NW CYPRESS
PEDIATRICS AND FAMILY MEDICINE

11240 FM 1960 West, Ste 210
Houston TX 77065
Phone: 281-469-7400
Toll Free: 1-877-563-0817
Fax: 281-469-7403

NEW PEDIATRIC PATIENT HISTORY INTAKE

To our new patients: *Welcome* to NW Pediatrics and Family Medicine, PLLC. To help us establish you with our practice, please provide us with your complete health history: body, mind and spirit.

Personal History

Name *(preferred)* : _____

Name *(legal)* : _____Date of Birth ___/____/_____ Age: ___

Home Address: _____City_____ State____Zip Code_____

Telephone: Home (___)_____ Cell (___)_____

What is your ethnic race?: ☐ White/Caucasian ☐ Black/African American ☐ Asian/Pacific Islander
☐ Hispanic/Latino ☐ Native American ☐ Other _____

Child's School _____ Birthplace_____

Who does the child live with?_____

Under whose policy is the child insured? _____

Employer of the insurance policy holder: _____

Name of Legal Guardian:_____ Relationship:_____

Telephone: Home (___)_____ Cell (___)_____

Email Address:_____ Occupation:_____

Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Mother's Name:_____ Date of Birth ___/____/_____ Age: ____

Telephone: Home (___)_____ Cell (___)_____

Email Address:_____ Occupation:_____

Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Father's Name:_____ Date of Birth ___/____/_____ Age: ____

Telephone: Home (___)_____ Cell (___)_____

Email Address:_____ Occupation:_____

Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Date of Last Examination_____

Child's Previous Pediatrician: _____ Tel: (___)_____

Referred by:_____

ALLERGIES (DRUG OR FOOD):	**Reaction(s)**

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____

Current Medications	Dose	Times / Day
Current Herbs / Vitamins/ Supplements	**Dose**	**Times / Day**

PAST MEDICAL, SURGICAL & TRAUMA HISTORY
PERSONAL AND FAMILY HISTORY

Birth History:

Mothers age at birth: _____ Complications during pregnancy? ☐ NO ☐ YES

if 'yes", complications were: _____

Birth weight: _____ ☐ Bottle Fed ☐ Breast Fed

Complications during/after birth? ☐ NO ☐ YES

if 'yes", complications were: _____

Was the baby full term?: ☐ NO ☐ YES Delivery: ☐ Vaginal ☐ C-Section

Birth Hospital (for newborns only): _____

Past Medical History: Please check the medical problems pertaining to your child:

☐ Recurrent ear infections
☐ Recurrent sore throat
☐ Asthma
☐ Heart murmur
☐ Seizures
☐ Eczema
☐ ADHD/ADD
☐ Autism Spectrum
☐ Allergies
☐ Diabetes
☐ Down Syndrome

Shot record brought today to the clinic?: ☐ NO ☐ YES Shots up to date?: ☐ NO ☐ YES

Ever seen a specialist?: ☐ NO ☐ YES If "yes" for what? _____

_____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior illness, injury, hospitalization, surgery, and/or trauma:

Condition	Date(s)

Last Dental Visit:_____

Any additional important health history:

_____

_____

_____

_____

Social History:

Who does the child live with?_____

Anyone smoke at home? ☐ NO ☐ YES If yes who smokes in the child's home? _____

Any pets? ☐ NO ☐ YES If “yes' what type of animals?_____

Where does the child reside during the day?_____ Daycare?: ☐ NO ☐ YES

How many hours does your child sleep in a day?_____

Water supply at home: ☐ City/Municipal ☐ Well

Are there any problems with your home?_____

What year was the home or apartment built?_____Paint chipping on the wall? ☐ NO ☐ YES

Any recent travel? ☐ NO ☐ YES If “yes” when/where: _____

Language spoken at home: _____

Child's current grade level at school: _____ Any failed grades? ☐ NO ☐ YES

Problems in school? ☐ NO ☐ YES If yes problems are: _____

Has your child been exposed to anyone who has been recently incarcerated, or had Tuberculosis?

☐ NO ☐ YES If yes please explain: _____

_____

_____

Does your child smoke?	☐ NO ☐ YES	Use drugs?	☐ NO ☐ YES
Drink alcohol?	☐ NO ☐ YES	Have history of depression?	☐ NO ☐ YES
Drink caffeine?	☐ NO ☐ YES	Suicide attempts?	☐ NO ☐ YES

Diet:

What type of milk does your child drink? ☐ Whole ☐ 2% ☐ Skim ☐ Formula (type) _____

How much milk is typically consumed in 24 hours?_____

How many ounces of juice or soda does your child drink per day? _____

Does your child eat non-food materials (dirt/paper, etc)? ☐ NO ☐ YES If yes they are: _____

_____

Any concerns about your child’s diet? ☐ NO ☐ YES If yes they are: _____

_____

Safety:

Do you have a smoke detector? ☐ NO ☐ YES What is your water heater temperature? _____

Is your home child proof? ☐ NO ☐ YES

Any guns in the house? ☐ NO ☐ YES

Any swimming pools in the house? ☐ NO ☐ YES

What child-accessible medications do you have in your medicine cabinet? _____

_____

Family History:

Does the child's mother or father have any medical problems? ☐ NO ☐ YES

If yes, what problems?_____

_____

_____

List siblings:

Name _____ age: _____ ☐ male ☐ female

General health status: _____

Name _____ age: _____ ☐ male ☐ female

General health status: _____

Name _____ age: _____ ☐ male ☐ female

General health status: _____

Name _____ age: _____ ☐ male ☐ female

General health status: _____

Are there any deceased siblings?: ☐ NO ☐ YES If "yes" please explain:

_____

_____

Has any blood relative ever had the following:

Cancer, including Leukemia ☐ NO ☐ YES If "yes" who?: _____
Tuberculosis ☐ NO ☐ YES If "yes" who?: _____
Diabetes ☐ NO ☐ YES If "yes" who?: _____
Heart Trouble ☐ NO ☐ YES If "yes" who?: _____
Heart Attack ☐ NO ☐ YES If "yes" at what age?: _____
High Blood Pressure ☐ NO ☐ YES If "yes" who?: _____
Stroke ☐ NO ☐ YES If "yes" who?: _____
Epilepsy ☐ NO ☐ YES If "yes" who?: _____
Bleeding Disorder ☐ NO ☐ YES If "yes" who?: _____
Asthma ☐ NO ☐ YES If "yes" who?: _____
Allergies ☐ NO ☐ YES If "yes" who?: _____
Migraine Headaches ☐ NO ☐ YES If "yes" who?: _____
Alcoholism ☐ NO ☐ YES If "yes" who?: _____
Anemia ☐ NO ☐ YES If "yes" who?: _____
Mental Illness ☐ NO ☐ YES If "yes" who?: _____
Suicide ☐ NO ☐ YES If "yes" who?: _____
Birth Defects ☐ NO ☐ YES If "yes" who?: _____
Sudden Death ☐ NO ☐ YES If "yes" who/why?: _____
SIDS ☐ NO ☐ YES If "yes" who?: _____
HIV/AIDS ☐ NO ☐ YES If "yes" who?: _____
Other Serious Disease ☐ NO ☐ YES If "yes" who/what?: _____

_____

GROWTH & DEVELOPMENT

At what age did your child sit up alone? _____
At what age did your child start walking? _____
At what age did your child start talking? _____
How does your child compare to other children his/her age? _____

_____

EMERGENCY CONTACT: *(When guardian is unable to be reached)*			
NAME *(list 3 contacts)*		**PHONE**	**RELATIONSHIP**
1.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
2.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
3.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
Advance Directive: ☐ Full code *or* ☐ Do Not Resuscitate			

This history record has been designed to facilitate our patients continuity of care at **NW Pediatrics and Family Medicine, PLLC**. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

_____ _____

Physician Signature *Date Signed*

_____

Printed name of individual completing form

_____ _____

Signature of individual completing form *Date Completed*

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CONSENT TO MEDICAL CARE AND TREATMENT OF A MINOR

Clinics and hospitals are unable to treat or care for minors (children) without consent from parents or legal guardians. If a child has a medical emergency when parents or legal guardians are not readily available to provide consent, then problems can occur. Complete this form and leave it with the person who is responsible for your child in your absence. In case of a medical emergency, this form must be brought with the child to the clinic or hospital.

I, _____ (print name), the natural parent/legal guardian of _____ (print name), authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment and procedures are immediately necessary or advisable in the interest of my child's health and well-being.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the proposed treatment, its anticipated results, possible alternatives, and the risks, complications, and anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

Provided that proper photo identification and this written notice is presented, the following individual(s) are authorized to bring the aforementioned minor child to clinic visits.

Authorized individual(s)	Relationship to Minor	Phone Number

Signature of Parent/Legal Guardian: _____

Witness: _____

Date: _____ Termination Date: _____

INFORMATION ON THE MINOR

Minor's Name: _____

Date of Birth: _____

Allergies and Drug Reactions:

_____

_____

Chronic Illnesses:_____

Regular Medications: _____

_____

Blood type: _____

Date of Last Tetanus Immunization: _____

Other Pertinent Information: _____

_____

_____

_____

CONTACT INFORMATION

Child's Physician: _____

Physician's Phone Number: _____

Parent/Guardian Address: _____

Parent/Guardian Home Phone Number: _____

Parent/Guardian Work Phone Number: _____

INSURANCE INFORMATION

Insurance Name: _____

Claims Address: _____

_____

Tel. No. _____

Membership Number:_____

Subscriber ID: _____

Subscriber name: _____

Subscriber SSN: _____

Subscriber DOB ____/_____/_____

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YOUR HEALTH INFORMATION PRIVACY PRACTICES

The Federal Health Insurance Portability and Accountability Act (HIPAA) laws are written to protect the confidentiality of your Health Information. The following notice details the policies and procedures that are used to ensure that your Health Information is not shared with anyone who does not require it. It also describes your rights to access and control your Health Information. “Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health services.

We will use and communicate your Health Information only for the purposes of providing treatment, obtaining payment and conducting health care operations. Your Health Information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your Health Information may be used:

To Provide Treatment

We will use your Health Information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between your provider, nurses, medical technicians and business office staff. In addition we may share your Health Information with other providers, referring providers, clinical and imaging laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

Your Health Information may be used with an invoice to collect payment for treatment that you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will only work with companies with a similar commitment to the security of your Health Information.

To Conduct Health Care Operations

We may use or disclose, as needed, your Health Information in order to support the business activities of this practice. These activities include, but are not limited to, quality assessment activities, employee performance evaluations, training for medical students, licensing, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk for you to write your name and indicate the nature of your visit. We may call your name in the waiting room when your provider is ready to see you. We may use or disclose your Health Information, as necessary, to contact you to remind you of your appointment.

Disclosure of Your Health Information

We may use or disclose your Health Information in the following situations without your authorization. These situations include:

- **Abuse, neglect, or domestic violence** — Government authorities will be notified only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with your agreement.
- **Public health and national security** — Federal officials or military authorities may require your Health Information to complete an investigation related to public health or to national security. Health Information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

- **For Law Enforcement—**As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limiting circumstances, if you are a victim of a crime or in order to report a crime.
- **Family, Friends and Caregivers—**With your permission, we may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. In an emergency when you are unable to tell us what you want, we will use our best judgment when sharing your Health Information only when it will be important to those participating in providing your care.

Other than stated above, or where Federal, State, or Local law requires us, we will not disclose your Health Information other than with your written authorization. You may revoke that authorization at any time, except to the extent that your provider or the provider's practice has taken an action on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your Health Information:

- **Restrictions—**You have the right to request a restriction of your Health Information. Your request must state the specific part of your Health Information to be restricted and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request, particularly if your provider believes that it is in your best interest to permit use and disclosure of your Health Information.
- **Confidential Communications—**You have the right to request to receive confidential communication from us be alternative means or at an alternative location; for example, through sealed mail, or with no family members present. We will make every effort to honor your reasonable requests for confidential communications.
- **Inspect and Copy Your Health Information—**You have the right to inspect and copy your Health Information, including your complete chart, imaging records and billing records. Under Federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation, or use in, a civil, criminal, or administrative action or proceeding, and Health Information that is subject to law that prohibits access to Health Information. Let us know if you would like a copy of your Health Information. There may be a reasonable fee to duplicate and assemble your copy.
- **Amend Your Health Information—**You have the right to ask us to amend your records if you believe your Health Information records are incorrect or incomplete. We will be happy to accommodate you as long as our office created and maintains this information. Please provide your request in writing and describe your reason for the change. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Documentation of Health Information—**You have the right to ask us for a description of how and where your Health Information was used by our office for any reason other than for treatment, payment or health operations. Please let us know in writing the period for which you are interested. There may be a reasonable fee for your request.
- **Request a Paper Copy of this Notice—**You have the right to obtain a copy of this notice of Health Information Privacy Practices.

We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of the notice and will inform you by mail of any changes.

You have the right to complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. Please let us know of your concerns or complaints in writing. We will not retaliate against you for filing a complaint.

Patient Acknowledgment

Printed name of patient or authorized person:_____

Signature of patient or authorized person: _____ Date: _____/_____/_____

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Written Acknowledgment of Receipt of NW Cypress Pediatrics and Family Medicine, PLLC

CONSENT AND NOTICE OF PRIVACY PRACTICES

☐ I acknowledge receiving the NW Cypress Pediatrics and Family Medicine, PLLC (referred to the clinic), **Notice of Privacy Practices** (referred to as "Notice" or "NPP"). The Notice explains how the clinic may use and disclose your protected health information for treatment, payment and health care operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

☐ I have read and understood the NPP and declined to receive a paper copy of the NPP.

General Consent to Treat

☐ I am the patient or parent/guardian of (_____). I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that the clinic and its physicians, associates or assistants believe are necessary for this patient. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers at NW Cypress Pediatrics and Family Medicine, PLLC to provide treatment to this patient as long as he or she is a patient in this office, or until I withdraw my consent.

☐ I have read the form and received the Notice of Privacy Practices has been read to me and/or provided to me in a language that I understand, and I have had an opportunity to ask questions about the NPP.

Electronic Medical Records and Electronic Prescriptions

☐ I voluntarily authorize NW Cypress Pediatrics and Family Medicine, PLLC to allow E-Prescribing for the patient's mail order prescription, which allows the health care providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent. I also allow release of ethnicity for purposes of electronic records tracking.

_____ _____
Name of Patient DOB: (Date of Birth)

_____ _____
Name of Patient's Representative (Printed) Relationship to Patient

_____ _____
Signature of Patient or Patient's Representative Date

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OFFICE POLICY

For All Visits

Please do not forget to:

- Bring a current immunization record and all relevant medical information
- Bring a copy of your current valid insurance card.
- Ensure the doctor listed as your PCP (for HMO, CHIPS or Medicaid) is a NW Cypress Pediatrics and Family Medicine, PLLC doctor.
- Arrive 15 minutes prior to your appointment and come 20 minutes prior to your appointment if your insurance or demographic information has changed.

Initial Visits

In order to save you time during your initial visit, please complete our patient forms on our website, **www.nwcypressmd.com**. You can print and return the copy via email, **info@nwcypressmd.com**, fax (281) 469-7403, or regular mail. You may also make an account on the Patient Portal link and input all of your information directly onto our electronic medical records. Additionally, you may request these forms to be email or faxed to you. If you are unable to fill out the forms before you arrive at our office, please come thirty minutes prior to your appointment so that you will have ample time to complete these forms.

Sick Visits

Please contact our office as soon as you feel your child needs to be evaluated. Please call early in the day so that we can give you the appropriate advice. We can see sick patients on the same day the appointment is made.

No Shows and Tardiness

We strive to offer excellent service to our patients in a timely manner. It is unfair to others if you do not show up for your appointment, come late or walk in without calling first. If you have an appointment and cannot make it, please contact us to either cancel or re-schedule your appointment 24 hours in advance. There will be a $25.00 charge if you fail to do so. If you know you will be at least 15 minutes late for your scheduled appointment, please call us as soon as possible, so we may adjust our schedules appropriately.

Medical Services: After Hours

- **Emergencies**
  - In the event of an emergency, dial 911.
  - If you suspect your child has swallowed medicine or poison, dial Poison Control at 1-800-222-1222.
- **Urgent Questions**
  - After hours, please refer to the medical advice link on our website. If you need further assistance, please call our office. Please do not call the doctor on call for refills on prescriptions. Please leave refill requests during regular office hours.
- **Non Urgent Questions**

If you have a non urgent question, please call (281) 469-7400. Leave your name, telephone number, time of your call, and question and we will return your call on the next business day.

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PAYMENT POLICY

Thank you for choosing NW Cypress Pediatrics and Family Medicine, PLLC. We are committed to providing you with quality and affordable health care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

1. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
2. Non-covered services. Please be aware that some – and perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.
3. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance at each visit. Often this verification requires us to share the reason for your visit with your managed care plan.
4. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.
5. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
We do not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance. You are responsible for timely payment of your account.

_____INITIAL

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with us, it is your responsibility to make sure the patient is currently under contract with your managed care plan.

Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan.

I have read and understand that I am personally responsible for payment on this account.

Assignment: I hereby authorize payment directly to NW Cypress Pediatrics and Family Medicine, PLLC. Any changes in this authorization must be received in writing within 30 days of the effective date.

I understand that this practice has a no show appointment fee of $25 dollars. I am responsible for paying the fee if I do not cancel an appointment with 24 hours notice.

In the event my insurance company deems a service to be “non-covered” I understand that I am personally responsible for payment.

I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature: _____ **Date:** ____/____/_____

Print Name: _____**Guarantor Date of Birth:** ____/____/_____

Relationship to Patient: _____

PATIENT(S) NAME: _____ **Date of Birth:** ____/_____/_____