NORTH POINT PEDIATRICS

PATIENT INFORMATION FORM

Please Complete This Entire Form (list all children the information applies to)

PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

PATIENT LAST NAME: GENDER: □ *M* □ *F* □ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: □ *M* □ *F* □ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: □ *M* □ *F* □ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: □ *M* □ *F* □ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: □ *M* □ *F* □ *Other*	PATIENT FIRST NAME:	MIDDLE INITIAL:	PATIENT DATE OF BIRTH:

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different)*:	CITY:	STATE:	ZIP:

PRIMARY PHONE: ( )	CELL PHONE: □ *Check if same as Primary* ( )	WORK PHONE: ( )	EXTENSION:

PREFERRED PHARMACY: Name, Address and Phone Number	ENABLE FOR PATIENT PORTAL: □ Yes □ No □ Not Applicable

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African-American □ Hawaiian Native/ Pacific Islander □ White □ Declined to Specify □ Other (Details) ________________________________

GUARANTOR INFORMATION

(Individual responsible for bills and payment – If you are an 18+ year old patient, this would be YOUR name)

GUARANTOR LAST NAME:	GUARANTOR FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT *(Check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Self □ Other *(Specify)*:

STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP

PRIMARY PHONE: ( )	CELL PHONE: □ *Check if same as Primary* ( )	WORK PHONE: ( )	EXTENSION:

E-MAIL ADDRESS: □ None	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:
GENDER: □ Male □ Female □ Other	EMPLOYER NAME:	EMPLOYER PHONE #: ( )
	Receive Statements via: □ Mail □ Email	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

OTHER PARENT

PARENT LAST NAME:	PARENT FIRST NAME:	MIDDLE INITIAL:	RELATIONSHIP TO PATIENT *(Check all that apply)*: □ Mother □ Father □ Stepmother □ Stepfather □ Legal Guardian □ Self □ Other *(Specify)*:

STREET ADDRESS: □ *Check if same as patient*	CITY:	STATE:	ZIP:

PRIMARY PHONE: ( )	CELL PHONE: □ *Check if same as Primary* ( )	DATE OF BIRTH *(mm/dd/yyyy)*:
	E-MAIL ADDRESS:	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

PLEASE CONTINUE ON THE NEXT PAGE

*********PLEASE LIST BELOW PEOPLE GIVEN PERMISSION TO BRING IN YOUR MINOR CHILD FOR MEDICAL CARE**********

CONTACT NAME:	RELATIONSHIP TO CHILD*:*	CONTACT PHONE:
CONTACT NAME:	**RELATIONSHIP TO CHILD:**	**CONTACT PHONE:**

□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
May pick up prescriptions	**May pick up forms**	**May pick up medical records**	**May speak to nurse or doctor for medical advice**

INSURANCE INFORMATION ONLY IF CURRENT INSURANCE CARD NOT PRESENT

(*Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: ☐ **Yes** ☐ **Yes, but pending, not active, or you're not contracted** ☐ **No *(Self Pay)***			
PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
SUBSCRIBER:	**RELATION TO PT:**	**SUBSCRIBER:**	**RELATION TO PT:**
Policy ID:	**Group ID:**	**Policy ID:**	**Group ID:**
GENDER: □ **Male** □ **Female** □ **Other**		**GENDER:** □ **Male** □ **Female** □ **Other**	
DATE OF BIRTH:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**	**SOCIAL SECURITY #:**

CONFIDENTIAL COMMUNICATION

(*I hereby request to receive confidential communications from North Point Pediatrics in the following manner)*

PHONE MESSAGES – Please leave messages as follows
(Check All That Apply)

Primary Phone: ☐ Mom ☐ Dad ☐ Both

☐ Self (for 18+ year old patients)

☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

Cell Phone: ☐ Mom ☐ Dad ☐ Both

☐ Self (for 18+ year old patients)

☐ **BRIEF MESSAGE** ☐ **DETAILED MESSAGE**

APPOINTMENT CONFIRMATIONS/RECALLS

CONTACT: (Check one)

☐ Mom ☐ Dad ☐ **Self (for 18+ year old patients)**

VIA THE FOLLOWING METHOD: (Check one)

☐ Text message

☐ Home/Cell Phone – automated call

☐ Email address

If needed, I agree to participate in Telehealth visits through a HIPAA Compliant platform. _____YES _____NO

Telephone. Email Contacts

I hereby consent and agree that: (1) anyone acting on behalf of North Point Pediatrics (herein known as "NPP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of NPP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) NPP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with NPP and that NPP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying NPP staff. □ **Accept** □ **Decline**

Initials: _____

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize North Point Pediatrics to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and heath care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of NPP for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If North Point Pediatrics is not a provider on my insurance, full payment is due on the date of service. If North Point Pediatrics is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, if I miss a schedule appointment, I understand I may be charged $35. If I miss two scheduled appointments I may be charged $75. ***By signing below, I am acknowledging that I have read and understand the above statements.***

_____	_____	_____
Parent, Legal Guardian, or Patient (18 or older) Printed Name	**Parent, Legal Guardian, or Patient (18 or older) Signature**	**Date Signed**

In the event that your insurance company does not cover these screenings, you will be responsible for the payment of these services.

Please check the test(s) you are consenting to:

_____**HEARING** - I select to have the Hearing Screening administered today and agree to pay these fees in the event that my insurance company does not cover.

Hearing Screening Fee: **$23.00 Usually necessary for school**

_____**BASIC VISION CHART** - I select to have Basic Vision administered today and agree to pay these fees in the event that my insurance company does not cover.

Vision Screening Fee: **$27.00 Usually necessary for school**

_____**SPOT VISION** (Ages 6 months to 4 years or for children not able to do the eye chart or other concerns) - I select to have the Spot Vision test administered today and agree to pay these fees in the event that my insurance company does not cover. **Vision Fee: $10.00**

_____I decline all the vision and hearing screenings for my child today. (STATE REQUIRED FOR CHILDREN AGES 4 & 5)

*****If you decline today and later require test(s) for school, you will be charged a $40 administrative fee in addition to any insurance responsibility.

Child's Name: _____ ___ Date of Birth: _____

Parent/Guardians Signature: _____

Date: _____

Information from the American Academy of Pediatrics

Patient Education on Billing

As you may know, there are very specific regulations about billing for health care services. As your health care provider, we are obligated to follow those regulations in how we report services provided to you. Additionally, every insurance plan may have different rules that vary from insurer to insurer and may even vary between plans of the same insurer.

- All physicians/providers must report services using a variety of codes to tell the insurance company what was done and why.
- It is not uncommon for patients in the course of a visit to receive management and treatment services for a separate and specific problem, as well as routine or preventive services at the same visit. This results in billing a sick visit with a well visit.
- Both services must be reported to the insurance company and may result in an additional co-payment or charge as per the insurer's plan rules which we are obligated to follow.
- There are many different insurance companies and plans; addressing a problem may trigger a co-payment or additional charges to your account.
- Your financial responsibility is determined by the rules of your insurance company, which we are obligated to follow.
- If you have questions, please check with your insurance plan.

We are dedicated to providing the best possible care for you and your family and to being respectful of your time. If our business office can help, please call them at (678) 336-1409.

YOUR COPY TO KEEP

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Version 3.0 Effective Date: _____, 2013

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. *Payment:* We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan. *Health Care Operations:* We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures

Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order. *Law enforcement purposes:* We may disclose information needed or requested by law enforcement officials or to report a crime on our premises. *Deaths:* We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. *Serious threat to health or safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for workrelated injuries or illness.

Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information. *Messages*: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights

You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

☐ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

☐ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

☐ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

☐ You have the right to request that we amend your information.

☐ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.

☐ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices

We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint..

Contact Person

If you have any questions, requests, or complaints, please contact:
Ginger McGee Practice Manager
At (770) 664-0088

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____
Date:_____

Parent Notification

North Point Pediatrics follows the guidelines of the American Academy of Pediatrics regarding patients care. Your child will be given a depression and behavior screening form to complete. This is recommended by the AAP. This is billable to your insurance.

The guidelines are targeted for youth ages 10 to 21, and distinguish the differences between mild, moderate and severe forms of Major Depressive Disorder.

While the guidelines suggest ways to involve family members in a teen's mental health treatment, they also recommend that the pediatrician spend time alone with the adolescent.

After your child's doctor reviews the form, they will determine if any concerns need to be addressed.

_____Yes, I give permission to my child to complete these forms.

_____No, I do not give permission to my child to complete these forms.

Child's Name: _____ ___ Date of Birth: _____

Parent/Guardians Consent: _____

Date: _____

PHQ9-A PATIENT TO COMPLETE (NOT PARENT)

Name:_____ Clinician:_____ Date:_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.				
	(0) Not at All	**(1) Several Days**	**(2) More than Half the Days**	**(3) Nearly Every Day**
1. Feeling down, depressed, irritable or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep or sleeping too much?				
4. Poor appetite, weight loss or overeating?				
5. Feeling tired or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading or watching tv?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead or of hurting yourself in some way?				

In the past year, have you felt depressed or sad most days, even if you felt ok sometimes?

Yes ☐ No ☐

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult ☐

Has there been a time in the past month when you have had serious thoughts about ending your life?

Yes ☐ No ☐

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes ☐ No ☐

***If you have had thoughts that you would be better off dead or hurting yourself in some way, please discuss this with your Health Care Clinician, go to a Hospital Emergency Room or call 911.*

Office Use Only **Severity Score:_____**

Modified with permission from the PHQ (Spitzer, Williams and Kroenke, 1999) by J. Johnson (Johnson, 2002)

This is an optional form that is billable to your insurance.

Child's Name/Date of Birth:_____

PATIENT TO COMPLETE (NOT PARENT)

Crafft Screening

Part A

During the PAST 12 MONTHS, did you:

1.	**Drink any alcohol (more than a few sips)?**	**No ☐**	**Yes ☐**
2.	**Smoke any marijuana or hashish?**	**No ☐**	**Yes ☐**
3.	**Use anything else to get high?**	**No ☐**	**Yes ☐**

"Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you "sniff" or "huff".

If the patient answer NO to ALL of the questions in Part A, ask the CAR question only. If the patient answered YES to ANY of the questions in Part A, ask ALL SIX CRAFFT questions.

Part B

1.	**Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?**	**No ☐**	**Yes ☐**
2.	**Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in?**	**No ☐**	**Yes ☐**
3.	**Do you ever use alcohol or drugs when you are by yourself or alone?**	**No ☐**	**Yes ☐**
4.	**Do you ever FORGET things you did while using alcohol or drugs?**	**No ☐**	**Yes ☐**
5.	**Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?**	**No ☐**	**Yes ☐**
6.	**Have you ever gotten into TROUBLE while you were using alcohol or drugs?**	**No ☐**	**Yes ☐**

Child's Name/Date of Birth:_____