First Steps™
PEDIATRICS & ADOLESCENT MEDICINE

New Patient Information

Important information for your first apppointment

1. Please plan to arrive at least 15 minutes before your appointment to complete necessary paperwork before your visit.
2. When you come for your appointments please bring all insurance information and completed New Patient Packet. Patients who have Medical ID card will not be seen without the current card.
3. The policy for referring patients to specialist, for procedures, or any treatment not provided in our office is that a referral request is given at least 48 hours before the time of the referral is needed. If you are requesting a referral to a specialist, our physicians must have seen the patient in the last 6 months. The only exception will be for emergency situations or current ongoing referrals.
4. It is not our routine practice to call in prescriptions for antibiotic therapy with out seeing the patient. There are acute appointments available on a daily basis. Please call as early as possible to schedule your child in for an acute visit.
5. If we are going to be your primary care physician, be sure that your insurance company is notified and Dr. Suray's, Dr. Schwartz's, Dr. Seningen's, Dr. Reynolds', or Dr. Mehta's name appears on the card.
6. Please remember, payment is expected at time of service, including insurance co-payments.

THANK YOU

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Patient Registration Information

Patient Name:			Sex:	Date of Birth:	Age:
Last	First	MI	M F		

Street Address:	City & State:	Zip	Home Phone:

Medication Allergies :	Social Security Number:

Emergency Contact:	Relationship:	Home Phone: Work Phone:
Additional Contact Outside the Home:	Relationship:	Home Phone: Work Phone:
Father's name:	Address: (Leave blank if same as patient)	Home Phone: Cell Phone:
Father's Employer:	Permission to contact at work: Please circle YES NO	Work Phone:
Mother's Name:	Address: (Leave blank if same as patient)	Home Phone: Cell Phone:
Mother's Employer:	Permission to contact at work: Please circle YES NO	Work Phone:

Referred to the Practice by:

Primary Insurance Carrier:	Address:	ID or Policy Number:
Subscriber's Name and Date of Birth:	Referrals Required: Please Circle YES NO	Group Number:
Secondary Insurance Carrier:	Address:	ID or Policy Number:
Subscriber's Name:	Referrals Required: Please Circle YES NO	Group Number:

Parent, Patient or Guardian's Signature:	Date:
X	

Thank you for your cooperation

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Complete Patient Medical History

Patient Name: _____

Date of Birth: _____ Sex: _____ Age: _____

Medication Allergies: _____

Please list all individuals living in household and their relationship to the patient: _____

_____

_____

Please list all medications patient is currently taking including Vitamins, fluoride, herbal supplements and over the counter medications: _____

_____

_____

Current Diet: _____ If infant;Breast or Formula: _____ Brand: _____

Appetite: _____ Feeding problems: _____

List all allergies to foods or environment: _____

_____

Please list previous illnesses, surgeries and past hospitalizations with dates:

_____

_____

_____

If menstrual; date of first period: _____ Date of last period: _____

	Dates of past immunizations			
DTaP				
HIB				
Polio				
MMR				
Hepatitis B				
Varicella				
Prevnar				
Other				

Which parents work outside the home? _____

What kind of sitter arrangements does the child have? _____

If divorced or unmarried is the other parent involved with the child? _____

Has child ever eaten anything unusual such as paint chips, dirt, plants, etc.? _____

If yes, please explain:_____

_____

Was child adopted? _____ If yes, at what age? _____

Mother's health during pregnancy of this child: Good_____ Complications _____

If complications, please describe:_____

_____

Which pregnancy number was this for Mom? _____ Normal delivery or c- section? _____

What was child's birth weight?_____ Birth length?_____

Where was child born? Name of Hospital: _____

Was the child diagnosed with any problems at birth? _____

Was child hospitalized after mother's discharge? _____

Of the child's 4 grandparents, how many are living and well? _____

Do any blood relatives of child have any of the following conditions:

Disease	No	Yes	Whom- specify relationship to child plus Maternal or Paternal
Diabetes			
Kidney Disease			
Blood Disorders			
Arthritis			
Asthma			
Eczema			
Thyroid Disorder			
High Blood Pressure			
Heart Disease			
Cancer (specify)			
Tuberculosis			
Seizure Disorder			
Mental Retardation			
Seasonal Allergies			
Unusual Defects or Syndromes			
Other conditions not listed			

Compared to other children was this child's development: Slower, Faster, or Average? (please circle)

If attending school, type of grades achieved: _____

Are there any problems with child getting along at home or with playmates? _____

If yes, please explain_____

_____

Has child even been under professional mental health care of counseling? _____ If yes, by whom?

_____

Please list all pets in the home or that child has contact with: _____

_____

Water source: City _____ Well _____ Bottled _____

Is home air-conditioned? Yes___ No ___

Heat source: Gas _____ Electric _____ Other _____

Smokers present in home? Yes _____ No _____ Whom? _____

Has child ever had any of the following conditions? Please check and explain in lines below

Allergies		Nosebleeds		Bed wetting		Bleeding tendency	
Asthma		Measles		Eczema		Rheumatic Fever	
Anemia		Pneumonia		Frequent Diarrhea		Fractures (specify)	
Chicken Pox		Slow Growth		Frequent Illness		Mononucleosis	
Backaches		Ear Infections		Unusual Weight Loss		Attention Deficit	
Sore Throats		Vision Problems		Unexplained Fevers		Worms	
Headaches		Hearing Problems		Urine/ Kidney Problems		Eating Disorder	
Seizures		Speech Problems		Menstrual difficulties		Depression	
Sore or Swollen Joints		Protein, Blood or Sugar in Urine		Problems with walking or posture		Loss of Consciousness or Been knocked out	

_____

_____

_____

_____

_____

_____

Parent, Patient or Guardian's Signature: Date:

X_____ _____

Thank you for your cooperation

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Treatment Authorization Form for Minors

Patient Name: _____Date of Birth:_____

I (we) consent to any necessary examination, anesthetic, medical or surgical treatment, and/or hospital care to be rendered to the above named minor under the supervision and on the advice of a duly licensed physician during the period of my (our) absence. This form gives my legal consent for treatment.

Parent(s) Signature(s): _____
Date

_____
Date

The following individuals have my (our) permission to bring the above named child to the Physician's Office for Well Child Exams, Immunizations, Allergy injections, or any treatments deemed necessary by the physician after evaluation of the child.

NAME OF INDIVIDUAL	RELATION TO CHILD
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____
6_____	_____

Any additions or deletions of this form are the sole responsibility of the parent.

Thank You.

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Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, and will bill participating insurance companies as a courtesy to you. If we do not receive a payment from your insurance company within 45 days of the date of service, you will be expected to resolve the balance. You are responsible for all charges. We also bill secondary insurances as a courtesy to you. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Managed Care. If you are enrolled in a managed care insurance plan (i.e. HMO) you must receive a referral from our office before seeing a specialist. Retroactive referrals will likely be denied by your HMO.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service unless other arrangements have been made. 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. First Steps Pediatrics accepts cash, personal check, visa and master card. There is a service charge for returned checks of $30.00.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered insurers. You may be responsible for payment of these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current photo identification and current, valid insurance to provide proof of insurance. If you are not able to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. 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. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so that 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.

7. Nonpayment. Patients with a balance outstanding more than 60 days must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty and we are available to discuss, in confidence, options, which may be suitable to your situation. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed Appointments/Late Cancellations: Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Notice of Privacy Practices

Effective Date: April 14, 2003. **Revision Date: January 1, 2006**

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by First Steps Pediatrics

Privacy Contact. If you have any questions about this policy or your rights contact the Privacy Officer, 304/723-4000.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond First Steps Pediatrics. This includes for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside First Steps Pediatrics that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

Fundraising. As a not for profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation.

PATIENT RIGHTS

You have the following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record First Steps Pediatrics has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. First Steps Pediatrics is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.
.
Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. Due to agency policy, we are not able to provide information by email.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Program Director and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer in writing at our office further Information. You also may complain to the Secretary of Health and Human Services if you believe First Steps Pediatrics has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. First Steps Pediatrics reserves the right to change its Privacy Policy based on the needs of First Steps Pediatrics and changes in state and federal law.

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Authorization and Acknowledgement

Patient Name: _____Date of Birth:_____

Authorization For Treatment:

I hereby authorize First Steps Pediatrics & Adolescent Medicine, P.L.L.C. to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis and ongoing medical care of this patient.

Acknowledgement of Notice of Privacy Practices:

I acknowledge that I have reviewed/received a copy of the Notice of Privacy Practices. I understand that information the Physician Practice above acquires or creates about me will only be disclosed to others for treatment, payment, and health care operations as set forth in the Notice or as authorized by me in writing. Any restrictions on the release of my health information are to be noted on the separate Patient Confidentiality Form provided by the office staff upon request.

I certify that I have read this form and that I understand its contents.

X_____ Date:_____
(Signature of patient or responsible party/Relationship)

_____-_____-_____
(Social Security Number)

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Insurance Coverage Verification

Patient Name: _____ Date of Birth: _____

Please contact your insurance company regarding your policy benefits before your visit to our office.

Insurance Company Name_____

Insurance Policy Number_____

First Steps Pediatrics is participating with my insurance company? YES NO

Does your insurance policy have Well Child/Preventative benefits? YES NO
If NO, please complete the Repeat/Sick section of this form.

Well Child/Preventative Coverage

Co-Pay_____ Deductible_____

Yearly Maximum_____ Policy Limitations_____

Immunizations	YES	NO
Routine Hearing	YES	NO
Routine Vision	YES	NO

Is the annual Well/Preventive visit renewed per:

Calendar year Enrollment year
(Please circle one)

Repeat & Sick Visits

Co-Pay_____ Deductible_____

Yearly Maximum_____ Policy Limitations_____

Parent/Guardian Signature_____ Date_____

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Authorization for Release of Protected Health Information

***Authorization to release my PHI is hereby granted to*:**

_____
Name of Facility or Physician

_____
Address City St Zip

_____
Telephone Number Fax Number

Records are requested for the purpose of (Provide a Detailed Description): _____

***Medical Records being released to*:**

First Steps Pediatrics & Adolescent Medicine, P.L.L.C.

Three Robinson Plaza, Suite 100
Route 60 & Park Manor Drive
Pittsburgh, PA 15205
Phone: (412)788-1999 Fax: (412)294-5103

Information regarding the patient named below:

_____
Name

_____
Address City St Zip

_____ _____
Date of Birth Social Security Number / MR#

Please Include The Following: Dates From: to:

All Records*		Discharge Summary		Growth Charts	
Lab Findings		Office Notes		History & Physical Notes	
Other Diagnostic test		X-Rays		Surgeries & Procedures	
Pap Results		Immunizations		***Justification**	

HIV, BEHAVIORAL HEALTH AND SUBSTANCE ABUSE INFORMATION CONTAINED IN THESE RECORDS WILL BE RELEASED THROUGH THIS AUTHORIZATION UNLESS OTHERWISE IINDICATED BELOW:
DO NOT RELEASE: __ HIV __ SUBSTANCE ABUSE __ BEHAVIORAL HEALTH/PSYCHIATRIC __ OTHER
I understand the following:
* That my health records will not be released or obtained by FSP unless permission is provided for herein as evidenced by the signature on this Authorization for Release of Protected Health Information.
*That the release of my health records will be for the purpose stated on this form, and only those items checked off will be released.
*That the Authorization is in effect for a period of 365 days unless a specific timeframe less then one year is documented.
*That I have the right to revoke this Authorization form at any time by sending a written request to the above listed facility/physician. My decision to revoke the Authorization does not apply to any release of my health records that may have taken place prior to the date of my request to revoke and may result in my insurance company not being able to pay for my medical care and I may be liable for payment of the claim.
* I am entitled to a copy of this completed Authorization form.

Signed_____ Date:_____
(Parent Guardian Self)

Patient Eligibility Screening Record
Pennsylvania Department of Health
Vaccines for Children Program

Date: _____

Patient: _____
Last Name First Name MI

Date of Birth: _____

Parent/Guardian/
Individual of Record: _____
Last Name First Name MI

Provider's Name: _____

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger who receive immunizations through the VFC Program. The parent, guardian, individual of record or the healthcare provider may complete the record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of eligibility status is not required, the provider must retain this or a similar record for each child receiving vaccine.

This child qualifies for vaccination through the VFC Program because he/she (check only ONE box):

□ is enrolled in Medical Assistance
(this includes Medical Assistance managed care plans)

or

□ does not have health insurance

or

□ is American Indian or Alaskan Native

or

□ has health insurance that DOES NOT cover vaccines
(Applicable only to children attending a Federally Qualified Health Center or Rural Health Clinic)

This form may be copied as needed.