MINOR/CHILD CONSENT

Kids Count Pediatrics, PLLC
1919 North Bridge Street
Elkin, NC 28621
(P) 336-835-7337
(F) 336-835-7301

I am the parent, guardian, or personal representative of _____

_____ and there are no court orders now in effect that
Please Print Name of Minor/Child

prohibit me from signing this consent. I do hereby request and authorize the doctor and practice staff to perform necessary services for the child named above, including but not limited to x-rays, and treatment, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

KIDS COUNT PEDIATRICS
PATIENT REGISTRATION FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRITY - PLEASE READ AND SIGN THE THREE STATEMENTS ON PAGE 2

Office Use Only
KCP RCD# _____

☐ Patient ☐ Guarantor ☐ Patient Same as Guarantor

Patient Name: _____
Prefix *First* *Middle* *Last* *Suffix*

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ (Cell/Work/Other): _____

Birthdate: _____ Social Security #: _____

Marital Status: _____ Sex: Male / Female Occupation: _____

Employer: _____ Employment Status: _____

****** Insurance - Primary** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insurance Name: _____

Insurance ID: _____ Other Insurance ID: _____

Policy Group: _____ Group Name: _____

****** Insurance - Secondary** [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insurance Name: _____

Insurance ID: _____ Other Insurance ID: _____

Policy Group: _____ Group Name: _____

Patient Race: _____ Patient Is Student: No / Full Time / Part Time

Guarantor Information (Person Responsible for Payment of Services not covered by Insurance)

Guarantor Name: _____
Prefix *First* *Middle* *Last* *Suffix*

Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ (Cell/Work/Other): _____

Birthdate: _____ Social Security #: _____

Marital Status: _____ Sex: Male / Female

KIDS COUNT PEDIATRICS
PATIENT REGISTRATION FORM

VERIFICATION OF INFORMATION

I affirm that all of the information provided on the previous page is true and accurate to the best of my knowledge. I also acknowledge and understand that I must bring a copy of my insurance card for each visit to confirm that my coverage is still in effect. I understand that failure to bring my card to each and every visit may require me to pay full charges at the time of my visit.

_____ _____

Patient or Guardian *Date*

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize release of all medical information necessary to process my insurance claims or that are pertinent to my medical care. I authorize payment of medical benefits to Kids Count Pediatrics. I also request payment of any government benefits to Kids Count Pediatrics. I understand that Kids Count Pediatrics is a Provider Based Facility which will include billing for Part A and Part B of my insurance if I have Medicare. I understand that if I fail to comply with the stipulations set forth in this paragraph or with my particular insurance policy, that I will be responsible for any and all non-reimbursed charges, including any fees incurred by KCP to collect my payments.

I further understand that I am responsible for any services provided to me that are not reimbursed by my insurance policy, including but not limited to co-pays, deductibles, and/or non-covered services. I understand that should my insurance company, or I fail to reimburse Kids Count Pediatrics for services received, I can be refused further services and dismissed from the practice.

_____ _____

Patient or Guardian *Date*

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I acknowledge that I have received and read the HIPAA material of Kids Count Pediatrics (by handout, office posting, or Internet posting).

☐ Yes, I accept this material

☐ No, I have refused to read and accept this material

_____ _____

Patient or Guardian *Date*

As required by the HIPPA you have a right to request that communications concerning your personal health information be made through confidential channels. In an effort to better serve our patients, we are asking that you sign below indicating your preference of how we should provide you with test results.

☐ Yes, you may leave any test/lab results or appointment information with a family member. Please list any names that we may leave information with about any of the above. _____

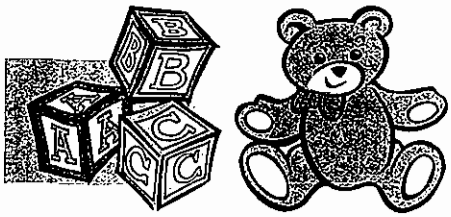
_____

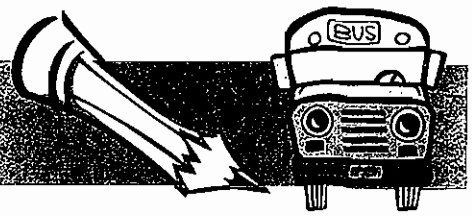
☐ Yes, you may leave any test/lab results or appointment/referral information messages on my answering machine.

☐ I want any and all test/lab results or appointment/referral information given to me only.

_____ _____

Signature *Date*





PEDIATRIC HEALTH HISTORY

Your child's health is of utmost importance to us. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle the item and we will be happy to discuss it with you. All information will be treated confidentially.

Date _____ SS/HIC/Patient ID # _____

Child's Name _____ ☐ M ☐ F Date of Birth _____ Age_____

Mother's Name _____ Phone: Home (_____) _____ Work (_____) _____

Father's Name _____ Phone: Home (_____) _____ Work (_____) _____

Home Address _____

E-mail _____ Phone: Cell #1 (_____) _____ Cell #2 (_____) _____

Child's School _____ Grade _____

Previous Physician _____ City/State _____ Phone (_____) _____

ALLERGIES

Substance	Reaction

MEDICATIONS

Medication Name	Dosage

MEDICAL HISTORY

Please check ☑ if child has ever had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis/Bronchiolitis
- ☐ Bronchopulmonary Dysplasia (BPD)
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Immune Deficiency/HIV
- ☐ Measles (10-day)
- ☐ Measles, Rubella (3-day)
- ☐ Mumps
- ☐ Prematurity
- ☐ Rheumatic fever
- ☐ Pneumonia
- ☐ Sickle Cell Disease
- ☐ Whooping cough
- ☐ Other_____

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Mood swings
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Tiredness
- ☐ Weight loss/gain

CARDIOVASCULAR
- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heart beat

EYES
- ☐ Crossed or wandering eyes
- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems

HEARING/SPEECH
- ☐ Difficulty hearing
- ☐ Earache
- ☐ Ear infections
- ☐ Hoarseness
- ☐ Speech problems _____

DENTAL
- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Sensitivity to hot/cold
- ☐ Thumb-sucking
- ☐ Last dental check-up Date _____
- ☐ Brush, how often? _____
- ☐ Floss, how often? _____

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloody or dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomachaches
- ☐ Vomiting
- ☐ Worms

GENITO-URINARY
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Diaper rash, persistent
- ☐ Discharge from vagina or penis
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

MUSCLE/JOINT/BONE
- ☐ Broken bones or sprains
- ☐ Coordination problems
- ☐ Posture problems
- ☐ Pain, weakness, swelling in:
  - ☐ Arms ☐ Hips
  - ☐ Back ☐ Legs
  - ☐ Feet ☐ Neck
  - ☐ Hands ☐ Shoulders

NOSE/THROAT/CHEST
- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Mouth-breathing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Strep throat
- ☐ Tonsil infections
- ☐ Wheezing

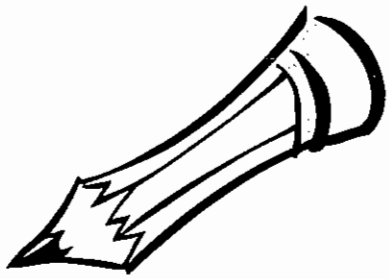
SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Front and Back

DIET

How often does your child eat the following:

	3 Times Daily	Daily	Weekly	Monthly
Beans, peas	☐	☐	☐	☐
Breads, cereals, grains	☐	☐	☐	☐
Candy	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐
Eggs	☐	☐	☐	☐
Fruits	☐	☐	☐	☐
Meats	☐	☐	☐	☐
Poultry, fish	☐	☐	☐	☐
Sodas	☐	☐	☐	☐
Vegetables, green	☐	☐	☐	☐
Vegetables, yellow	☐	☐	☐	☐



What vitamin supplements does your child take? _____ How often? _____

Is there fluoride in your water? ☐ Yes ☐ No

HOSPITALIZATIONS

Reason	Date	Hospital, City, State

INJURIES

Serious Injuries/Illnesses	Date	Outcome

Has your child ever had a blood transfusion? ☐ Yes ☐ No

IMMUNIZATIONS

Please check ☑ whether or not your child has been given the following immunizations. If yes, please fill in the date(s) given.

YES	NO	DATE		YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	Hepatitis B	☐	☐	_____	Polio shots, series of 3	☐	☐	_____	Measles Vaccine
☐	☐	_____	DPT, series of 3 shots	☐	☐	_____	Polio booster shots	☐	☐	_____	Mumps Vaccine
☐	☐	_____	DPT booster shots	☐	☐	_____	Polio by mouth, series of 3	☐	☐	_____	Rubella Vaccine
☐	☐	_____	Hib (Influenza)	☐	☐	_____	PCV7 (Pneumococcal)	☐	☐	_____	Chicken Pox Vaccine

FAMILY HISTORY

Please give the following information about your child's immediate family:

	Age	General Health		Age	General Health	
Father	_____	_____	Sibling	_____	_____	☐ M ☐ F
Mother	_____	_____	Sibling	_____	_____	☐ M ☐ F
Have any of your children died? ☐ Yes ☐ No			Sibling	_____	_____	☐ M ☐ F

Please check ☑ conditions that any of the child's blood relatives (including parents and siblings) have had and the relationship to the child:

Condition	Relationship	Condition	Relationship
☐ Alcoholism	_____	☐ HIV/AIDS	_____
☐ Allergies	_____	☐ Kidney disease	_____
☐ Anemia	_____	☐ Lung disease	_____
☐ Arthritis	_____	☐ Mental disease/disorder	_____
☐ Asthma/emphysema	_____	☐ Mental retardation	_____
☐ Birth defects	_____	☐ Muscle disorders	_____
☐ Bone/joint disorders	_____	☐ Rheumatic fever	_____
☐ Cancer	_____	☐ Seizures/convulsions	_____
☐ Diabetes	_____	☐ Sickle cell anemia	_____
☐ Epilepsy	_____	☐ Skin disease	_____
☐ Eye or ear disorders/Hearing loss/Blindness	_____	☐ Stroke	_____
☐ Genetic defects	_____	☐ Thyroid disease	_____
☐ Heart disease	_____	☐ Tuberculosis	_____
☐ Hemophilia	_____	☐ Venereal disease	_____
☐ High blood pressure	_____	☐ Other	_____

only fill out if child is under 2 years old

* AND HEALTH HISTORY

Place of birth _____ Obstetrician _____ Mother's age at birth _____

During the pregnancy which conditions did you have? Please ☑ all that apply:

- ☐ Alcohol use
- ☐ Anemia
- ☐ Diabetes
- ☐ Drug use, non-prescription drugs (Please list) _____
- ☐ Drug use, prescription drugs (Please list) _____
- ☐ Drug use, controlled drugs such as narcotics (Please list) _____
- ☐ Edema (Swelling)
- ☐ Exposure to chemical or radiation
- ☐ Fever
- ☐ German measles
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Protein in urine
- ☐ Tobacco use
- ☐ Urinary tract infection
- ☐ Venereal disease
- ☐ Other illnesses or infections _____

DELIVERY Please check ☑ all that apply:

☐ On time ☐ Premature ☐ Late ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section

Please describe _____

INFANT HEALTH

Birthweight _____ Length _____

Discharge weight _____ Age when discharged _____

INFANT HEALTH PROBLEMS Please check ☑ and describe.

- ☐ Birth defects _____
- ☐ Breathing problems _____
- ☐ Infection _____
- ☐ Jaundice _____
- ☐ Transfusion _____
- ☐ Other _____

FEEDING

☐ Breast fed ☐ Formula fed

DEVELOPMENTAL Please note age at which your child:

Lifted head	_____	Wk.
Rolled over	_____	Mo.
Cooed/Laughed	_____	Mo.
Sat up	_____	Mo.
Stood up	_____	Mo.
Walked	_____	Mo.
Finger fed	_____	Mo.
Drank from cup	_____	Mo.
Spoon fed	_____	Mo.
First word	_____	Mo.
Toilet trained	_____	Mo.
Dressed self	_____	Mo.

EDUCATION AND SOCIAL HISTORY

Please explain any problems or concerns you have about your child in any of the following areas:

Appearance/Weight/Height _____

Behavior _____

Friends _____

Grades/learning ability _____

Sexuality _____

How many hours per day does your child watch television or play video games? _____ Get exercise? _____

Do you suspect that your child is involved with: ☐ Drugs ☐ Alcohol ☐ Tobacco ☐ None

Have you noticed any of the following warning signs of drug abuse:

Angry behavior	☐ No	☐ Yes	Depression	☐ No	☐ Yes
Changes in appearance	☐ No	☐ Yes	Signs of drugs in the house	☐ No	☐ Yes
Changes in attitude	☐ No	☐ Yes	Skipping school	☐ No	☐ Yes
Changes in friendships	☐ No	☐ Yes	Withdrawal from friends or family	☐ No	☐ Yes

Front and Back

Adequate number of working smoke alarms?	☐ Yes ☐ No	Safety plugs in unused wall sockets?	☐ Yes ☐ No
Does child use car seat/seat belt?	☐ Yes ☐ No	Safety gate for stairs?	☐ Yes ☐ No
Medicines, cleaning supplies, chemicals out of reach?	☐ Yes ☐ No	Know dangers of peeling paint, mice/rats in the home?	☐ Yes ☐ No
Syrup of Ipecac in the home?	☐ Yes ☐ No	Does child know how to swim?	☐ Yes ☐ No
Know poison control phone number?	☐ Yes ☐ No	Are guns in the home in locked storage?	☐ Yes ☐ No
Water heater set below 120°F?	☐ Yes ☐ No	Does child use bicycle helmet?	☐ Yes ☐ No

PARENT CONCERNS Reason for visit today and any other concerns or questions you have about your child.

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Signature of Parent, Guardian or Personal Representative _____ Date _____

Please print name of Parent, Guardian or Personal Representative _____ Relationship to Patient _____

DR. COMMENTS

Physician Signature _____ Date _____

UPDATES (To be filled in at future appointments)

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

Please describe _____

Parent/Guardian Signature _____ Date _____ Physician Signature _____ Date _____

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

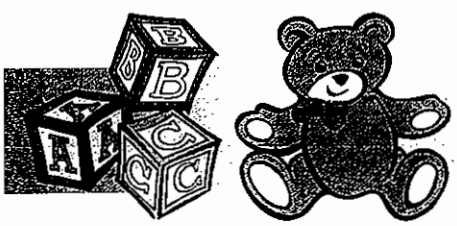
Please describe _____

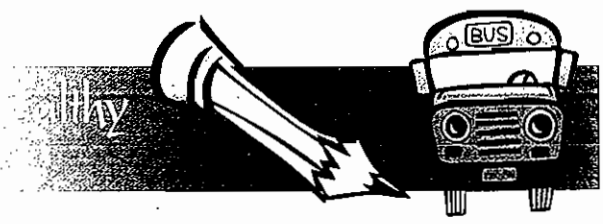
Parent/Guardian Signature _____ Date _____ Physician Signature _____ Date _____

Has there been any change in child's health since last appointment? ☐ Yes ☐ No

Please describe _____

Parent/Guardian Signature _____ Date _____ Physician Signature _____ Date _____





KIDS COUNT PEDIATRICS

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

I consent to and authorize _____ **to release Protected Health Information to:**

KIDS COUNT PEDIATRICS
(Organization or Person(s) or class of persons authorized to receive the information)

1919 North Bridge Street
(Address) Elkin, NC 28621

P: 336-835-7337
F: 336-835-7301

Description of information that may be used/disclosed:
(The information may include medical information, alcohol/substance abuse treatment, psychiatric care, psychological assessments, developmental disabilities, substance abuse, and/or HIV/AIDS if applicable)

☐Medical Information from the most recent visit/admission to include physician notes/summaries and diagnostic results.

☐Medical Information including physician notes/summaries and diagnostic results for the periods from _____ to _____.

☐Other: Specify information to release_____

for the periods from _____ through _____.

☐ All Medical Information

(Note: Medical Information relating to care provided outside this practice should be requested from the specific provide/f which the care was obtained.)

The information will be used/disclosed for the following purposes:

Please specify the reason for this request, e.g. treatment, insurance, legal, etc

_____

_____

☐ At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by submitting a notice of revocation in writing to the Practice Manager. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me. This authorization expires _____.

rent signature ->

_____

_____

Name of Patient)

Patient's Date of Birth

_____

KIDS COUNT PEDIATRICS

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

I consent to and authorize Kids Count Pediatrics to release Protected Health Information to:

_____

(Organization or Person(s) or class of persons authorized to receive the information)

_____

(Address)

Description of information that may be used/disclosed

(The information may include medical information related to genetic, alcohol, psychiatric care, psychological assessments, de disabilities, substance abuse and/or HIV/AIDS, if applicable)

☐Medical Information from the most recent visit/admission to include physician notes/summaries and diagnostic results.

☐Medical Information including physician notes/summaries and diagnostic results for the periods from _____ to _____.

☐Other: Specify information to release_____

for the periods from _____ through _____.

☐All Medical Information

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_____

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nt
nature —>

_____

_____

Name of Patient) Patient's Date of Birth