PLEASE FILL OUT THIS FORM COMPLETELY. Thank You.

Date this form is being completed: / /					
Last Name		**First Name**		**Middle Initial**	
Date Of Birth		**Sex**		**Home Phone**	
Street Address		**City, State & Zip**			

PARENT/GUARDIAN # 1 *Please note if "same" as patient's info above

Full Name			
Relation To Patient			
Date Of Birth	/ /	Social Security Number	- -
Home Street Address *			
City, State & Zip *			
Home Phone Number *	( )		
Cell Number	( )	Work Number	( )
E-Mail Address	@		
Name of Employer		Occupation	
Active Military?		Is the patient living with this parent/guardian?	

PARENT/GUARDIAN # 2 *Please note if "same" as patient's info above

Full Name			
Relation To Patient			
Date Of Birth	/ /	Social Security Number	- -
Home Street Address *			
City, State & Zip *			
Home Phone Number *	( )		
Cell Number	( )	Work Number	( )
E-Mail Address	@		
Name of Employer		Occupation	
Active Military?		Is the patient living with this parent/guardian?	

SIBLINGS

Full Name	Sex	Date Of Birth	Patient Of Pedi-Care?
	M F	/ /	
	M F	/ /	
	M F	/ /	
	M F	/ /	
	M F	/ /	

EMERGENCY CONTACT – Please list an individual living locally (*other than parents/guardians*)

Full Name	Relation To Patient	Phone Number	City Of Residence
		( )	

SOCIAL INFORMATION / HISTORY

Which pharmacy do you primarily use?	**Pharmacy:** **Town/Street:**
Religious/Personal Beliefs (*optional*)	
Living Situation (child lives with...)	
Smokers in home	
Pets	
Who referred you to Pedi-Care?	

Name: , **Date Of Birth:**

BIRTH HISTORY

Hospital Name	
Name of Doctor/Midwife that delivered baby	
Birth Weight	
Term or Premature? (weeks)	
Vaginal or Cesarean Birth?	
Pregnancy Complications	
Delivery Room/Nursery Complications	

FAMILY HISTORY (Please fill out / check all conditions present in each person or family)

Relation	Date Of Birth	Asthma /Allergies	High Blood Pressure	High Cholesterol	Heart Disease	Diabetes	Cancer	Anemia	Developmental / Learning / Behavior Disorders	Other
Biological Mother										
Biological Father										
Siblings' Names	Date Of Birth									
Biological Mother's Family										
Biological Father's Family										

PATIENT'S HEALTH (Please indicate if "none" at this time)

Allergies		
Medication / Food / Other	Reaction	Date

Hospitalizations / Surgeries / Injuries	
Specify	Date

Current Problems / Medications	
Specify	Date Of Onset / Date Began

Name: ,	Date Of Birth:

PATIENT'S SIGNIFICANT PAST ILLNESS (Please circle all that apply)

Ears/Eyes/Nose/Throat	Respiratory	Genitourinary
Ear Infection Hearing Loss Eye Infection Visual Loss Eye Injury Nose Bleed Tonsillitis Large Tonsils / Adenoids Seasonal Allergies	Croup Epiglottitis Pneumonia Bronchitis Asthma	Urinary Tract Infection Genital Infection Vaginal Discharge Abnormal Menses
	Heart	**Extremities & Skin**
	Heart Murmur Abnormal Rhythm	Bone Infection Easy Bruising Skin Infection Joint Infection Arthritis
Neurological	**Digestive Tract**	**Other Childhood Infections**
Recurrent Headaches Seizures Recurrent Fainting Muscle Disease Cerebral Palsy Meningitis Learning / School Related Problems Behavior Concerns Emotional Difficulty Social Difficulty	Hepatitis Intestinal Infection Recurrent Vomiting Chronic Diarrhea Recurrent Abdominal Pain **Allergic** Food Allergies Anaphylaxis	Chicken Pox (DATE: ____/____/________) Mumps Measles Roseola Mononucleosis

*** * * * PLEASE COMPLETE ALL SECTIONS * * * ***

SECTION ONE – HIPAA (Privacy Act)

We are required by State and Federal laws, including the HIPAA Rules, to safeguard general and health-related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients (and/or their authorized representatives) when they first become our patient.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You are not making any statement about the content of the Notice of Privacy Practices or about your agreement or disagreement with any portion of it.

Acknowledgment

I acknowledge that Pediatric Care Associates of CT, P.C. (Pedi-Care) has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Bernadette Mongillo

203-924-7334, ext. 130

I also understand that I am entitled to receive updates upon request if Pediatric Care Associates of CT (Pedi-Care) amends or changes its Notice of Privacy Practices in a material way.

____ ________________________________

Signature of patient or patient's representative Date

____ ________________________________

Printed name of patient/patient's representative Relationship to patient

SECTION TWO – Informed Consent

I have read and agree to comply with the above office policies. By seeking and receiving pediatric care ad Pedi-Care, I am agreeing to be personally and fully responsible for payment.

- ☐ As a self-paying patient, I understand that I am expected to pay for services at the time of the visit and that if I do not, I will incur a Billing Fee.
- ☐ As a patient with a participating insurance, I am expected to pay my co-pay or deductible at the time of visit or incur a billing fee. I understand that it is my responsibility to know the coverage limits of my health plan, and those services and diagnoses that are not paid by my insurer may be billed to me. If my insurer subsequently pays for any services that I have paid for, Pedi-Care will refund any payments to me.

Printed Name of Financially Responsible Party:	
Signature:	**Date:**

INSURANCE COVERAGE AND BILLING POLICIES FOR HEALTH CARE

The physicians at Pedi-Care provide health care management according to the medical protocols set forth by the American Academy of Pediatrics. These "best practice" protocols are the most up-to-date standard of care and include the following parts to your child's medical evaluation:

FOR CONCUSSION:

1. A neurovestibular history and neurovestibular exam (oculomotor and balance)
2. Neurocognitive testing
   *King Devick (eye tracking speed)
   *ImPact test (memory, processing, visual motor speed and reaction time)

FOR WELL –CHILD VISITS:

1. Comprehensive history and exam
2. Vision and hearing, Photoscreening, VEP (visual evoked potential) OAE (Otoacoustic emissions)

FOR ADD/ADHD VISITS:

1. Comprehensive history and exam
2. Vanderbilt tests, Quotient test

Insurance companies that recognize current standard of care will cover your child's visit and testing. However, there are some insurance companies that may deny coverage for the King Devick and ImPact tests, Vanderbilt and Quotient Tests.
We will make every effort to provide your insurer with the necessary documentation to obtain complete coverage for your child's visit. However, if your insurer does not pay for testing, then you may be billed for that portion of your child's evaluation. Our billing staff can provide you with the fees involved and payment options and you are welcome to call us with questions. Thank you.

____ ____________________
Parent/Guardian Signature Date

Pediatric Care Associates of CT PC (dba Pedi-Care)
25 Constitution Blvd., So., Shelton, CT 06484 (203) 924-7334
Karen L. Laugel, M.D., Melanie Georgalas, M.D., Nicholas P. Mongillo, M.D.
Michelle Rivelli, M.D., Christa L. Johnson, M.D., Kevin W. Benson, M.D.

Everything below this line is for OFFICE USE ONLY

THIS SECTION IS TO BE COMPLETED BY PEDIATRIC CARE ASSOCIATES OF CT (PEDI-CARE) IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): ____

____ ________________________

Name and title of employee Date