PCP:
Preferred Name:
Pronouns:

PATIENT INTAKE - PEDIATRIC

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name *(Last, First, MI)* **:**	☐ M ☐ F Legal sex	**DOB:**
Legal Guardian:		
Address:		
Contact Number:	**Email:**	
Emergency Contact:	**Emergency Contact Number:**	
Insurance:	**Insurance ID:**	
Group:	**Insurance Contact Number:**	

Preferred Pharmacy:	**Pharmacy Contact Number:**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signatuer that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The practice has the right to email any major operation changes, including but not limited to, location and provider updates.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a detailed message on your contact number with personal health information? YES NO

If YES, please name the members allowed: _____

This consent was signed by: _____

[PRINT NAME PLEASE]

Signature: _____ Date: _____

Patient Financial Policy

You are responsible for having your current insurance card and copayment at every visit.

Copayments will be required upon check in. Failure to provide copayment may result in a canceled appointment. If we have to bill you for a copayment for any reason, a $10.00 processing fee will be added.

Due to increasing Medicare requirements and restrictions, our clinic can no longer accept new patients with Medicare as their primary or secondary insurance. If you begin care with our clinic after August 1, 2018 and later transition to Medicare as either your primary or secondary insurance, we will be unable to continue your care due to Medicare policies. Please be aware that Medicare may no longer pay for routine labs. It is the patient's responsibility to confirm this prior to completing any outside lab test.

The patient's insurance company will be billed if the correct information is given, and insurance payments are current. If insurance is not valid at the time medicial services are provided, the patient is responsible for cash payments. The patient will authorize payment from their insurance company directly to MSFMD. The person responsible for payment agrees that all services not coverege under insurance payment will become their responsibility and payment will be made to MSFMD.

Payments not received within thirty days of invoice will be considered delinquent and you will be contacted by our billing department for payment in full or to make arrangements.

MSFMD will promplty process and bill your medical services through insurance. We expect you to promptly pay your portion of your bill. If we have to send out more than one statement for patients with remaining balances unpaid, we will add a service charge of $5.00 for every additional statement we mail out. To avoid additional fees, please promptly pay our bill by calling our billing department at (360)734-3378.

Patients that are past due with no response to our billed invoices must contact our billing department to coordinate payments or if your account is past 90 days overdue you will be submitted to a collection agency.

We reserve the right to hold medication requests and patient referrals until payment has been made or a payment arrangement is on file with our billing department.

No shows and late cancellations will result in a $40.00 fee. After three no show appointments, we maintain the right to discharge the patient from the practice.

As a patient of MSFMD we offer an on call provider for urgent needs of current patients only. Non urgent matters will be assessed and a $40.00 fee may apply.

Cash payments will need to be paid in full for all services provided on the date of service. No exceptions.

NSF checks and returned funds will be charged a $35.00 fee and balance will be due in full with a payment of cash or credit.

MSFMD reserves the right to change the term/fees without notice.

By signing below I certify:
The personal information I provided is true and correct.
I have read, understand and agree with the financial policies and terms outlined above.
I understand that it is a crime to falsify information or withhold necessary information, punishable by law.
I have also been given a copy of the Privacy Policy and I understand and accept it.

Signature: _____Date: _____

Printed legal name: _____Date: _____

Please list your current medical concerns / reason for today's visit.

_____

_____

_____

LIFESTYLE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL	
Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (ie, climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (ie, work or recreation, less than 4x/week for 30 min)
	☐ Regular vigorous exercise (ie, work or recreation 4x/week for at least 30 min)

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PRO
Mother			□ MGM		
			□ MGF		
Father			□ PGM		
			□ PGF		
Sibling(s) How many?	☐ M #				
	☐ F #				

HEALTH HISTORY

ADD / ADHD	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Encephalopathy Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Constipation	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO

Additional health concerns:

_____

_____

_____

SURGICAL HISTORY (Please list with dates)

_____

_____

_____

_____

Does anyone your child lives with smoke cigarettes / vape in the home? YES NO

Does your child have a latex allergy? (please circle) YES NO

List any medicine your child takes on a regular basis (including over the counter and herbals, inhalers and vitamins)		
Name of medication or supplement	Strength	Frequency taken

Allergies to medications	
Name of medication or supplement	Reaction you had

Are your child's immunizations up to date? (please provide us with a copy) YES NO

DRUG / SEXUAL HEALTH (Adolescent questionnaire)

Drugs	Do you currently use recreational or street drugs?	☐ YES	☐ NO
	Have you ever given yourself street drugs with a needle?	☐ YES	☐ NO
Sex	Are you sexually active?	☐ YES	☐ NO
	If yes, are you trying for pregnancy?	☐ YES	☐ NO
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ YES	☐ NO

MENTAL HEALTH

Is stress a major problem for you?	☐ YES	☐ NO
Do you feel depressed?	☐ YES	☐ NO
Do you panic when stressed?	☐ YES	☐ NO
Do you have problems with eating or your appetite?	☐ YES	☐ NO
Do you cry frequently?	☐ YES	☐ NO
Have you ever attempted suicide?	☐ YES	☐ NO
Have you ever seriously thought about hurting yourself?	☐ YES	☐ NO
Do you have trouble sleeping?	☐ YES	☐ NO
Have you ever been to a counselor?	☐ YES	☐ NO