Shelby Pediatrics, LLC

Karen S. Smith, MD

430 Fourth Ave., Suite 1
Sidney, OH 45365
937-419-TOTS (8687)

Welcome,

Thank you for choosing Shelby Pediatrics, LLC for your child's care. We appreciate the trust you have placed in us and look forward to developing a long and healthy relationship with you and your child(ren). Our goal is to provide exceptional care in a comfortable, welcoming, and fun environment for children.

Please review the following office policies.

- **Late Policy**: If your child is 15 minutes late or more
  - *Wellness appointment*: You may be asked to reschedule.
  - *Sick visit*: We will try and work them in but there may be a wait as we see the patients first who have arrived on time.
- **No Show:** In the event that your child does not show up for an appointment, we will notify you of the no-show and ask you to call our office to reschedule your child's appointment. After the 3rd missed appointment in a one-year time span, we may dismiss your family from the practice.
- **Cancellations:** If you need to cancel your child's appointment, please make sure you give us a 24-hour notice. This is so we can fill that empty spot for another child that needs to be seen. If you fail to inform us 24 hours in advance, you may be charged a no show.
- **Patient Dismissal:** Dr. Smith may release you from our practice for disruptive behavior, non-compliance with medical advice, or if your family has more than 3 no shows.

We look forward to working together to achieve your child's optimal health. If you have any questions, please do not hesitate to ask.

Please sign below, indicating that you understand these policies.

Signature of Patient or Guardian: ___________________________________ Date:____________

Print Name: ___________________________________ Relationship: ______________________

With you every step of the way!

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Patient Information

First Name ______________________ Middle Initial ____ Last Name _____________________

Preferred Name _________________________ Date of Birth ____/____/____ Sex M F

Address ____ SSN ______-_____-_______

City ______________________________ State _____________________ ZIP_______________

Primary Phone (_____) ____________ Cell ☐ Secondary Phone (_____) ____________ Cell ☐

Email ___________________________________ Text reminders to Primary ☐ **OR** Secondary ☐

Language___________________ Race___________________ Ethnicity ____________________

After Visit Patient Care Summary: Portal ☐ Paper ☐

How did you hear about us?____

Parent/Guardian Information

Parent/Guardian's Name _______________________________ Date of Birth____/____/_____

SSN _____-_____-_____ Relationship: Mother Foster Legal Guardian Step Other

Marital Status: S M D W Employer___________________ Occupation__________________

Home Phone (____) ________________ Cell Phone (____) _______________ Text (Yes) or (No)

Below Information is Same as Child ☐

Address ____________________________ City________________ State______ ZIP_________

Parent/Guardian's Name _______________________________ Date of Birth ____/____/____

SSN _____-_____-_____ Relationship: Father Foster Legal Guardian Step Other

Marital Status: S M D W Employer___________________ Occupation__________________

Home Phone (____) ________________ Cell Phone (____) _______________ Text (Yes) or (No)

Below Information is Same as Child ☐

Address ____________________________ City________________ State______ ZIP_________

With you every step of the way!

Emergency Contact (Someone other than a parent/guardian)

Name ______________________________ Address/City/Zip ______________________________

Phone (_____) ____________________________ or (_____) ______________________________

Relationship to Patient ____

Sibling Information

First Name___________________ Last Name___________________ Birthdate ____/____/____

First Name___________________ Last Name___________________ Birthdate ____/____/____

First Name___________________ Last Name___________________ Birthdate ____/____/____

First Name___________________ Last Name___________________ Birthdate ____/____/____

Insurance Information

Primary:

Cardholder's Full Name: First_______________________ Last ___________________________

Date of Birth ____/____/____ SSN_____-_____-______ Employer________________________

Address (if different than patients)____

City______________ State __________ Zip_______________Phone (____) ________________

Ins. Company______________________________ ID#__________________________________

Group#____________________________ Effective Date of Insurance ______/_______/_______

Secondary:

Cardholder's Full Name: First_______________________ Last ___________________________

Date of Birth____/____/____ SSN_____-_____-______ Employer ________________________

Address (if different than patients)____

City______________ State __________ Zip_______________ Phone (____) ________________

Ins. Company______________________________ ID#__________________________________

Group#_____________________________ Effective Date of Insurance______/_______/_______

With you every step of the way!

Patient’s Name: ____________________________________ Today’s Date: _________________

Date of Birth: ____/____/____

I (We) authorize the following people to **bring my child in for, and consent to, treatment, or receive medical advice over the phone if they are taking care of my child in my absence.**

Name: ____ Date of Birth ____/____/____

Relationship: _________________________________ Phone (____) ________________________

Name: ____ Date of Birth ____/____/____

Relationship: _________________________________ Phone (____) ________________________

Name: ____ Date of Birth ____/____/____

Relationship: _________________________________ Phone (____) ________________________

☐ My Child is 16 years of age or older, and has my permission to seek medical care without a parent or guardian present. I understand that the details of the visit will remain private or confidential between patient and provider, unless patient is at risk for harm.

_____ Parent/Guardian Initials

Privacy Policy

I have received a copy of the Welcome Letter, Financial Policy, HIPAA, and Portal information. I hereby authorize Shelby Pediatrics, LLC to furnish information to insurance carriers concerning illness and/or treatment. I understand that I am responsible for any amount not covered by insurance, including copay and deductibles.

Signature: ____ Date: ______________________

Print Name: ___________________________________ Relationship: _______________________

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Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2) Co-payments are due at the time of service.

3) Self-pay patients are expected to pay for 50% at the time of service. If you wish to pay in full at the time of service, there with be a 30% discount.

4) If we do not participate in your insurance plan, you will be responsible for all charges for services rendered.

5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Balance is due 10 days after receiving the bill.

6) Any balance outstanding longer than 90 days will be forwarded to a collection agency.

7) For scheduled appointments, prior balances must be paid prior to the visit.

8) We accept cash, checks, Visa, MasterCard, American Express, and Discover.

(9) A $30 fee will be charged for any checks returned for insufficient funds.

Signature of Patient or Guardian: ___________________________________ Date: __________

Print Name: ______________________________ Relationship: __________________________

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Medical Release Form

Patient Name: ____ Birthdate: _____________________

Street Address: ____

City: _________________________________ State: _______________ Zip Code: _______________

Person filling out form (print name): ____________________________ Relationship:________________

I Hereby Authorize: **To Release to:**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Purpose for Request (Check all that applies)

Change of Physician Insurance Continuity of Care HIV Personal Other: _____________

Information to Release:

All Clinical Records Progress Note Lab Reports Immunizations Other: _____________

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I release Shelby Pediatrics, LLC from all legal responsibility or liability that may arise from authorized release of information.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, we must have permission by parent/guardian.
- Shelby Pediatrics, LLC will not transfer this information without permission, unless the law authorizes or compels us to do so.
- This authorization will include the release of information concerning HIV testing or treatment of AIDS, Aids related conditions, drugs, or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric or psychological conditions.

Signature of Patient or Guardian: ____ Date: ___________

Print name of Patient or Guardian: ____

With you every step of the way!

Child's Name: ____ Date of Birth: _____________________

Social History

Is the child yours by _____birth_______adoption_______stepchild______other_________

Number of persons who lives in the household_________number of siblings___________

Alcohol intake ____

Animal Exposure ____

Bike Helmets____

Blind or serious difficulty seeing____

Bully/Being bullied? ____

Caffeine intake____

Changes in family/social situation? ____

Tobacco use____________Do any household members use tobacco________________________

Childcare____

Deaf or serious difficulty hearing____

Exercise? How much? ____

School Name? Grade? ____

Seat Belt/care seat____

Siblings____

Smoke alarm/CO detectors in home____

Surgical History

Please list all surgeries____

____

____

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

____

____

____

With you every step of the way!

Child's Name: ____ Date of Birth: _____________________

Medical History
Please circle all that apply

ADD/ADHD
Allergies
If yes to what____________________
Anemia
Anxiety Disorder
Asthma
Bedwetting
Bladder or kidney problems
Blood Diseases
Cancer
Chicken Pox
Chronic Ear Infections
Congenital Anomalies
Constipation
Depression

Autism Spectrum Disorder
Developmental or Behavioral Disorder
Diabetes
Difficulty Swallowing
Ear or Hearing Problems
Head Injury/Concussion
Heart Problems
Hospital Admission Other Than Birth
Mental Illness
Muscle, Joint or Bone Problems
Seizures/epilepsy
Skin Problems
Thyroid Problems
Vision or Eye Problems
Other________________________________

Family History
Check all disease that apply.

- ☐ Allergy — Family Member________________________________
- ☐ Anemia — Family Member________________________________
- ☐ Anxiety Disorder — Family Member________________________________
- ☐ Asthma — Family Member________________________________
- ☐ Blood Disorder — Family Member________________________________
- ☐ Depressive disorder — Family Member________________________________
- ☐ Developmental — Family Member________________________________
- ☐ Diabetes — Family Member________________________________
- ☐ Liver Disease — Family Member________________________________
- ☐ Disorder of Thyroid gland — Family Member________________________________
- ☐ Heart Disease — Family Member________________________________
- ☐ High Cholesterol — Family Member________________________________
- ☐ Hypertensive disorder — Family Member________________________________
- ☐ Immunodeficiency disorder — Family Member________________________________
- ☐ Kidney disease — Family Member________________________________
- ☐ Malignant neoplastic disease — Family Member________________________________
- ☐ Mental disorder — Family Member________________________________
- ☐ Migraine — Family Member________________________________
- ☐ Seizures — Family Member________________________________
- ☐ Substance abuse — Family Member________________________________
- ☐ Tuberculosis — Family Member________________________________
- ☐ Other, please list _____________________ — Family Member________________________________

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