A Children's House for Pediatric Dermatology
NEW PATIENT QUESTIONNAIRE

Patient Name: ____ Nickname: ____________________
Last First Middle

Address: ____ Home phone: __________________
City Zip

Date of Birth: ______________ SSN: ____________ Current Age: ________ Male/Female: __________

School: ____________________ Current grade: ______ Hobbies/Sports: ________________________

Mother's Name: ____ Cell: ________________________

Mother's Occupation: ___________________________ Mother's Email: ____________________________

Father's Name: ____ Cell: ________________________

Father's Occupation: ___________________________ Father's Email: ____________________________

Siblings (names and ages): ____

Patient lives with: ____

Religious/spiritual /faith affiliation, if any: _________________________ May we pray with you?: Yes or No

How did you hear about us? ____

Current Pediatrician (name and info): ____

Current Subspecialists: ____

Preferred Pharmacy (address and phone): ____

Current problems (include onset, timing, location, associated symptoms, previous treatments with response):

____

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____

Current skin care regimen (soaps, moisturizers, over-the counter medications, etc), if any:

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____

Birth history (weight, length, full-term, complications): ____________________

Health Conditions: ____________________

Developmental or learning issues: ____________________

Previous surgeries or hospitalizations: ____________________

Medications, include vitamins, etc: ____________________

Allergies to medication, food, etc: ____________________

Review of systems	**Yes**	**No**	**Family history**	**Yes**	**No**	**Relationship**
Weight loss or gain			Skin cancer			
Recent fever			Melanoma			
Vision changes			Eczema			
Ear/nose/throat issues			Asthma			
Swollen glands			Hay fever			
Recurrent infections			Autoimmune disorders			
Breathing problems			Bleeding problems			
Heart problems			Anesthesia problems			
Bleeding problems			**Social history**	**Yes**	**No**	**Explanation**
Vomiting/diarrhea			Vaccines up to date			
Muscle aches/weakness			Pets			
Swollen joints			Alcohol use			
Kidney/bladder issues			Tobacco use			
Irregular periods			Illicit drug use			
Headaches			Sexually active			
Depression/anxiety						
Difficulty sleeping						

Person completing form and relationship to patient: ____________________

Physician signature and date reviewed: ____________________

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that A Children's House for Pediatric Dermatology has made the *Notice of Privacy Practices* available to you prior to any services being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below. This includes authorization to enter personal and medical information into your electronic health records through Practice Fusion who may utilize your de-identified information, as well as release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process payments and medical/prescription benefits.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of the Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication or PHI be made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines or voicemail, and leaving lab or procedure results with a family member.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

I wish to be contacted in the following manner (check all that apply):

Preferred phone number: ___________________________ Alternate phone number: ______________________

Phone number for text messages: ___________________ Email address: ________________________________

- O Do not leave a message
- O Leave a message with a call back number only
- O Leave a message with detailed information
- O Discuss medical information with me only
- O Leave medical information with a family member
- O Mail correspondence through USPS to home address on file
- O Text message with information (when available)
- O Email with information (when available) from a unencrypted email server which may be unsecure

I wish to be contacted in the following manner to have my appointments confirmed (check all that apply):

- O Cell phone
- O Text message
- O Email

Patient Name: ____ Patient's Date of Birth: ____________________
(Please Print Name)

Patient's Guardian/Legal Representative: ____
(Please Print Name)

Relationship to Patient: ____

SIGNATURES:

Patient: ____ Date: _________________

Legal Representative: ____ Date: __________________

A CHILDREN'S HOUSE FOR PEDIATRIC DERMATOLOGY
FINANCIAL POLICY and ACCEPTANCE OF LIABILITY

Thank you for choosing A Children's House for Pediatric Dermatology as your health care provider. It is our goal to meet patient needs and address any patient concerns effectively. In an effort to keep patients informed about our policies so they can make educated decisions regarding their health care, we ask that all patients read and sign a copy of our Financial Policy prior to receiving services and treatment.

PAYMENTS are expected at the time services are rendered. This includes payment of all fees including fees for the office visit and any procedures performed in the office. If you are unable to pay at the time of service, your appointment may be rescheduled.

INSURANCE is not accepted in our office as we are not contracted with any insurance companies. Therefore, we do not file claims with your insurance. We will provide you with an itemized receipt upon payment that you can independently submit to your insurance carrier for possible out-of-network reimbursement.

OUTSIDE SERVICES may be necessary for your medical care. PATHOLOGY is ordered by our physician when a skin biopsy is performed. We utilize a licenced dermatopathology lab that specializes in the microscopic diagnosis of skin disorders. Pathology charges will come directly from the lab. LABORATORY TESTING fees for bloodwork and microbial cultures will also billed directly from the lab. As well, HOSPITAL fees for outpatient surgical procedures will be authorized and billed from those entities. All of these fees may or may not be covered by your insurance. We will specifically discuss this with you if it is determined that these services are recommended for approriate diagnosis or treatment in your care.

RETURNED CHECKS will result in a $50.00 service charge. The check amount plus the service charge is to be paid within 10 days of notification. Failure to pay in full in 10 days will result in collection through the appropriate means.

WALK OUT POLICY: Payment for services is expected on the day of service. Any patient who walks out without making or arranging payment will be assessed a $50.00 walk out fee.

NO SHOW/LATE CANCELLATION POLICY: As a courtesy, we make every effort to confirm appointments in advance; however, it remains your responsibility to know and to keep your appointment. If you are unable to attend an appointment, please let us know as soon as possible so we can assign your time slot to someone else. We ask for at least one business day cancellation notice for all appointments. We reserve the right to charge the following fees for missed appointmets: $50.00 for an office visit and $100.00 for a procedure visit. Emergencies are considered on an individual basis and you must contact our office to discuss this with our staff.

LATE POLICY: If you are more than 15 minutes late to your scheduled appointment, we will make every effort to work you into the doctor's schedule but this may require that you wait for other patients who have arrived on time. However, we may have no choice but to reschedule your appointment.

REQUESTS FOR MEDICAL RECORDS and COMPLETION OF FORMS: You will assessed $25.00 per request. Upon receipt of payment, documentation can be picked up at the office within 3-5 business days, unless otherwise notified.

BILLING STATEMENTS and DELINQUENT ACCOUNTS will not occur since payment is expected at the time of service.

CREDIT CARDS, CHECKS and CASH are accepted payments.

I have read the Financial Policy of A Children's House for Pediatric Dermatology. I understand and agree to adhere to the policies as outlined. I further agree to be responsible for all charges.

Patient name: ______________________________ Legal representative name:______________________________

Signature of legal representative: ______________________________________Date: ________________________

PARENTAL PREAUTHORIZATION FOR MINORS

For families who have established relationships with our practice, it may be convenient to have on file prior authorization for medical care for children when a parent cannot be present for treatment. Please complete the following form if you want to authorize the treatment in advance.

I request and authorize A Children's House for the Soul and its personnel to deliver medical care to my child listed below:

Child Name ______________________________ Date of Birth ___________

If we are not available during our child's visit, please try to contact us regarding the health care of our child at the following number:

Parent Name ______________________________ Phone _______________

If you would like to authorize another adult(s) (ie nanny, family member, etc) to accompany your child to their visits and you allow them to act on your behalf in your absence, please list below:

Authorized Caregiver _________________________ Relationship to child ______

Authorized Caregiver _________________________ Relationship to child ______

Note: If any special parental or custodial relationship exists (such as if the child has one parent only, if there is joint custody or if legal custody is held by guardians in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Explanation ____

____

Parent or Guardian Name ________________________ Date _____________

Parent or Guardian Signature _____________________ Date _____________

Relationship to Patient _________________________