card information in a secure environment provided by Authorize.net. All patient balances that are **90 days past due or greater** will be charged to the credit card on file automatically. Please keep in mind this is an **automatic** process and includes **all** personal balances due (including but not limited to copays, deductibles, coinsurance, missed appointment fees, etc). The only way to prevent this automatic charge is to do one of the following:

- Call or send in your payment at the time it is due by any financial means you choose (check, credit card or come in to the office if you would like to pay by cash). You are not required to use the credit card we have on file.

- Call to set up a recurring monthly payment plan

- Call to dispute charges or indicate there is an ongoing insurance issue that needs to be resolved. We will notate your account and hold the automatic charge to your credit card until the dispute is resolved.

There is a $25.00 charge for a returned transaction due to invalid, expired credit card or incorrect billing address information, this fee is non-negotiable

Please sign below, asserting that you agree to provide and keep current, valid credit card information on file at our office. You agree that you have been given a copy of this billing policy and understand its content

Patient Name(s): _____ PCC Acct # _____

Last 4 digits of CC to be used : _____

Parent Signature: _____

If your credit card billing address is different than the address we have associated with your childs account, please indicate the alternate address below:

_____

Street Address City State Zip Code

** Please see back for our Patient Financial policy , an additional signature is required **

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa and MasterCard.

Your Insurance

- We have made prior arrangement with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and only require you to pay the authorized amount at the time of service. This many include amounts deemed co-payment, co-insurance and/or deductible amounts when they are known at the time of the visit, when unknown you will receive a statement from our office indicating any balance due. Our policy is to collect these fees at the time of your visit.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.

- If your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

Printed name of patient(s) Printed name of responsible party

_____ _____

Signature of patient or responsible party if a minor date

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Seth D Kaplan, M.D., P.A. dba TLC Pediatrics of Frisco for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize TLC Pediatrics of Frisco to:

1. Release any information necessary to insurance carriers regarding my illness and treatments.
2. Process insurance claims generated during examination or treatment.
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from TLC Pediatrics of Frisco on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ I have received a copy of TLC Pediatrics of Frisco Office Policies

Initial Here)

**** Please see other side – additional signatures are required****

Recognition of review of the notice of privacy practices

I have reviewed this office's Notice of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Parent/Legal Guardian Date

Please initial the following for approval of Protected Health Information (PHI) to be communicated to you.

_____ Our practice may use your child's PHI to contact you by phone, voicemail, email or by mailing appointment reminder postcard to the designated address completed by you.

_____ Our practice may use or disclose your child's PHI to contact you by phone, email, text or voicemail message to reference clinical care, including laboratory results of a non-urgent nature or routine. Our practice may use or disclose your PHI for other services that benefit you, such as, but not limited to, immunization records may be Fax upon your request, verbal or written to other facilities or entities designated by you. For example, you can request by phone that your child's immunization records be faxed to the school nurse, childcare at other facilities.

Emergency contact: Please provide name, relationship and contact number

Name	Relation	Telephone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sign below **ONLY** if you are rejecting your Notice of Privacy Practices

*I acknowledge that I have **refused** to receive or revise the Notice of Privacy Practices offered by Frisco's TLC Pediatrics. I also understand that I do not have to sign this acknowledgement of receipt for my children to receive treatment by TLC Pediatrics de Frisco.*

_____ _____

Signature of parent/guardian legal Date

Seth D. Kaplan, M.D.

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Seth D. Kaplan, M.D., P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.
7. A copying fee will be charged based on the current rules of the Texas Medical Board.

TLC Pediatrics of Frisco
Seth D. Kaplan, M.D.,P.A.

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

Release protected health information from the health records of:

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

Release protected health information from:
Name: _____

Address: _____

Tel # _____ **Fax #** _____

Release my protected health information to:

TLC Pediatrics of Frisco
11700 Teel Pkwy, Suite 200
Frisco TX 75033
(214) 618-6272 fax (214) 618-6277

The reasons or purposes for this release of information are as follows:

_____

Patient signature (or parent, guardian or legal representative):

_____
(Date)

This consent expires one year from signature date listed above unless revoked earlier.

*** Please Note: Disclosure information is listed on the back of this form ***