HINTON HEALTHCARE GROUP

NEW PEDIATRIC PATIENT INFORMATION FORM

(The information provided is strictly confidential)

PATIENT INFORMATION

Childs First Name: ______________________________ Childs Last Name: _______________________________

Date of Birth: ___________________ Gender: ____________________ Ethnicity: ____________________

Address: ____ APT #: ____________ City: ________________

State: _____________ Zip: __________________ Social Security #: _________________________

Is child in foster care N / Y **If yes, is it temporary or permanent** ___________________ (paperwork is needed)

With whom does this child live with primarily: ☐Both parents ☐ Mother ☐ Father ☐ Other Relatives ☐Foster Home ☐Guardian(s)

PARENT/GUARDIAN INFORMATION

Name: ____

Relationship: __________________________________

DOB: ___________________ SSN: _________________

Address: _____________________________________

APT #: ___________City: ______________________

State: ___________ Zip: ______________________

Phone: _______________________________________

Voicemail

☐ May leave Detailed Voice Message

☐ Call Back Number Only

Email: _______________________________________

Name: ____

Relationship: _________________________________

DOB:_________________ SSN:___________________

Address: _____________________________________

APT #: _________ City: _________________________

State: ____________ Zip: ______________________

Phone: _______________________________________

Voicemail

☐ May Leave Detailed Voice Message

☐ Call Back Number Only

Email: ____

INSURANCE INFORMATION

Primary Insurance: _____________________________________ Policy Holder: _________________________

Relationship to Patient: ____________________ D.O.B: _________________ S.S: ________________________

Secondary Insurance: ___________________________________ Policy Holder: _________________________

Relationship to patient: ___________________ D.O.B: __________________ S.S: ________________________

I authorize my family insurance benefits to be paid directly to Hinton Healthcare Group. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information above.

____ ______________________

Signature of Patient/Guardian **Date**

Child's Past Medical History

Has your child ever been treated for or diagnosed with: (explain)

Allergies: ______ ADHD: ______ Anemia: ______

Asthma: ______ Autism: ______ Cancer: ______

Constipation: ______ Diabetes: ______ Depression: ______

Ear Infections: ______ Eczema: ______ Fractures: ______

Food Allergies: ______ Heart Problems: ______ Hearing Issues: ______

Mental Illness: ______ Migraine Headaches: ______ Obesity: ______

Orthopedic Issues: ______ RSV: ______ Seizures: ______

Strep Throat: ______ Sinus Infections: ______ Speech Delay: ______

Urinary Tract Infections: ______ Vision Issue: ______ Wheezing: ______

Other chronic medical conditions: ______

Has your child had any surgeries or procedures: No / Yes (explain) ______

______

Is your child in counseling currently or previously: No / Yes (explain) ______

______

Does your child receive therapies of any kind? ______

Current Medications: ______

Social History/Preventative Care

Do any household members use tobacco products: (cigarettes, vape, chewing tobacco, etc) N / Y

Any recent family changes or stress: ______

Do you have any concerns about your child? ______

Has your child seen a dentist in the past year? N / Y Has your child had a vision screen in the past year? N / Y

Has your child had a hearing screen in the past year? N / Y Is your child up to date on immunizations? N / Y

Family History

If any blood relative has had any of the following, please list who

ADHD: ______ Allergies: ______ Anemia: ______

Asthma: ______ Anxiety: ______ Bleeding Tendency: ______

Cancer: ______ Chronic Lung Disease: ______ Depression: ______

Diabetes: ______ Drug/Alcohol Problem: ______ Epilepsy: ______

Glaucoma: ______ Hearing Issues: ______ Heart Disease: ______

High Blood Pressure: ______ High Cholesterol: ______ Kidney Disease: ______

Mental Illness: ______ Migraine Headaches: ______ Obesity: ______

Pneumonia: ______ Stroke: ______ Thyroid Disease: ______

Tuberculosis: ______ Ulcers: ______ Vision Issues: ______

Please list other family history if not listed above: ______

Siblings

Name: ______________________________ DOB: ______________

Name: ______________________________ DOB: ______________

Name: ______________________________ DOB: ______________

EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)

Name: __________________ Number: ______________ Relationship: __________

Name: __________________ Number: ______________ Relationship: __________

HIPPA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Person(s) who we may discuss your health information with

(Please be aware that you are authorizing Hinton Healthcare Group to discuss any of your child (s) health information with the person(s) listed below, and that if at any time those persons(s) listed should change it is your responsibility to inform Hinton Healthcare Group.)

Name: __________________ Number: ______________ Relationship: __________

Name: __________________ Number: ______________ Relationship: __________

Assignment of Medical Benefits, Consent to Treat and Authorization to Release Information

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations.

FINANCIAL POLICY: Hinton Healthcare Group is committed to providing your child with the best possible primary care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. Payment for all services provided by the practice is due in full at the time the services are rendered. If you have private insurance, we will file your visit. Your full copayment is expected per visit. You will be billed in full for any services that your insurance plan deems to be a noncovered service or any balances due after we have received payment from your insurance carrier. All patient balances are payable upon receipt of the statement.

We accept Cash, debit & credit cards (Visa, MasterCard, AMEX, and Discover Card) as payment for services rendered. Refunds will be handled as a credit to the patient's account or issued a check. Hinton Healthcare Group reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. You will be responsible for all collections related fees which may represent 1/3 of the balance due.

______________________________ ______________________

Signature of Patient/Guardian **Date**

HINTON HEALTHCARE GROUP

Provider Policies and Expectations

Regular Office Hours: Hinton Healthcare Group hours vary from each location. All locations are closed from 12:00 p.m. to 1:00 p.m. for lunch. All physician visits are by appointment only.

Insurance Billing: Hinton Healthcare Group accepts most major insurance policies. It is the patient's responsibility to check if our doctors are covered by your specific insurance plan. If one of our providers is not listed or covered, we are still able to see you out of network. Patients will be responsible for balance due. We do accept self-pay for patients with no medical insurance.

Medical Records and Confidentiality: Your medical records are confidential and require your written authorization before they can be released to other health care providers or other approved recipients. Medical records will be completed within 30 days from the date they are requested.

Appointment Cancellations and Late Policy: Hinton Healthcare Group has a "No Call, No Show and Cancellation Policy". We require a 24-hour cancellation notice for all appointments, failing to do so may result in a fee of $25.00. Please be aware that if you are more than 15 minutes late you may be asked to reschedule.

Protected Health Information: "Protected Health Information" (PHI) is information that identifies you and relates to your identify and your past, present or future medical history. It includes your medical records and personal information such as your name, social security number, address, and phone number.

Family and Medical Leave Act: The family and medical leave act (FMLA) paperwork will be an additional charge of $25.00 and will take up to 7 business days to complete. All FMLA paperwork will require a visit with a provider prior to completing the form.

Patient Fusion: All patients are automatically enrolled into our patient fusion program if an email is provided. Along with our appointment reminder/follow up text if a mobile number is given.

By my signature, I acknowledge that I understand my rights as a patient concerning my protective health information. I authorize Hinton Healthcare Group to perform the necessary health care services I/My child may need.

Patient/Guardian Name (Print): ______________________________

______________________________ ______________________________

Signature of Patient/Guardian **Date**