Initial History Questionnaire

Form Completed By: _____

Relationship to Patient: _____

Date Completed: _____

Child's Name: _____

Birth Date: _____

Age: _____ ☐ M ☐ F ☐ Other

Birth History

☐ Don't know birth history

Birth Weight: _____ Term ☐ Preterm ☐ _____ Weeks

Delivery Method: Vaginal ☐ Cesarean ☐ If cesarean, why? _____

Prenatal/Neonatal Complications? Yes ☐ No ☐ If yes, please explain:

General

DK = Don't Know

Does your child have any current serious illness or chronic medical conditions?

Yes ☐ No ☐ DK ☐ If yes, please explain:

Has your child had any surgeries or hospitalizations?

Yes ☐ No ☐ DK ☐ If yes, please explain:

If your child allergic to any medications?

Yes ☐ No ☐ DK ☐ Hasn't taken any prescription medications ☐

Biological Family History

DK = Don't Know

Please indicate if any of the child's biological family members have the following:

Childhood Hearing Loss	Y☐ N☐ DK☐	Kidney Disease	Y☐ N☐ DK☐
Asthma	Y☐ N☐ DK☐	Diabetes Before Age 25	Y☐ N☐ DK☐
Heart Disease Before Age 55	Y☐ N☐ DK☐	Bedwetting After Age 10	Y☐ N☐ DK☐
High Cholesterol/Takes Medication	Y☐ N☐ DK☐	Epilepsy/Seizures	Y☐ N☐ DK☐
Bleeding Disorders	Y☐ N☐ DK☐	Developmental Disability	Y☐ N☐ DK☐
Mental illness/Depression	Y☐ N☐ DK☐	Immunodeficiency	Y☐ N☐ DK☐
ADHD	Y☐ N☐ DK☐	Eczema/Allergies	Y☐ N☐ DK☐

Please provide explanation for all items with "yes" response. Include any additional history not indicated above.

Social History

Please indicate child's living situation if not with both biological parents:

Lives with adoptive parents ☐ Joint Custody ☐ Single Custody ☐

Lives with foster family ☐ Other ☐ _____

Is there tobacco use in the home?

Yes ☐ No ☐

Patient Past Medical History

Does your child have or had any additional medical problems not discussed under "General" section

Yes ☐ No ☐ If yes, please explain:

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OVER THE RAINBOW
PEDIATRIC URGENT CARE & WELLNESS

Patient's Name:

Last: _____ First: _____ MI: _____ Sex: M / F

Birthdate: _____/_____/_____ Home Phone #: _____Cell#: _____
Select as Primary □ Select as Primary □

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____ Email: _____

How would you like to receive communications from us: Text Email Phone call

Ethnicity: Hispanic/Non-Hispanic **Race:** African American / Asian / Caucasian / Native American

Pacific Islander / Other: _____ / Refuse **Preferred Language:** _____

Primary Insurance Plan:_____ Policy #_____ Subscriber:_____

Secondary Insurance Plan:_____ Policy #_____ Subscriber:_____

Parent/Guardian's Name:

Last: _____ First: _____ Birth Date: ____/____/____

SS #: _____Home Phone #: _____Cell Phone #: _____

Address: _____ Apt: _____City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____Work Phone #: _____

Parent/Guardian's Name:

Last: _____ First: _____ Birth Date: ____/____/____

SS #: _____Home Phone #: _____Cell Phone #: _____

Address: _____ Apt: _____City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____Work Phone #: _____

Emergency Contact/Relationship: _____Phone #: _____

I HAVE READ AND UNDERSTAND THE FOLLOWING FINANCIAL STIPULATIONS:

I authorize Wee Care Pediatrics to provide medical care for my child as necessary. I understand that I am financially responsible for any amount not covered by my insurance plan and co-pay's or deductibles are due at the time of service. I authorize Wee Care Pediatrics to release my insurance information for the purpose of administrating claims for benefit reimbursement. I understand it is my responsibility to update changes on my health insurance or contact information, failure to do so may result in my financial responsibility and or collections and fees for unpaid balances due. All information provided will be protected in accordance with HIPAA guidelines.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____
Parent or Legal Guardian

Payment Policy and Procedures

Thank you for choosing Wee Care Pediatrics for your child's medical care. The following is an explanation of our payment procedures and office policies. Please read carefully, print and sign below.

1. Payment is due at the time of service. We do not bill for deductibles or co-pays. We accept cash, Visa, MasterCard, Discover and American Express. ***We do not accept personal checks***. Patients utilizing our cash pay program must pay before each visit.
2. The parent or guardian who brings the child for their visit is responsible for payment at the time of service. We do not intervene between divorced/separated parents or in the matter of custody issues, reimbursement will need to be between parents or guardians.
3. Appointments must be canceled more than 4 hours prior to the scheduled appointment time to avoid a $45.00 cancellation fee.
4. Account balances must be paid prior to any future visits. If a balance is due, a payment must be collected, or payment arrangements made before being seen. Emergent cases will be considered.
5. Account balances that exceed 90 days past due are sent to a collection agency. You will be responsible for all collection and legal fees that accrue by the agency. Payment must be made before any future appointments. By signing below, you are agreeing that a collection agency may contact you via phone or personal email if your account is sent to collections.
6. We will gladly bill your primary and or secondary insurance for you. It is your responsibility to keep your **Coordination Of Benefits** current with your insurance providers. Failure to do so may result in lack of payment from your carriers. We are not responsible for non-payment from your insurance plan due to missing COB's and any balances will become subscriber responsibility due in full. ***Failure to disclose a Commercial Insurance as Primary when you have Nevada Medicaid constitutes Medicaid Fraud and Abuse**. Medicaid states we must bill your Primary Insurance first before billing Medicaid.
7. In order to bill your insurance company, we must have an up-to-date insurance card. If we are unable to verify your insurance coverage at time of service, you will be considered a cash pay patient.
8. Most importantly, Wee Care Pediatrics wants the best care possible for your child and we understand you may have certain financial difficulties. Please feel free to discuss any financial matters with our billing department.

   I have read the above policy and agree to abide by the terms of this agreement.

Signature: _____/_____ Date: _____
Parent or Legal Guardian Print Name Signature

Patient Name: _____ DOB: _____

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Treatment Authorization

I authorize Wee Care Pediatrics to provide medical care, treat and diagnose my child

_____/_____.
Patient Name DOB

The following people are authorized to bring my child in for medical care in my absence.

_____/_____
Name Relationship to child

_____/_____
Name Relationship to child

_____/_____
Name Relationship to child

I understand that the above parties will remain on the list of authorized persons to bring my child in for medical care until I update or revoke it. I will have the opportunity to update or change this list on the Annual Update Sheet every year. Furthermore, I agree to be directly responsible for all costs and expenses connected with the examination, medical treatment and diagnosis for my child/dependent in my absence. I understand that the copay, deductible or account balance is still due at the time of service.

Signature: _____ Date: _____
Parent or Legal Guardian

Printed Name: _____ Relationship: _____

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PEDIATRIC URGENT CARE & WELLNESS

Patient Name: _____ DOB: _____

Acknowledgement of Notice of Privacy Practices

The Notice of Privacy Practice describes how this office will use and disclose your protected health information, your privacy rights regarding your protected health information, this office's obligations concerning the use and disclosure of your protected health information. I acknowledge that the Notice of Privacy Practices will be furnished to me for my review at any time upon my request. I further acknowledge that the Notice of Privacy Practices may be located at www.weecarelv.com under patient forms as well as posted in office for review. Please advise our front desk if you would like a copy for immediate review.

No Show Policy

A **$75.00 No Show fee** will be billed to those who miss their scheduled appointments. You are responsible for canceling or rescheduling your appointment if you cannot attend. We gladly send a courtesy reminder by text or email prior to your appointment day and time. A warning letter will be sent on the 3rd No Show and upon the 4th No show, you will be dismissed from the practice. I understand that it is my responsibility to arrive on time for my appointment and I may not be seen if I am late. Wee Care Pediatrics requires a 4 hour cancellation notice. Any appointments canceled less than 4 hours prior to their appointment time will be subject to a $45.00 cancellation fee.

3 Strike Policy

Wee Care Pediatrics tries to provide a welcoming and friendly experience and does not tolerate the mistreatment of staff or property. Instances where a strike may be given: Abusive behavior towards staff, destruction of any Wee Care property such as furniture or exam rooms, will receive a strike. Extreme instances such as theft of Wee Care property, supplies or equipment will result in immediate dismissal. We simply ask that patience and kindness be observed while at Wee Care Pediatrics.

Signature: _____/ _____Date: _____
Parent or Legal Guardian Printed Name