MILESTONE PEDIATRICS
4043 S Rt 59, Naperville, IL 60564
(630)420-4275

PATIENT(S) INFORMATION

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Name: ______________________ **Male/Female** Date of Birth: __/__/____ Ethnicity: ________

Family Status: Married ____ Divorced ____ Widowed ____ Single ____

Child(ren) live with: Mother Father Both

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name	**Mother's/Guardian's** Name
Address:	Address:
City: ______ State: ___ Zip: ______	City: ______ State: ___ Zip: ______
Cell: ______ Work: ______	Cell: ______ Work: ______
Employer	Employer
Occupation:	Occupation:
Social Security #	Social Security #
Birthdate	Birthdate
Insurance Name	Insurance Name
Eff Date: __/__/____ Primary or Secondary	Eff Date: __/__/____ **Primary** or Secondary
Are you the insurance holder? Y N	Are you the insurance holder? __Y __**N**

CONTACT INFORMATION

If we are unable to reach you, is it okay to leave confidential information on your voicemail? **YES** NO

If yes, please list phone number: ______________________

Would you like to receive health information and/or reminders via email from our office? YES NO

If yes, please list an email: ______________________________

Authorized Persons

Name(s) of person authorized to ***accompany*** child for medical treatment and to make medical decisions in the event that a parent/legal guardian is unavailable. *A **parent/legal** guardian MUST be present at visits where vaccines will be given.

Name: ______________________ Relation to patient: ______________________

Name: ______________________ **Relation** to patient: ______________________

Print Name: ______________________ **Signature:** ______________________ **Date:** __/__/____

Annual Review &/or updated: Date: _________ Signature: ______________________

MILESTONE PEDIATRICS

James R. Pera, MD
Kerry Brennan, CPNP
Michael J. Reicherts, MD
Laurie Strausberger, CPNP
Holly Loux, MD
Janel Hoffman, CPNP

MEDICAL HISTORY FORM

Date: ______________________

Child's Name: ______________________________ Date of Birth: ______________________

Birth History:

Birth Weight: __________ Birth Hospital: ________________ Boy: ____ Girl: ____

__Full-Term (>37wks) __Vaginal __Forceps __Vacuum

__Premature (<37wks) __C/Section – due to: ______________________________

Pregnancy Concerns: ____

Newborn Concerns: ____

Child's Past Medical History:

Does your child have a history of any medical conditions? __None

Or please circle below any that apply:

Genetic:	chromosome abnormality				
Development:	delay-speech/language	delay-motor skills	autism		
Learning:	special education	dyslexia			
Behavior/Mood:	ADHD	anxiety	obsessive-compulsive	depression	
Hearing:	ear tubes	hearing loss			
Vision:	glasses	amblyopia	strabismus	cataract	
Neurologic:	seizures	migraines	head trauma	concussion	
Respiratory:	seasonal allergies	asthma	RSV	pneumonia	
Cardiac:	heart murmur	VSD/ASD	arrhythmia		
Endocrine:	diabetes	thyroid disease			
Gastrointestinal:	acid reflux	jaundice	bowel disease		
Urology:	bladder infections	kidney disease	kidney stones		
Genital:	vaginal discharge	menstrual problems	STD		
Muscle/Bone:	club foot	in toeing	scoliosis	broken bone(s)	hypotonia	spinal bifida
Skin:	eczema	acne	warts	MRSA	vitiligo	hemangioma
Infections:	meningitis	HIV	TB	scarlet fever	other_____________
Cancer:	leukemia	cancer-/tumor			
Blood:	anemia	sickle cell	hemophilia		

Other Medical Conditions: ____

Has your child ever seen a specialist (medical or mental health) __Yes __No

Please describe who and why____

For Females -Age at time of first period____________

Child's Past Surgeries:

__Tonsils/Adenoids __Ear Tubes __Hernia Repair __Circumcision __Appendectomy

Other Surgery related to: __heart __mouth/face __bones/muscles __kidney/bladder __genitals __eyes __intestines/colon

Hospitalizations?: ____

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Name:______________________ DOB:______________________

Allergies:____

Current Medications: ______________________________________

Family History:

	Name	DOB		Name	DOB
Brother (s):	________	____	Sister(s):	________	____
	________	____		________	____
	________	____		________	____

List any medical conditions with the **child's family members:**
(mom; dad; child's grandparents; child's aunts; uncles; cousins; siblings)

Disease/Condition	Who	Age	Comments
Heart Attack			
Other Heart Problems			
Diabetes			
Seizures			
High Blood Pressure			
High Cholesterol			
Cancer			
Blood Disorder			
Congenital Disorder			
Allergies or Asthma			
Mental Health			
Other			

Care/Education/Activities:

__home __day care __preschool __K -12th grade __home school __college

Participate in any sports: __yes __no if yes, type______________________

Home Environment:

Parents: __married __live together __divorced __single parent

Patient lives with: both parents mom dad other__________

Occupation: mom______________________ dad______________________

Smokers: __yes __no

Pets: __yes __no type: ____________

How did you hear about our practice: ______________________________?

______________________ Date: ______________________

Reviewed by Provider

Annual Review &/or updated: Date: ____________ Signature: ______________________

Patient's Name ____ ________________________________ Date of Birth ________________

Authorizations and Agreements

Authorization for Treatment

I agree to any examination, treatment, and procedure that may be performed during office visits, including emergency treatment, considered necessary by the physician and/or his/her healthcare providers.

Release of Information

I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological) advice, treatment, or supplies provided to me for the purposes of administration, review, investigation, or evaluation. A photo static of this authorization shall be considered as effective and valid as the original. I will notify the facility in writing of any information I do not want released.

Assignment of Insurance Benefits

I authorize the assignment of benefits payable to Milestone Pediatrics and/or its designee for physician services and supplies by government and or any other private third party payer. **I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.**

Financial Policy

* **Co-payments** are required to be paid at the time of checking in for your appointment. If you are unable to pay at that time, a **$25.00** surcharge will be applied to the account if the co-pay is not paid within 3 business days.

Self-Pay Accounts are required to be paid at the time of check-out after your office visit has been completed. All services that were provided at the time of service must be paid in full.

Insurance – as a courtesy, out office will bill all insurance companies for the services provided. Upon response of insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid in full within 30 days of receiving the billing statement. It is your responsibility to notify our office of any insurance or demographic changes. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

* **In divorce situations, the person bringing the child into the office is the responsible party.** A divorce decree is a document that involves you, your ex-spouse and the courts. Although a divorce decree may state that an ex-spouse is responsible for medical bills, our office has no authority to enforce compliance.

I agree to pay any outstanding balance within 30 days after receiving a statement from Milestone Pediatrics notifying me of such balance. Please be aware that if any outside lab or x-ray services are required, you will receive a separate bill for those services from the lab or x-ray provider.

If previous arrangements have not been made with our billing department, any account balance outstanding greater than 30 days will be charged a **$5.00 re-bill fee.** Any balance over 60 days will be forwarded to a collection agency, additional charges may apply and your family may be dismissed from the practice.

Not all services provided by our office are covered by every plan. Any service determined as 'not covered' by your plan will be billed to your account. So please check with your insurer about any services that may be excluded in your policy.

Referrals/Preauthorizations

It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered.

Advance notice is needed for all non-emergent referrals, most insurances require 7 to 10 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, your primary care physician must approve referrals before being issued.

Release of Medical Records

Consent for Release of Medical Records is required to be signed by parentilegal guardian of minor or adult patient prior to release of records completion. This includes school, camp, sports, FMLA, disability, etc. We follow Illinois law regarding record copying fees.

Office Policies

Red Flag / Identity Theft

Our office strives to prevent the intentional misuse of patients names, identities, and medical records to report criminal activity relating to identity theft to appropriate authorities. As a result, a copy of your photo ID and insurance card will be collected during the patient registration process. A copy of our office's Identity Theft Policy is available for your review.

***Additional Fees**

In the event that any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may incur. A $35.00fee will be charged for any checks returned for insufficient funds, plus any bank fees required.

Form Completion

We follow Illinois law regarding medical record copying fees. If your child has school, camp, or sports forms to be completed, we have a 3 to 5 day turnaround time for forms. **There is a $10.00 fee for FMLA or disability form completion.**

***Missed Appointments**

We request 24 hour notice for cancelling any appointments. If 3 or more appointments are missed or cancelled same day, you may be dismissed from the practice. **You may incur a $25 charge for each missed or same day cancelled appointment.**

Late Policy

Our office policy is to see our patients at their scheduled time. Sometimes, unforeseen situations occur that make our providers run behind schedule. We will always try to keep you informed if we are running late. We also ask that you make us aware if you are running late. In order to stay on time, we need our patients to be on time. If you are running late, please call our office and make us aware. If you are **15 minutes** or later for your scheduled time, we may ask that you reschedule your appointment in order to service all of our patients better.

Notice of Private Practices

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

____________________________ ____________________________ __________________

Signature of Patient/Guarantor | Print Name of Patient/Guarantor | Date

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting. of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with our office. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations), You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

Your health information is kept in an electronic format. A Health Information Exchange allows health care providers to access clinical information about patients from other treating facilities. The practice participates in two health information exchanges: the Community Connect Health Information Exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago (the "Exchange"), and *CareEverywhere®*.

- **Community Connect Health Information Exchange.** We, along with certain other health care providers and practice groups in the area, participate in a health information exchange operated by Ann & Robert H. Lurie Children's Hospital of Chicago ("Lurie Children's"). The Exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange; including Lurie Children's Affiliates. Through the Exchange, we may electronically disclose demographic information including cellular phone numbers and/or email addresses you provide, and medical, billing, and other health-related information about you to other health care providers that participate in the Exchange

and request such information for,purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations.

- **CareEverywhere®.** We have a software product called *CareEverywhere®* that allows us to exchange health information with other providers that have the *CareEverywhere®* product. The *CareEverywhere®* exchange facilitates the electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers also have the *CareEverywhere®* software. Through the software *CareEverywhere®*, we may electronically disclose demographic, medical, billing, and other health-related information about you to other health care providers that participate in the Exchange and request such information for the purposes including but not limited to facilitating or providing treatment, arranging for payment for health care services, or otherwise conducting or administering their health care operations. Due to our participation in the Exchange, your electronic health information from our practice may be made available to other providers through Lurie Children's shared electronic medical record.

You may opt out of participation in the exchanges described above at any time by contacting the practice. Health information that has already been shared cannot be revoked. However, if you do not consent to sharing health information for treatment purposes in the health exchanges described above, your health information will not be stored in an electronic health record. Hardcopy (paper) health records may not be immediately available or transmittable to your other health care providers for treatment purposes, including in emergency situations.

Illinois Immunization Registry: We may disclose information concerning your immunization records to the Illinois Department of Public Health ("IDPH") for inclusion in a centralized database of children's immunization records. Such information may be used by IDPH, public vaccine providers, community health centers, the Centers for Disease Control and Prevention, or any other person or entity providing immunization services or approved by IDPH as needing to know your health or immunization status. Such information may be used by these recipients to: provide immunization services to you; monitor your immunization status; promote adherence to recommended immunization schedules; assist in the preparation of vaccination documentation required by your school; prepare statistical reports on immunization status of groups of patients in which neither you nor any other patient may be individually identified; and otherwise monitor and promote your health and the health of children in Illinois generally. You have the right to opt out of participating in this registry.

You may opt out of certain provisions of the Notice, as indicated herein, by providing separate written notice. We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice at our office or on our practice website. Changes to the Notice are applicable to the health information we already have.

Parent/Guardian Signature for patient under 18 years of age: **Date:**

____ __________________

Patient Name:_______________________________________

Parent/Guardian Name:__________________________________