St. Clair PEDIATRICS

4941 Benchmark Centre Drive #100, Swansea, IL | Phone 618.624.9970 | Email customerservice@stcpeds.com

New Patient Form

Welcome to St. Clair Pediatrics!

St. Clair Pediatrics offers general pediatric services for children from birth to age 18. We aim to provide the best quality of care and support for you and your children. Our pediatricians are highly skilled, experienced physicians practicing only pediatrics. We have an excellent staff of caring, well-trained nurses and registered medical assistants. Our office is open six days a week, including a half-day on Saturday. Nursing advice is available during office hours. We also have after hour providers available by phone 24 hours a day 7 days a week for urgent questions. Our office provides the following services:

Newborn Care: We believe in close monitoring of newborns, especially within the critical first several weeks of life. Your first several visits will focus on feeding issues (breast or bottle feeding), weight gain, early infant development, and keeping your child healthy.

Well-child Visits/Sports Physicals: Some of the most important aspects of your children's care are ensuring their overall health and monitoring their continued development at every stage of life. At each check-up we discuss not only physical health, but also issues of growth and development, nutrition, safety, and social challenges.

Sick Visits: We understand the urgency involved in dealing with sick children and make every effort to schedule same-day sick appointments. Our providers will take the time needed to explain your children's diagnosis and treatment options. We believe in the rational use of antibiotics and are aware of the risks associated with their over-use. Our providers prescribe antibiotics only when they are indicated and educate parents in situations when they are not needed.

Vaccinations: We are dedicated to ensuring your children stay protected from all serious vaccine-preventable diseases. Our office offers many of the newer vaccines as they become available. We try to limit the number of shots your children get through the use of combination vaccines.

Laboratory Services: Our office has the ability to test for a variety of diseases including anemia, lead toxicity, kidney and urinary tract diseases, strep throat, RSV, and influenza.

Electronic Medical Record (EMR): Our office utilizes an EMR that creates computerized printouts for prescriptions and information sheets for parents. Everything you receive from our office will be easy to read and pertinent to your children's care. With our EMR, our patients' charts are always in the office and can be accessed by multiple staff members, allowing quicker response times to phone calls and parental questions.

Other Office Information

Office Hours: The office is open 8:00 AM to 5:00 PM Monday through Friday and 8:00 AM to 12:00 PM on Saturday.

*The office is closed daily for lunch from 12:00-1:00 PM.

After Hours: Our providers are available after-hours. If you have an urgent question and cannot wait to discuss it during regular office hours. You may call our office at 618-624-9970 and select option 2. You will be directed to our on-call provider. Please note, after hours calls should be reserved for urgent questions only.

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Questions During Office Hours: During office hours, the nursing staff and doctors will be happy to answer questions. Please allow us time to check the messages and return the calls. If there is a prescription to be called in, please allow us time to complete the request. Please contact the pharmacy prior to picking up the prescription to ensure that the medication is ready.

New Patient Packet

Scheduling Appointments: You may call or visit the office to schedule your child's next exam. Routine physicals should be scheduled from four to six weeks in advance. Please remember that many schools require physical exams for general admittance and/or participation in school-sanctioned sporting activities. By reviewing school calendars and scheduling these appointments well in advance, you can avoid a last minute rush. If your child becomes acutely ill, we will schedule an appointment based on urgency. We understand that illness is never convenient. For any ailment requiring immediate attention, please call us before coming to the office and we will arrange for you to be seen as soon as possible.

Insurance & Billing: We accept most insurance plans. (For a complete list, please visit our website at www.stclaitpediatrics.com.) It is your responsibility to verify network participation, covered benefits, and eligibility on your plan. It is also your responsibility to update our office of all insurance and address changes at the time of service.

Payment: All co-pays are due at time of visit. The person bringing the child in for services is responsible for payment. You may pay with cash, check, American Express, Visa, MasterCard, or Discover.

Cancellation Policy: If you are unable to make it to your scheduled appointment time and need to cancel, please notify the office as soon as possible. If it is after hours, please call and leave a voice mail message. If you miss an appointment or cancel less than 24 hours prior to your scheduled appointment time, you will be charged a $15.00 fee. After a total of three no shows per family, you could be dismissed from our practice.

Add On Appointments: If you ask the doctor to see another child in addition to the one scheduled for the appointment, you may be charged a fee of $15.00 plus the standard co-pay.

Returned Check Fee: There will be a $20.00 fee applied to all returned checks. After a total of 3 returned checks per family, you will no longer be allowed to pay with checks. All unpaid returned checks will be turned over to the States Attorney's office for prosecution.

Copies of Medical Records: Requests for copies of medical records must be in writing. Please allow plenty of time to copy and print records. Various fees may apply.

Request: Prescription Refills, Shot Records, or Physical Forms for School. You may call, fax, e-mail, or request in person copies of prescription refills, shot records, or physical forms for school. Please allow 24 hours for the request to be completed.

Immunization Records: Please bring up-to-date immunization records with you to your children's well exams. We cannot give any additional vaccinations until we have a copy of all shots given. In addition, we are unable to release school physical forms without an up-to-date shot record.

**NOTE
Please bring patient's insurance card to every visit. Parents/Guardians are responsible for notifying our office of changes of address and/or insurance coverage. Whomever brings the patient(s) to their appointment is responsible for paying the Insurance Co-pay, if applicable. When writing a personal check, please have Driver's License or State ID available.

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Patient Information

Name: _____
First Middle Last

Preferred Name: _____ **Date of Birth:** _____

Address: _____
Street Address

City: _____ **State:** _____ **Zip:** _____

Primary Care Physician: _____ **Gender:** _____

How did you hear about us?

- ☐ Established Patient
- ☐ Friend/Neighbor
- ☐ Internet
- ☐ Insurance Company
- ☐ Other_____

Parent / Guardian Information 1

Name: _____ **Date of Birth:** _____
First Middle Last

Address: _____
Street Address

City: _____ **State:** _____ **Zip:** _____

Driver's License Number: _____ **Email:** _____

Employer Phone Number: _____ **Relationship:** _____

Home Phone Number: _____ **Mobile Phone Number:** _____

Parent / Guardian Information 2

Name: _____ **Date of Birth:** _____
First Middle Last

Address: _____
Street Address

City: _____ **State:** _____ **Zip:** _____

Driver's License Number: _____ **Email:** _____

Employer Phone Number: _____ **Relationship:** _____

Home Phone Number: _____ **Mobile Phone Number:** _____

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Emergency Contact Information

Other than parents

Name: _____ **Relation:** _____
First Last

Phone Number: _____

Siblings Information

Name: _____ **Gender:** _____ **Date of Birth:** _____

Name: _____ **Gender:** _____ **Date of Birth:** _____

Name: _____ **Gender:** _____ **Date of Birth:** _____

Name: _____ **Gender:** _____ **Date of Birth:** _____

Primary Insurance Information

Name: _____
First Middle Last

Date of Birth: _____ **Social Security Number:** _____

Name of Employer: _____ **Employer Address:** _____
Street Address

City: _____ **State:** _____ **Zip:** _____

Employer Phone Number: _____ **Insurance Name:** _____

Policy ID: _____ **Group Number:** _____

Preventive Coverage: _____ **Co-Payment:** _____

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Secondary Insurance Information

Responsible Person/Guarantor

Name: _____
First Middle Last

Date of Birth: _____ **Social Security Number:** _____

Name of Employer: _____ **Employer Address:** _____
Street Address

City: _____ **State:** _____ **Zip:** _____

Employer Phone Number: _____ **Insurance Name:** _____

Policy ID: _____ **Group Number:** _____

Preventive Coverage: _____ **Co-Payment:** _____

Assignment of Insurance Benefits/Consent to Treat/Privacy Policy

- I understand that I am financially responsible for all professional charges that my children may incur.
- All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.
- I hereby authorize payment of medical benefits direct to St. Clair Pediatrics, LLC. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal law.
- Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to St. Clair Pediatrics, LLC, to treat my child in their office as required by the events of that emergency situation.
- Acknowledgment of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy for St. Clair Pediatrics, LLC.

Parent/Guardian Name (Patient Name if 18 or older): _____

Date: _____

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Immunization Policy

In order to ensure the health and safety of our patients and their families, St. Clair Pediatrics require that all of our patients receive immunizations in accordance with the current vaccination schedule. This schedule follows the recommendations of the American Academy of Pediatrics (AAP), the Advisory Committee for Immunization Practices (ACIP), the Center for Disease Control and Prevention (CDC) and the World Health Organization (WHO). We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of vaccines. We firmly believe that delaying or "splitting up" the vaccinations puts your child and the patients at our practice at risk of contracting serious illnesses and possible death.

VACCINE	BIRTH	1 MONTH	2 MONTHS	4 MONTHS	6 MONTHS	9 MONTHS	12 MONTHS	15 MONTHS	18 MONTHS	19-23 MONTHS	4-6 YEARS	11-12 YEARS	16 YEARS
HEPATITIS B (HepB)	1ST DOSE		2ND DOSE		3RD DOSE								
ROTAVIRUS (RV) RV1 (2-dose series)			1ST DOSE	2ND DOSE	3RD DOSE								
DIPTHERIA, TETANUS & ACELLULAR PERTUSSIS (DTaP under 7 years)			1ST DOSE	2ND DOSE	3RD DOSE			4TH DOSE			5TH DOSE		
HAEMOPHILUS INFLUENZAE TYPE B (Hib)			1ST DOSE	2ND DOSE	3RD DOSE			4TH DOSE					
PNEUMOCOCCAL CONJUGATE (PCV13)			1ST DOSE	2ND DOSE	3RD DOSE			4TH DOSE					
INACTIVATED POLIOVIRUS (IPV under 18 years)			1ST DOSE	2ND DOSE	3RD DOSE			4TH DOSE			5TH DOSE		
MEASLES, MUMPS & RUBELLA (MMR)							1ST DOSE				2ND DOSE		
VARICELLA (VAR)							1ST DOSE				2ND DOSE		
HEPATITIS A (HepA)							1ST DOSE		2ND DOSE				
MENINGOCOCCAL (MenACWY-D under 9 months MenACWY-CRM under 2 months)												1ST DOSE	2ND DOSE
TETANUS, DIPHTHERIA & ACELLULAR PERTUSSIS (Tdap under 7 years)												1ST DOSE	
HUMAN PAPILLOMAVIRUS (HPV)												3 DOSE SERIES	
INFLUENZA					ANNUAL VACCINATION 1 OR 2 DOSES								

I have read and understand the above policy and agree to vaccinate my child as outlined above.

Patients Name: _____ **Date of Birth:** _____

First Last

Parent/Legal Guardian Signature: _____ **Date:** _____

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Patient Medical History Questionnaire

Patients Name: _____ **Date of Birth:** _____
First Middle Last

1. Is the patient adopted? _____ **If yes, in what country was the patient born?** _____

2. List any allergies to medication, food or environment. _____

3. Any pre-existing medical conditions?

- ☐ Asthma
- ☐ Allergies
- ☐ Diabetes
- ☐ ADHD
- ☐ Heart Disease
- ☐ Eczema
- ☐ Autism
- ☐ Other: _____

4. List any current medications and dosages: _____

5. List any hospitalizations or surgeries: _____

6. Check any that occurred during the pregnancy with this child?

- ☐ Group B Strep
- ☐ Infections
- ☐ Tobacco/Alcohol/Drug Abuse
- ☐ Hospitalizations
- ☐ High Blood Pressure
- ☐ Fetal Movement
- ☐ Bleeding/Spotting
- ☐ Gestational Diabetes
- ☐ Other: _____

Birth History

Check all that apply.

- ☐ Term > 37 Weeks
- ☐ Multiple Birth
- ☐ Morther's Age at Child's Birth _____
- ☐ Single Birth
- ☐ Born Premature at _____ Weeks
- ☐ Father's Age _____
- ☐ Birth Weight _____
- ☐ Birth Length _____

Labor: ☐ Induced ☐ Spontaneous **Delivery:** ☐ Vaginal ☐ Cesarean ☐ Breech (feet first)

Feeding: ☐ Breast ☐ Bottle **Hosptial:** _____

Complications: _____

Growth and Development

1. Did growth occurred at a normal rate? _____

Indicate in what month the following milestone was reached

Walked Unsupported: _____ Spoke Sentences: _____
Spoke Words: _____ Toilet Trained: _____

2. Describe any current growth or fine/gross motor difficulties: _____

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Social Factors

1. **Who lives with this child?** _____
2. **Mother's occupation:** _____
3. **Father's occupation:** _____
4. **Does anyone living with this child smoke?** _____
5. **Pets in home:** _____
6. **Where does this child live?** _____
7. **How old is this residence?** _____

Family Medical History

Check if child's natural parents, siblings, aunts, uncles or grandparents have had any of the following. Please also indicate which family member has that medical problem.

Condition	Family Member
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Heart Attack/Stroke before age 55	
☐ Sudden Death (cardiac, etc.)	
☐ Diabetes	
☐ Allergies	
☐ Eczema	
☐ Ashma	
☐ Cancer	
☐ Emotional Problems	
☐ Sight/Hearing Problems	
☐ Gastrointestinal Disease	
☐ Kidney Disease	
☐ Liver Disease	
☐ Epilepsy/Seizures	
☐ Headaches	
☐ Developmetal Delay	
☐ Autism Spectrum Disorder	
☐ Hyperactivity/ADHD	
☐ Alcohol/Drug Addiction	
☐ Blood Disorder	
☐ None of the Above	

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Authorization for Release of Health Information

Patients Name: _____ **Date of Birth:** _____
First Middle Last

I hearby authorize and request:

Name of Physician or Medical Facility: _____

Address: _____
Street Address

City: _____ **State:** _____ **Zip Code:** _____

To release to:

Name of Physician or Medical Facility: St. Clair Pediatrics, LLC

Address: 4941 Benchmark Centre Drive Suite 100

City: Swansea **State:** IL **Zip Code:** 62226

Medical Records Covering the Periods from: _____ ***to*** _____

Requested Medical Information is Needed for: _____

Reason for Transfer: _____ ***Medical Records May be Faxed to:*** 618-624-9973

I understand that my medical records or the medical record of the patient for whom I am signing may include Alcohol/Drug abuse, Psychiatric treatment or HIV/AIDS testing or treatment and are covered by Federal Regulations and cannot by disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that prior action has been taken on it. In any event, this consent will expire ninety (90) days from the date the authorization is signed. St. Clair Pediatrics, LLC, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

Signature of Patient/Responsible Party: _____

Relationship to Patient: _____ **Date:** _____

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Authorization to Release Medical Information

I hereby authorize St. Clair Pediatrics to release any information acquired in the course of my examination or treatment to any insurance company against which claims are filed on my behalf. I hereby authorize any insurance payments paid directly to St. Clair Pediatrics, LLC for medical benefits, if any, and otherwise payable to me for services rendered. I understand that I am responsible for payment of all charges for services rendered and that if my insurer fails to pay any portion of these charges for any reason, I will be responsible for all sums due St. Clair Pediatrics. If my account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

Signature of Patient/Responsible Party:_____ **Date:**_____

Agreement of Financial Responsibilty

Thank you for choosing St. Clair Pediatrics as your child's health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any preauthorization requirements of your insurance company.

- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate. I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party:_____ **Date:**_____

Print Name of Patient/Responsible Party:_____