Provider:

☐ Dr. Young

☐ Dr. Satterly

Young Pediatrics

Registration Form

Please Print

Today's Date ________________

Patient Information

Patient Name ____ Date of Birth_____________

(Last) (First) (Middle Initial)

Address ____ Sex _____M _____F

City ______________________________ State ____________________ Zip ____________

Home Phone (____) _____________ Cell/Alternate (____) _______________

Patients Social Security # _____________________________

Parent Information

Mother's Name ____________________________ Date of Birth _______________ S.S.#_________________

Address if different than patient's ________________________________ Occupation_______________

Employer name and address ____

____ Phone _______________

Father's Name ______________________________Date of Birth ______________ S.S. #_________________

Address if different than patient's ___________________________________ Occupation________________

____ Phone _______________

Employer name and address ____

____ Phone _______________

Siblings Name & Ages ____

Emergency contact (other than parents)__________________________________

Relation to Patient _______________________________ Phone _________________________

Collection Clause

In the event the undersigned customer fails to pay pursuant to the terms of this contract Young Pediatrics reserves the right to pursue all available legal remedies pursuant to the laws of the State of Illinois. Should your claim be referred to a collection agency and/or attorney for collections, the customer agrees to pay all necessary fees of collection, along with all legal fees with interest to be accrued at the annual rate of 10 % per annum.

____ ________________________

Printed Name of person responsible for account Date

____ ________________________

Signature of Person responsible for account Relation to Patient

Insurance Information

Primary Insurance ____ HMO or PPO

ID # _______________________________________ Group # _________________ Effective date__________

Person who carries this insurance _____________________________________ S.S. # ____________________

Relation to patient ___________________

Employer name and address (if not previously listed) ____

Secondary Insurance ____ HMO or PPO

ID # _______________________________________ Group # _________________ Effective date__________

Person who carries this insurance _____________________________________ S.S. #____________________

Relation to patient ___________________

Employer name and address (if not previously listed) ____

Who can we thank for referring you to Young Pediatrics? ___________________________

Young Pediatrics

History Questionnaire

Form Completed By ______________________ Date Completed

Patient Name

Date of Birth Male or Female

Household

Please list all those living in the child's home

Name	Relationship	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 (s) not in the home? __________________

____

Birth History

Birth Weight _________________ Birth Height ________________________

Mom's Gestation _______________weeks

Did mom have any illness or problem with her pregnancy? ______________

If yes, explain____

____

During pregnancy did mom

Smoke __________ Drink alcohol ________________

Use drugs or medications _____________ If yes please list what and when__

____

Was the delivery Vaginal? Or Cesarean?

If cesarean, why? ________________________________

____

Did baby have any problems right after birth? ________

If yes, explain ________________________________

____

Was initial feeding Breast? Or Bottle?

Did baby go home with mother form hospital? ________

If 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 surgery?	Yes	No	Explain ________________________________
Has your child ever been hospitalized?	Yes	No	Explain ________________________________
Is your child allergic to any medications or drugs?	Yes	No	Explain ________________________________

Development

Are you concerned about your child's 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? ____

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	Yes	No	Who ______________	Comments ____
Nasal Allergies	Yes	No	Who ______________	Comments ____
Asthma	Yes	No	Who ______________	Comments ____
Tuberculosis	Yes	No	Who ______________	Comments ____
Heart disease (before age of 50 years)	Yes	No	Who ______________	Comments ____
High Blood Pressure (before 50 years)	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)	Yes	No	Who ______________	Comments ____
Bed-Wetting (after 10 years of age)	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:

Condition	Yes	No		
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 visions	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 of age)	Yes	No	Explain	____
(for girls) Has she started her menstrual periods?	Yes	No	When	____
(for girls) Are there any problems with her periods?	Yes	No	Explain	____
Any chronic or recurrent skin problems	Yes	No	Explain	____
Frequent headaches	Yes	No	Explain	____
Convulsions or other neurologic problems	Yes	No	Explain	____
Diabetes	Yes	No	Explain	____
Thyroid or other endocrine problems	Yes	No	Explain	____
Any other significant problem	Yes	No	Explain	____
Use of alcohol or drugs	Yes	No	Explain	____

List any medications child is currently taking ____

Child Name ____________________________________ DOB _______________

Young Pediatrics

Missed Appointment Policy

Office Policy Addressing Missed Appointments

- After the first missed appointment, a $25.00 fee will be charged. The appointment may be rescheduled.
- If a second scheduled appointment is missed, a $25.00 fee will be charged. Missed appointment letter is sent, again reiterating our policy. The appointment may be rescheduled.
- If a third scheduled appointment is missed, it will be necessary to terminate our professional relationship with the patient and family. Termination letter is sent.

As a parent/guardian of a patient of Young Pediatrics I agree to pay any charges that may accumulate from missed appointments.

____   _______________

Parent's Signature   Date

Child Name ____________________________________ DOB _______________

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

This office is required by Federal Regulations to inform our Patients in regards to the use of your child's health information in accordance to Health Insurance Portability & Accountability Act of 1996 or HIPAA.

PLEASE READ THE FOLLOWING CAREFULLY!

I understand that as part of my child's health care, Young Pediatrics originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment
- A means of communication among health professionals who contribute to my child's care.
- A source of information for applying diagnosis and treatment information to my bill.
- A means by which a third-party can verify the services billed to me actually took place.

I understand and have been provided access to a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. This notice is located in the waiting area in plain view. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent, allowing treatment, or making payment for services rendered.
- The right to object to the use of my child's health information for directory purposes.

I understand that Young Pediatrics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat my child as permitted by Federal Regulations. I understand that Young Pediatrics reserve the right to change their *Notice of Privacy Practices.* I further understand that Young Pediatrics may use a computerized state vaccine registry to track immunization requirements and maintain immunization records. Young Pediatrics may enroll patients unless you inform us in writing that you do not wish to participate.

Please note that I consent to the following uses of my child's medical information (Initial Below)

______ I allow my child's immunization records to be faxed or mailed to their school/daycare.

______ I allow my Child's immunization records to be faxed or mailed to me.

______ Other: ____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my child's protected health information to another entity. I hereby consent to such disclosure for these permitted uses. I also hereby consent to such disclosures via fax.

I fully understand and accept the terms of this consent.

____

Parent/Guardian Printed Name & Relation

____ ____________________

Signature **Date**

Child Name ____________________________________ DOB _______________

Consent for Release of Information to Designated Family Member or Caregiver

This gives Young Pediatrics permission to discuss treatment with designated person and/or treat patient with the designated person's consent. Parent/Guardian has the right to revoke this consent for release at any time with notification to Young Pediatrics.

Name to receive info and/or seek treatment	Relationship to Patient
Name to receive info and/or seek treatment	Relationship to Patient
Name to receive info and/or seek treatment	Relationship to Patient
Name to receive info and/or seek treatment	Relationship to Patient

____ ___________________

Patient name Date of Birth

Parent name	Parent Signature	Date
Witness name	Witness Signature	Date

Young Pediatrics

The Importance of Immunizing Children: Our Practice Policy

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines **do not** cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single **most important** health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son, Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox…I long regret bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen.*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines many of you have never seen a child with polio, tetanus, whopping cough, bacterial meningitis or even chickenpox, or known a friend or family member whose child died for one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit**. In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Young Pediatrics**. Such additional visits will require additional co-pays on your part. Furthermore, please realize that you will be required to sign a "Refusal to Vaccinate: acknowledgement in the event of lengthy delays.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

I have read and understand the Vaccine Policy Statement.

____

Patient name

____

Signature , patient or Representative

____

Date Relationship to Patient

Young Pediatrics

4804 South State Route 159
Glen Carbon, IL 62034
P: 618.288.9305
F: 618.288.9308

I, ________________________, hereby give my consent to ***Young Pediatrics*** to use or disclose, for the purpose of
(Name of Patient or Authorized Agent)

carrying out treatment, payment, or health care operations, all information contained in the patient record of

____.
(Patient's Name and Date of Birth)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available by posting in the office and personal printed notice upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the physician/practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practice's office.

Signed: ____Date: __________________

If you are not the patient, please specify your relationship to the patient _______________________________

CONSENT FORM DEFINITIONS

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 C.F.R. 3.20) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Except as prohibited under 45 C.F.R. 164.502(a)(5)(i), underwriting, enrollment, premium rating, and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information