Premium Pediatrics, Inc
330-652-3100
Comprehensive Health Care for Infants, Children & Adolescents

Patient Name | Date of Birth | ☐ Male ☐ Female | Social Security Number

Patient Address (Street, City, State, Zip Code)

Primary Phone Number | Secondary Phone Number

Mother/Guardian's Name | Relationship to patient | Date of Birth | Phone Number | Phone Number

Mother/Guardian's Address (Street, City, State, Zip Code)

Mother/Guardian's Place of Employment | Work Phone Number

Father/Guardian's Name | Relationship to patient | Date of Birth | Phone Number | Phone Number

Father/Guardian's Address (Street, City, State, Zip Code)

Father/Guardian's Place of Employment | Work Phone Number

Full name and age of siblings

Emergency Contact (Other than Parent) | Relationship to Patient | Emergency Contact Phone Number

Insurance Information

Primary Insurance Plan Name | Group Number | Policy Number | Primary Insurance Phone Number

Primary Insurance Address | Copay

Guarantor's Name (or Party Responsible for Payment) | Social Security Number | Guarantor's Date of Birth | Relationship to Patient

Secondary Insurance Plan Name | Group Number | Policy Number | Secondary Phone Number

Secondary Insurance Address | Copay

Guarantor's Name | Guarantor's Date of Birth | Relationship to Patient

I authorize Premium Pediatrics, Inc. to release vaccination information and/or complete requested physical examination or medication forms for my child's school.

School's Name | Parent's Signature

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Patient Authorization for Medical Treatment and Release of Information

I, _____, hereby voluntarily consent to such medical treatment and such procedures as deemed necessary to be performed by my physician and/or such consultants or assistants selected by her and the employees of Premium Pediatrics, Inc. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of treatment or examination at Premium Pediatrics, Inc.

I hereby authorize Premium Pediatrics, Inc., my physicians, and any other person who provides care and treatment to me to release any and all information including, but not limited to, medical and financial information to my health insurance company, Medicare, Medicaid and/or any other payer of benefits related to my health care visit. Additionally, I authorize the release of the information described herein to such other persons or agencies deemed appropriate by Premium Pediatrics, Inc. and its employees, for the following purposes: for continuity of care, legal, quality review, billing, statistical purposes, transfer to another institution or physician, ambulance companies and transport agencies, and all other agencies and third party entities which may be involved in providing additional care and/or the processing claims incurred by me or provided on my behalf. This authorization shall also include the release of any information regarding HIV antibody testing and acquired immunodeficiency syndrome (AIDS), drug and/or alcohol abuse mental and physical conditions and communicable disease. I understand this authorization will remain in full force and effect until such time as I provide the office with written revocation valid for one (1) year.

I further authorize the release of information from my medical record, to the extent necessary, to appointees of Premium Pediatrics, Inc.'s medical staff, its allied health professionals, employees and other agents as well as to accrediting and licensing/regulatory entities who have in turn agreed to keep such information confidential for the purposes of reviewing or auditing the performance of the practice in either its administration or the rendering of medical care. I also authorize Premium Pediatrics, Inc. to release information from my medical records to auditors or reviewers who are retained by the practice to audit the practice's processes in seeking reimbursement for services provided to me.

I agree that Premium Pediatrics, Inc. will not be responsible for any personal valuables left in any room within the practice, including: wallets, jewelry, watches, credit cards, eye glasses, clothing, etc.

I hereby authorize Premium Pediatrics, Inc. to release my Social Security number to any and all agencies or individuals, whom they deem appropriate to receive such information, including but not limited to, the use of my Social Security number in connection with the reporting of information to individuals under the provisions of Safe Medical Device Act.

In the event that I need a copy of my child's records, I will notify Premium Pediatrics, Inc. in writing. I am aware that this process may take up to 30 days, but are usually completed within 1-2 weeks. The first set of records that I receive will be free of charge. However, additional requests for records will require a fee of $10.00 to be paid before records are prepared.

Assignment of Insurance Benefits

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account and for any professional services rendered.

I hereby authorize payment directly to Premium Pediatrics, Inc. of the medical benefits otherwise payable to me, but not to exceed my indebtedness to the practice for charges made during this period of treatment. I also authorize payment directly to the physicians who may be involved in my care the amount of medical benefits otherwise payable to me, but not to exceed my indebtedness to the physicians for charges made during this period of treatment.

The undersigned patient, or legal representative thereof, hereby acknowledges his/her reading, understanding and agreement with all of the foregoing statements.

Patient/Guardian Signature_____ **Date** _____

Relationship to Patient _____

Authorization - Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child(ren) will need to present photo identification at the time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the provider, give authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

Identify any limitations of the proxy. If none, state "none"

_____

I, _____ (parent or legal guardian), give the person(s) listed below permission to bring my child(ren) to Premium Pediatrics, Inc. and discuss and share medical information about my child(ren). I further authorize them to see all necessary medical records and make healthcare decisions of a routine nature as determined at the sole discretion of the Premium Pediatrics, Inc. provider.

I also give them authority to make more serious or urgent health care decisions in the event that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

(IF ONLY PARENTS/LEGAL GUARDIAN ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE "NONE")

_____ _____

Name of Person (allowed to bring child) Relationship

_____ _____

Name of Person (allowed to bring child) Relationship

_____ _____

Name of Person (allowed to bring child) Relationship

_____ _____

Name of Person (allowed to bring child) Relationship

_____ _____

Signature (Parent/Legal Guardian) **Date**

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of Premium Pediatrics, Inc.'s Notice of Privacy Practices to review. I have also been informed of my responsibilities as a patient and am aware of my rights as a patient. I am aware that I may request my own copy of any of these documents.

_____ _____

Signature of Parent or Guardian Date

ADVANCE BENEFICIARY NOTICE (ABN)

Your health insurance may not pay for the vaccination(s). The plan that you have chosen as your health insurer does not necessarily cover all of your health-care costs. Insurance only pays for covered items and services. The fact that insurance may not pay for a particular service does not mean that you should not receive it, especially if your physician recommends that you receive the service.

The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services, knowing that you might have to pay for them yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s), if your health insurance does not include this as a covered item(s) or service(s).

Patient name: _____

Responsible party signature: _____

Relationship to patient: _____

Date: _____

Patient Name: _____

PAST MEDICAL HISTORY

Please estimate if exact dates/ages are unknown

Was your child born more than 3 weeks early? If so, how many weeks? _____ Birth weight? _____

C-Section or Vaginal delivery? _____ Was Hepatitis B given at the hospital? _____

Were there any complications with the pregnancy or delivery? *If yes, please list* _____

_____

Does your child have any medical problems? *If yes, please list* _____

_____

Has your child had any surgeries/hospitalizations? *If yes, please list surgery & date/age* _____

_____

What daily medication, if any, does your child take? _____

_____

SOCIAL HISTORY

Who lives at home with your child? _____

Are there any custody arrangements for your child? *If so, please provide any documentation of custody/custody changes to the front office staff.*

_____

What pets, if any, do you have? _____

Does your child attend daycare or school? *If yes, please specify* _____

What type of water do you have at home? *(city, well, bottled)* _____

Does anyone who lives with your child smoke? _____

Has your child traveled outside of the country? *If so, list when and where* _____

FAMILY MEDICAL HISTORY

Please mark if anyone in your child's family has the following health problems

Disease	Yes	No	Relationship to Patient	Disease	Yes	No	Relationship to Patient
ADHD				Heart Disease/Attacks			
Allergies				High Blood Pressure			
Anemia/Blood Disorder				High Cholesterol			
Asthma				Kidney Problems			
Autism/PDD				Learning Problems			
Cancer				Migraines			
Cystic Fibrosis				Sudden Infant Death			
Depression/Anxiety				Thyroid			
Diabetes				Tuberculosis			
Early Childhood Deafness				Other (please list)			
Epilepsy/Seizures							

Authorization for Release of Information

I hereby authorize to release information from the medical record(s) of:

Patient Name(s):	Date of Birth:	Social Security Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for transfer (optional): _____

Records to be released: _____

From: (Doctor or medical facility from which information is to be sent)

_____

_____

_____

_____

To: Premium Pediatrics, Inc.
918 Youngstown Warren Road
Suite C
Niles, Ohio 44446

I understand that information released pursuant to this authorization may contain information concerning my treatment, if any, for an alcohol, drug abuse, psychiatric, or AIDS-related condition, including HIV test results, unless I expressly indicate that such information cannot be released at the bottom of this authorization form.

I understand that I may revoke this authorization at any time, and without such prior revocation this authorization will automatically expire 60 days from this date.

I hereby agree to release and hold Premium Pediatrics, Inc. and its employees harmless from any legal claim that may arise in connection with the release and disclosure of any information provided pursuant to this request.

_____ _____
Parent/Legal Guardian Date

_____
(Relation)

_____
Witness

*If this authorization is signed by anyone other than the patient or parent(s), if minor, indicate the basis of authority and provide documentation evidencing such authority.

Redisclosure: The contents of this authorized release of information are to be treated as privileged and confidential. Redisclosure or duplication of this information to other unauthorized parties is strictly prohibited.