Registration Form

_____ _____ _____

First Name **Middle Name** **Last Name**

Date of Birth: _____

Preferred Phone Number: _____

Address (Including City & State): _____

_____

Mother's Info

Name: _____

Phone:_____

Email:

_____

***Date of Birth*:** _____

Father's Info

Name: _____

Phone:_____

Email:

_____

***Date of Birth*:** _____

Please inform us if either parent's address is different from above.

Insurance Information

☐ Not applicable, no insurance -if we do not file your insurance, we need this information for labs, vaccines, and other providers.

Primary Insurance Policy Name: _____

Insurance Policy/Member # _____ Group #: _____

Policy Holder's (PH) Name: _____

PH Date of Birth: _____ PH Social Security Number*: _____

**This information is sometimes requested when we do referrals or when contacting insurance companies. SSN is used only for insurance verification purposes.*

Race (circle one):

American Indian
Asian
Asian Indian
Black or African American
European
Filipino
Japanese
Korean
Native Hawaiian or other Pacific Islander
White

Ethnicity (circle one):

Central American
Cuban
Dominican
Hispanic/Latino Spanish
Latino/Lantin American
Mexican
Not Hispanic/Latino
Spaniard
Puerto Rican
South American

Consent to Treat

I understand that SEE Alternatives Pediatrics is a Nurse Practitioner owned and operated facility. The vast majority of my child's care will be provided by a nurse practitioner. We work with a collaborating physician via telecommunication and that physician will occasionally provide coverage in our office. We also consult with other physicians and healthcare providers regarding patient care as needed and appropriate.

I authorize SEEAP and their healthcare providers to provide medical care to my child that is necessary and appropriate.

I authorize SEEAP to access prescription medication data for the purpose of treating my child.

Signature of Parent/Guardian: _____ **Date:** _____

I understand that written authorization from a parent or guardian is required to provide treatment in the absence of a parent or legal guardian (ex: child is brought to office by a nanny or grandparent). Without written authorization, treatment may be delayed or refused until authorization is provided. Below is a list of individuals who have permission to bring my child in for treatment:

☐ No one other than parents listed above may bring my child for a visit.

Signature of Parent/Guardian: _____ **Date:** _____

Confidentiality and Privacy Notices

I understand that SEEAP has access to MUSC medical records through Care Link program. SEEAP and associates may access my child's medical records as needed for the purpose of referrals, accessing lab records, and coordination and continuation of care.

I understand I have access to SEEAP's Notice of Privacy Practices in the portal, on our website, in our lobby, and upon request. I have been given the opportunity to review the document.

I authorize SEEAP and Athena to communicate with me via text, phone, and email at the preferred contact listed above for appointment reminders, messages from providers, billing related issues and other general communication regarding the practice or my child's care.

I authorize SEEAP to add my email to an email list for the purpose of providing educational information and updates regarding the practice.

I authorize SEEAP to leave voicemail messages on the phone number(s) listed on my registration form with appointment reminders, lab results, and brief summary of medical care.

I understand that SEEAP highly recommends the use of the Patient Fusion portal for written communication with our providers and staff, as it is HIPAA compliant and provides a record of the communication. SEEAP discourages the use of email for communication regarding medical care.

Signature of Parent/Guardian: _____ **Date:** _____

Financial and Billing Policies and Procedures

I understand the co-payment outlined by my contract with the insurance company is expected in full at the time services are rendered. I understand that if SEEAP does not collect the co-payment, co-insurance, or deductible outlined in my plan, SEEAP is in violation of a binding agreement with the insurance company.

I authorize SEEAP to release any medical information necessary to my insurance carrier to obtain reimbursement for services rendered to my child/dependent.

I hereby authorize direct payment of benefits payable for these services to SEEAP. I understand that it is my responsibility to update SEEAP with any insurance coverage changes. I understand I am responsible to pay for any services that my insurance policy deems as non-covered services.

I understand that every insurance policy is unique, and I am fully responsible for understanding what my insurance coverage is. Some in office procedures are not covered by some insurance plans. SEEAP may send labs out to third party vendors. I am responsible for understanding what my patient responsibility may be for these services.

I understand that SEEAP is not in network with some insurance plans and that I am responsible for the charges incurred in full for the visit. If SEEAP files an out of network claim for the insurance, I will be billed an invoice after SEEAP receives notification from the insurance company of the covered/uncovered services.

I understand SEEAP accepts cash and credit card payments (including Health Savings Account credit cards). **We do not accept checks.** I guarantee payment for all services that are provided to my child.

Self-pay Statement (if applicable): I understand that payment in full is expected at the time services is rendered.

Signature of Parent/Guardian: _____ Date: _____

Well Child Care Vs Problem Specific Visits

I understand that well child healthcare is an important component of the healthcare of my child. I understand that these visits are what truly constitute preventative care and how SEEAP partners with me for optimal health and well-being for my child. We require children under 2 in our primary care practice be seen at the following ages: 3-5 days, 2-4 weeks, 2, 4, 6, 9, 12, 15, and 18 months of age. Children over 2 years are seen at least annually. I understand that SEEAP reserves the right to terminate care if regular well child care is not maintained.

I understand that a well visit is designed to review the general health and well-being of my child and to provide proactive information to prevent illness and maintain health. If my child has multiple complaints or issues that need to be addressed, I will be asked to schedule a visit specifically to address those complaints.

I understand that SEEAP is not a walk-in clinic and that SEEAP makes every effort to see my child for same-day sick visits. I will call the office or utilize the portal to schedule appointments.

Supplement Transparency Statement –
I understand that SEEAP practitioners may recommend supplements that may benefit the health of my child. I understand that supplements are not reviewed by the FDA as prescription medications are, and that supplements sold in our office or from our online account(s) may provide revenue for SEEAP.

By signing below, I indicate that I have reviewed and authorize the above statements.

Signature of Parent/Guardian: _____ Date: _____

Late Arrivals, Cancellation and No-Show Policy

We strive to schedule in a way that minimizes wait times and allow for patients to maximize their time with the provider. Because we offer longer appointment times than traditional offices, late arrivals, cancellations, and no-shows impact our patients and the practice a great deal. Our electronic medical record sends out text reminders for appointments to support you in rescheduling in a timely manner when there is a conflict with a scheduled appointment. If you do not receive these notices, please let us know.

Late Arrivals: A patient is considered late if he/she does not arrive within 10 minutes of the appointment time. Late arrivals may be asked to reschedule the appointment to a later time or date, especially if another patient will be impacted. If the appointment is not rescheduled, we reserve the right to shorten the duration of the appointment, especially when another patient will be impacted.

Same-Day Cancellation: We ask that you notify us at least 24 hours before the scheduled appointment, so we can offer that time to another patient.

No-Show: A "no show" is someone who does not attend the scheduled appointment date and time and does not communicate according to the cancellation policy. We understand that emergencies happen and there will be times that it is impossible to make an appointment time. Please notify us as soon as possible, even if the appointment time has passed, so we can get the appointment rescheduled.

*How we will handle late arrivals, same-day cancellations, and no-shows**.***

- A pattern of late arrivals (>3) will be considered as an offense.
- For the first offense, we will call to reschedule the appointment and give a written reminder of this policy.
- For a second offense we will call to reschedule the appointment and will give parents written notification of this policy (in person or by mail), a copy of which will be filed in the chart.
- For a third offense, a $50 dollar charge will be placed on the account and the fee must be paid to schedule another appointment. A final written notification will be provided (in person or by mail) and a copy will be filed in the chart.
- For any additional offenses, SEEAP reserves the right to terminate healthcare services.

By signing below, the parent/guardian listed below acknowledges receipt of this policy.

_____ _____

Signature Date

Medical Information

What symptoms is your child currently/recently experiencing?

☐ **None, my child is here for a well child visit and has had no recent symptoms.**

☐ Fever _____ ☐ Change in appetite/thirst ☐ Change in Energy Pattern ☐ Change in mood

☐ Eye drainage ☐ Watery eyes ☐ Vision problems

☐ Ear pain/tugging ears ☐ Hearing problems ☐ Sore Throat ☐ Hoarse voice

☐ Runny nose ☐ Sneezing

☐ Cough ☐ Trouble breathing ☐ Wheezing

☐ Chest pain ☐ Murmur/irregular heartbeat

☐ Abdominal pain ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in stool

☐ Painful urination ☐ Change in urinary pattern ☐ Blood in urine

☐ Headache ☐ Dizziness

Other:

Please list any current medications, supplements, or vitamins your child takes regularly.

Please list your preferred pharmacy (name of pharmacy and road name or phone number):

_____

Family history

Please circle any conditions that a parent, sibling, or immediate family member has experienced and indicate the individual's relationship to your child.

☐ Child adopted – little family history known

Condition	**Relationship to child**	**Condition**	**Relationship to child**
Allergies		ADHD	
Asthma		Anxiety	
Eczema		Depression	
Murmur		Autism	
Heart Disease		Bipolar	
High Blood Pressure			
Kidney Disease		Autoimmune disorder *(specify)*	
Diabetes (specify type 1 or 2)			
Thyroid Disorder *(specify)*		Cancer *(specify)*	
Other *(specify disease and relationship):*			

Medical History Information

Birth/Newborn History (first month of life):

Birth Weight _____lbs _____oz ☐Full Term ☐Premature, week _____

☐Vaginal ☐C-Section

Please circle any complications: Breathing Problems Blood sugar problems NICU stay Infection (mom or baby) Other:

Newborn History continued (please only complete if your baby is less than 2 months old)

Discharge Weight? _____

Did your newborn receive Hepatitis B Vaccination? ☐**Yes** ☐**No**

Did your newborn receive Vitamin K injection? ☐**Yes** ☐**No**

Did your newborn receive erythromycin ointment? ☐**Yes** ☐**No**

Was a metabolic screen performed on your newborn? ☐**Yes** ☐**No**

Did baby pass newborn screen? ☐**Yes** ☐**No**

What is mother's blood type? _____ What is baby's blood type (if tested)? _____

Breech presentation? ☐**No** ☐**Yes –** was baby scheduled for hip ultrasound? ☐Yes ☐No

Did mom receive antibiotics during the pregnancy or during the delivery? ☐**No** ☐**Yes**

What medical problems has your child had in the past?

Has your child had any surgeries? ☐**No** ☐**Yes**: _____

Please circle any of the following that your child has been diagnosed with and specify in the space below.

ADD/ADHD	Constipation	Muscle, Joint, or Bone Problem
Allergies (specify below)	Depression	Seizures/Epilepsy
Anemia	Developmental/Behavioral disorder	Skin Problem
Anxiety	Ear or Hearing Problem	Thyroid Problem
Asthma	Endocrine Issues	Vision/Eye Problem
Bladder or Kidney Problems	Head Injury/Concussion	Weight Issues
Blood Disease	Headaches	Other, specify:
Cancer	Heart Problem	
Chicken Pox	Hospital admission other than birth	
Chronic Ear Infections	Mental Illness	

Allergies – Please list and specify reactions to medications, foods, or environment:

☐**No Known Drug Allergies** ☐**No Known food/environmental allergies**

Vaccine History

Is your child up to date on vaccines? ☐**Yes** ☐**No,** describe: _____

Has your child experienced any reactions to vaccines? ☐**No** ☐**Yes, specify below**

Has anyone in your immediate family experienced any reactions to vaccines? ☐**No** ☐**Yes, specify below**

Social History

Who lives in your home? [Please include sibling(s) name(s) and age(s), if applicable.]

What school/pre-school/daycare does your child attend, if applicable?

What are parents' occupations and workplaces?

Mother:

Father:

Does your family follow any specific eating pattern (ie vegan, vegetarian, gluten or dairy free)?

Do you have pets in your home? ☐**No** ☐**Yes, what type:**

Is your child exposed to smoke (including vapes)? ☐**No** ☐**Yes**

Do you have smoke detectors in your home? ☐**Yes** ☐**No**

Do you have carbon monoxide detectors in your home? ☐**Yes** ☐**No**

Do you have a gun in your home? ☐**No** ☐**Yes, how secured?**

Do you have concerns about environmental exposures (moisture/mold, chemicals/toxins, heavy metals)?

☐**No** ☐**Yes**, please specify:

Which of the following does your child have/do while riding in a vehicle (please circle)?

Car seat 5-point harness Booster seat Seatbelt

What else should we know about your child/family?