PEDIATRIC NEW PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____State:_____Zip Code:_____Email: _____

Date of Birth:_____/_____/_____ Sex: ◯Male ◯Female SS # (optional): _____

Main Contact:

Parent/Guardian Name: _____ D.O.B____/____/____ Relationship:_____

Occupation:_____ Home Phone #:_____ Work Phone #:_____

Parent/Guardian Name: _____ D.O.B____/____/____ Relationship:_____

Occupation:_____ Home Phone #:_____Work Phone #: _____

◯Divorced ◯Separated

Are there any special custody arrangements we should be aware of ? ◯Yes ◯No

If Yes, please describe: _____

_____

Siblings: _____DOB:_____ /_____/_____ Other Siblings:_____DOB:_____/_____/_____

Living Arrangements: _____

Emergency Contact:_____Relationship:_____Phone #: _____

Referring Physician:_____Phone #: _____

OTHER PATIENT INFORMATION

Which racial category does the patient most closely identify with?

◯African American ◯Asian ◯Caucasian ◯Hispanic

◯Native American ◯Native Hawaiian ◯Pacific Islander ◯Other:_____(Please Specify)

Ethnicity: What is the patient's ethnicity? ◯Hispanic or Latino ◯Not Hispanic or Latino

What is the patient's language of preference? ◯English ◯Spanish ◯Other:_____(Please Specify)

PEDIATRIC NEW PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____/_____/_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID # _____

Name of Policy Holder:_____ DOB:_____/_____/_____ Group/Acct #:_____

Employer:_____ Employer Address: _____

City: _____ State: _____ Zip Code:_____ Work #: _____

Secondary Insurance:_____ Policy/ID #: _____

Name of Policy Holder:_____ DOB:_____/_____/_____ Group/Acct #:_____

Employer:_____ Employer Address: _____

City: _____ State: _____ Zip Code:_____ Work #: _____

GENERAL CONSENT FORM

Patient Name:_____ **Date of Birth:**_____/_____/_____

Assignment of Benefits. I authorize CORNERSTONE CHILDREN'S CLINIC, LLC to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that CORNERSTONE CHILDREN'S CLINIC, LLC. will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Consent for Treatment. I, as the patient or authorized representative of the patient, hereby grant consent for CORNERSTONE CHILDREN'S CLINIC, LLC. to provide all medical, preventative or behavioral treatments, tests and/or diagnostic tests to treat myself/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantees have been made to me by the clinic or healthcare provider as to the results of healthcare services including diagnosing, examinations, or treatments in any clinic or hospital, or other healthcare organization.

Electronic Prescription. I understand CORNERSTONE CHILDREN'S CLINIC, LLC. utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize CORNERSTONE CHILDREN'S CLINIC, LLC., its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize CORNERSTONE CHILDREN'S CLINIC, LLC. to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs.

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #:_____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not Do not leave message.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

GENERAL CONSENT FORM (continued)

Medication Management

The undersigned, as a patient or authorized representative of a patient, understand and agree that Advanced Practice Registered Nurses (APRNs) do not treat chronic pain or obesity. I understand that as part of regular practice, my healthcare provider will review the Louisiana Prescription Monitoring Program to ensure that healthcare services are provided prudently. I also understand that some providers may choose to not write/prescribe controlled or scheduled medications and that I must abide by that decision while remaining a patient at this clinic. In addd1on, I understand and agree that should my healthcare provider choose, in his or her sole professional judgment within his or her scope of practice, licenses, and/or collaborative practice agreement, to prescribe controlled or scheduled medications that I will be subject to drug screens, with or without notice, to ensure that I am taking the medication as directed and that I am taking no other narcotic medication or illicit substance. I understand and agree that should my drug screen provide results that indicate I am not taking the medication as prescribed or in a manner that is contraindicated and my adversely affect my health, that the healthcare provider may not write any other scheduled medications to me in the future and that I could also be caused to be discharged from the clinic and the healthcare provider's practice.

Healthcare Provider

The undersigned, as a patient or authorized representative of a patient, hereby understands, and agrees that healthcare services may be provided by an Advanced Practice Registered Nurse (APRN), Registered Nurse (RN), Licensed Clinical Social Worker (LCSW), or a Physician. Also, I understand that the APRN has a collaborating physician who may or may not be at the clinic, and I am a patient of the APRN and this clinic, and not the patient of the collaborating physician. Further, I understand that the collaborating physician works, owns or operates another clinic and that he or she may or may not be available to provide healthcare services and may or may not accept my insurance or payments

Notice of Privacy Practices

The undersigned, as a patient or authorized representative of a patient, hereby understands and agrees that as part of my healthcare, this organization utilizes health records describing my health history symptoms, examinations, test results, diagnoses, treatment, and any management for future treatment, in order for my healthcare provider to seek reimbursement as well as for various uses related to my healthcare provider's clinic administration. I consent to my provider using and disclosing my health information in connection with my treatment in order to get paid for healthcare related services provided to me and as necessary for clinic administration. I understand that medical Information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers who accept me for medical or institutional care. In addition, I understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, agents, including, but not limited to payment, utilization review and quality assurance review, and to support applications for patient assistance.

Minor Patient Photograph (when applicable)

I consent for CORNERSTONE CHILDREN'S CLINIC, LLC. to photograph the minor patient for identification and or documentation purposes.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

FINANCIAL POLICY

Patient Name:_____ Patient Date of Birth:_____/_____/_____

Please read prior to receiving services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.**
- I understand and agree that the clinic will submit these charges to my healthcare insurer and if these charges are not covered by my insurance it is still my personal obligation to pay any and all charges.
- I assign all rights and causes of action, including but not limited to the title to any cause or action or rights of the patient with respect to collection of insurance benefits under Louisiana law.
- I further authorize any and all insurers that I might have of whatsoever nature, form of description, to pay my healthcare provider, and/or clinic, any and all amounts that may be due me by the said insurer. I further authorize any and all insurance companies that I have, to pay directly my treating provider, and/or clinic, and its agents or or third-party providers, any benefits due and payable under the terms of any and all insurance policies that I might have that would be effective for coverage and/or benefits to me.
- All charges for treatment become due and payable thirty(30) days after the date of service. This periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 30 days, CORNERSTONE CHILDREN'S CLINIC, LLC. will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.**
  If your insurance plan requires a referral authorization from a primary care provider please present this at your initial visit. If you request an office visit without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient's responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **AUTOMOBILE ACCIDENT PATIENTS AND WORKERS COMPENSATION** We DO NOT deliver healthcare services for the direct purpose to engage in litigation (e.g. accident or injury evaluation and/or management, workers compensation, for the purposes of litigation) I understand that this does not mean that he clinic and/or healthcare provider will not provide emergency stabilization or healthcare services immediately following an accident injury, or other trauma, but that the clinic and/or healthcare provider will not provide healthcare services post-accident, injury or other trauma for the sole purpose for intent to engage in litigation.

- **Treatment of Minors**
  The undersigned, as a patient or authorized representative of a patient, understands and agrees that the parent or legal guardian must consent to the treatment of the child (for the purposes of this agreement a minor or child is defined as any person under the age of majority [17 or younger] in Louisiana) prior to the provision of healthcare services. The consent and authorization may be amended or revoked at any time by the parent or legal guardian.

- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of CORNERSTONE CHILDREN'S CLINIC, LLC..

- **Reproduction of Medical Records**
  The undersigned, as a patient or authorized representative of a patient, understands and agrees that upon each visit the patient has an opportunity to receive a printed summary of their visit, a copy of any diagnostic tests or procedures, and any diagnostic tests or procedures, and any pertinent health education. I also understand that there is certain information about my health and healthcare services received available online thru the patient portal. I agree and understand that should I, or other party I designate in writing on a properly executed Consent to Release Protected Health Information form to receive my medical record, want a printed copy of my entire medical record that I will be required to pay the Louisiana mandated medical record reproduction fees as described in RS 40·1299.96 "If the original treatment records are generated, maintained, or stored in paper form, copies shall be provided upon payment of a reasonable copying charge, not to exceed one dollar ($1.00) per page for the first twenty-five (25) pages, fifty cents ($.50) per page for twenty-six (26) to three hundred fifty (350) pages, and twenty-five cents ($.25) per page thereafter, a handling charge not to exceed twenty-five dollars ($25.00) for hospitals, nursing homes, and other health care providers, and actual postage". "If treatment records are generated, maintained, or stored in digital format, copies may be requested to be provided in digital format and charged at the rate provided by this item: however, the charges for providing digital copies shall not exceed one hundred dollars ($100.00), including all postage and handling charges actually incurred. If requested, the healthcare provider shall provide the requester, at no extra charge, a certification page setting forth the extent of the completeness of records on file."

FINANCIAL POLICY

- **SECONDARY INSURANCE:** The Louisiana Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage

- If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care provider is listed as your primary care provider with your insurance company, if required by your contract with your insurance company.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (985) 500-3500.

- We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

Patient Name: _____ DOB ____/____/____
First M.I. Last

☐ M ☐ F

REASON FOR VISIT TODAY: _____

_____

_____

ALLERGIES (Include medications, foods, x-ray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. List any additional information on back of sheet) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

FAMILY HISTORY – Is there a family history of:

Is there a family history of:	YES	NO	Relationship	Onset Age	Cause of Death?
ADD/ADHD	☐	☐			
Allergies	☐	☐			
Asthma	☐	☐			
Birth Defects	☐	☐			
Cancer	☐	☐			
Cardiovascular Disease	☐	☐			
Coronary Artery Disease	☐	☐			
Deafness	☐	☐			
Depression	☐	☐			
Developmental Delay	☐	☐			
Developmental Dislocation of Hip	☐	☐			
Diabetes	☐	☐			
Eczema	☐	☐			
Elevated Lipids / Cholesterol	☐	☐			
Eye Problems	☐	☐			

Is there a family history of:	YES	NO	Relationship	Onset Age	Cause of Death?
Genetic Disease	☐	☐			
Heart Attack - at less than 55	☐	☐			
Hemoglobinopathy/Sickle cell	☐	☐			
High Blood Pressure	☐	☐			
Kidney Disease	☐	☐			
Learning Disability	☐	☐			
Mental Disability	☐	☐			
Migraines	☐	☐			
Obesity/Overweight	☐	☐			
Scoliosis	☐	☐			
Seizure Disorder	☐	☐			
Stroke < 55	☐	☐			
Sudden Infant Death Syndrome	☐	☐			
Thyroid Disease	☐	☐			
Other:_____	☐	☐			

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____ DOB____/____/____
First M.I. Last

MEDICAL HISTORY

Please write an "X" next to the complaint(s) or ailment(s) that apply to the patient. If you are unsure, place a question mark (?)

Abdominal Pain	☐ Yes	☐ No	Overweight / Obesity	☐ Yes	☐ No	Seizure Disorder	☐ Yes	☐ No
Acne	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Sickle Cell	☐ Yes	☐ No
ADD/ADHD	☐ Yes	☐ No	Prematurity	☐ Yes	☐ No	Speech Delay	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Psychiatric / Mental Health Problems	☐ Yes	☐ No	Stomach Ache / GERD	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Pyelonephritis	☐ Yes	☐ No	Strabismus / Eye Problems	☐ Yes	☐ No
Allergic Rhinitis	☐ Yes	☐ No	Renal Disease / Kidney Problems	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No	Underweight	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Seizures, Febrile	☐ Yes	☐ No	Urinary Tract Infection	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No				Vision Problems	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No						
Cancer	☐ Yes	☐ No						
Cadiovascular Disease	☐ Yes	☐ No						
Chickenpox	☐ Yes	☐ No						
Congenital Heart Disease	☐ Yes	☐ No						
Concussion	☐ Yes	☐ No						
Constipation	☐ Yes	☐ No						
Coronary Artery Disease	☐ Yes	☐ No						
Deafness	☐ Yes	☐ No						
Depression	☐ Yes	☐ No						
Developmental Delay	☐ Yes	☐ No						
Developmental Dislocation of Hip	☐ Yes	☐ No						
Diabetes	☐ Yes	☐ No						
Eating Disorder	☐ Yes	☐ No						
Eczema	☐ Yes	☐ No						
Elevated Lipids / Cholesterol Disease	☐ Yes	☐ No						
Fainting	☐ Yes	☐ No						
Food Allergy	☐ Yes	☐ No						
Fracture	☐ Yes	☐ No						
Genetic Disorder	☐ Yes	☐ No						
Growth / Weight Problems	☐ Yes	☐ No						
Headaches	☐ Yes	☐ No						
Head Injury	☐ Yes	☐ No						
Hearing Problems	☐ Yes	☐ No						
Heart Murmur	☐ Yes	☐ No						
History of Wheezing	☐ Yes	☐ No						
High Blood Pressure	☐ Yes	☐ No						
Inhaler/Neb Use	☐ Yes	☐ No						
Learning Disability	☐ Yes	☐ No						
Migraines	☐ Yes	☐ No						
Otitis Media, Recurrent	☐ Yes	☐ No						

Other?_____

BIRTH HISTORY

Place of birth: _____

Child's birth weight: ___lb.____oz.

Duration of pregnancy:_____

Mom's Age_____Dad's Age _____

Problems with pregnancy? ☐ Yes ☐ No

(if Yes please specify) _____

Prenatal care given? ☐ Yes ☐ No

(if Yes please specify) _____

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps / Vacuum

If C-Section, why? _____

Was baby breech? ☐ Yes ☐ No

Any medications/smoking during pregnancy? ☐ Yes ☐ No

(if Yes please specify) _____

Problems with labor/delivery? ☐ Yes ☐ No

(if Yes please specify) _____

Length of stay in nursery:_____

Any nursery complications? ☐ Yes ☐ No

(if Yes please specify) _____

Birth Defects? ☐ Yes ☐ No

(if Yes please specify) _____

Child's discharge weight: ___lb.____oz.

Is the baby circumcised? ☐ Yes ☐ No

HepB given? ☐ Yes ☐ No Date_____

Passed Hearing Test? ☐ Yes ☐ No

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____DOB_____/____/_____
First M.I. Last

ADOLESCENT HISTORY

OB/GYN HISTORY (females only)

Has your period started? ☐ Yes ☐ No Last Menstrual cycle:_____duration (days)____No. of Pregnancies:_____No. of Deliveries: _____

TOBACCO HISTORY

Is child an active cigarette smoker? ☐ Yes ☐ No

Has child ever been a cigarette smoker? ☐ Yes ☐ No *If Yes, smoked average of_____packs/day for_____years. Quit in_____(yr)

Does child use other tobacco products? ☐ Yes ☐ No *If yes, please specify _____

Does anyone smoke inside/outside house? ☐ Yes ☐ No

ALCOHOL AND DRUG HISTORY

Has child ever been diagnosed with alcoholism? ☐ Yes ☐ No Does child currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Has child ever used: Alcohol ☐ Yes ☐ No Marijuana ☐ Yes ☐ No Recreational drugs ☐ Yes ☐ No

Metabolic Steroids ☐ Yes ☐ No Abused prescription drugs ☐ Yes ☐ No

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Signature_____ Date_____
Patient/Legal Representative

_____ Date_____
Relationship to Patient

_____ Date_____
Witness

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO CORNERSTONE CHILDREN'S CLINIC, LLC.

Name of Patient:_____ D.O.B._____ Age:_____
LAST FIRST M.I.

I,_____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to CORNERSTONE CHILDREN'S CLINIC, LLC.

Address: 44546 South Airport Rd., Ste F ☐
Hammond, LA 70403

Phone: (985) 500-3500

Fax: (985) 500-3600

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. CORNERSTONE CHILDREN'S CLINIC, LLC. Physician Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient

_____
Witness Signature