SEE ALTERNATIVES Pediatrics

NEW PATIENT REGISTRATION FORM

Patient Name

First: _____ Middle: _____ Last: _____

Date of Birth: _____ ☐ Male ☐ Female Pronouns: _____

Preferred Phone Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ Date of Birth*: _____

Phone Number: _____ Email Address: _____

Father's Name: _____ Date of Birth*: _____

Phone Number: _____ Email Address: _____

Please inform us of any non-traditional parenting or custodial arrangements.

Insurance Information

Please provide insurance information, even if we do not file your insurance, as this is needed when we order vaccines, referrals, and labs/procedures. Bring your insurance card(s) to your first visit. If you have secondary insurance, please notify us at your first visit.

☐ Not applicable, self-pay

Primary Insurance Policy Name: _____

Insurance Policy/Member #: _____ Group #: _____

Policy Holder's (PH) Name: _____

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

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

Race (choose one):

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

Ethnicity (choose one):

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

SEE ALTERNATIVES PEDIATRICS: NEW PATIENT REGISTRATION FORM

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 occasionally provides 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 relative or nanny). 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 on page 1 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.

In 2022 new laws became active requiring electronic sharing of medical records among electronic medical records to improve communication among healthcare providers providing care for patients. We allow this record sharing feature for patients, unless we are notified in writing by the parent or legal guardian.

We are required to share vaccine administration data with SIMON, the state vaccine registry. We share this information automatically, unless we are notified in writing by the parent or legal guardian.

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 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 Athena 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:** _____

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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 if I do not provide SEEAP with my insurance information in a timely manner, I will be deemed a self-pay patient and will be responsible for the charges when the insurance information was unavailable. Please note that some insurance companies require direct communication from you regarding coordination of benefits, and may withhold payment if you do not communicate.

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, and 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 healthcare 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 may be asked to schedule a visit specifically to address those complaints. I understand that if my child is scheduled for a well visit, but has an illness or complaint, SEEAP will bill for both a well visit and a problem-focused visit, which may result in a co-payment or deductible charge.

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 to schedule a visit when I want my child to be seen.

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 multiple 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 reminders, 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 of Parent/Guardian: _____ **Date:** _____

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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.

_____

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

☐ No known drug allergies ☐ No known food/environmental allergies

_____

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):

_____

VACCINE HISTORY

Is your child up to date on vaccines? ☐ Yes ☐ No – no vaccines to date ☐ No – partially vaccinated

Has your child experienced any reactions to vaccines?

☐ No ☐ Yes, specify: _____

Has anyone in your immediate family experienced any reactions to vaccines?

☐ No ☐ Yes, specify: _____

FAMILY HISTORY

Please check 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		☐ Diabetes *(specify type 1 or 2)*: _____	
☐ Asthma			
☐ Eczema		☐ Thyroid Disorder *(specify)*: _____	
☐ Murmur			
☐ Heart Disease		☐ Autoimmune disorder *(specify)*: _____	
☐ High Blood Pressure			
☐ Kidney Disease		☐ Cancer *(specify)*: _____	
☐ ADHD			
☐ Anxiety		☐ Other *(specify disease and relationship)*:	
☐ Depression			
☐ Autism			
☐ Bipolar			

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MEDICAL HISTORY INFORMATION

Birth/Newborn History (first month of life)

Birth Weight: _____ lbs _____ oz Location of Delivery: _____

Born at _____ weeks gestation via ☐ Vaginal ☐ C-Section

Any complications? ☐ Jaundice ☐ Breathing problems ☐ Blood sugar problems ☐ NICU stay

☐ Infection (mom or baby) ☐ Other: _____

Additional Newborn History (please only complete if your baby is less than 6 months old)

Discharge Weight: _____ lbs _____ oz

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

Did your newborn receive erythromycin ointment? ☐ Yes ☐ No

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

Did your baby pass the hearing screen? ☐ Yes ☐ No

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

Did your baby have a bilirubin test performed? ☐ No ☐ Yes, results: _____

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

Breech presentation? ☐ No ☐ Yes If 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 check any of the following that your child has been diagnosed with and specify in the space below.

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

_____

_____

Details:

SOCIAL HISTORY

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

☐ Parents separated/divorced. Please advise us of both parent's address and provide a copy of legal agreement regarding medical decision making.

Does your family follow any specific eating pattern (ie vegan, vegetarian, gluten or dairy free) or does your child have any dietary restrictions?

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

_____

What are parents' occupations and workplaces?

Mother: _____

Father: _____

Do you have pets in your home? ☐ No ☐ Yes, describe: _____

Is your child exposed to cigarette smoke or 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, secured with: _____

Do you use sunscreen for your child (if older than 6 months)? ☐ No ☐ Yes, describe: _____

Do you use insect repellant for your child (if older than 6 months)? ☐ No ☐ Yes, describe: _____

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

☐ No ☐ Yes, please specify: _____

Which of the following does your child use while riding in a vehicle?

☐ Car seat ☐ 5-point harness ☐ Booster seat ☐ Seatbelt

What else should we know about your child/family?