Welcome to Green Mountain Pediatrics!

Patient Information (please print) Date: ___________

____

First Name Last Name Middle Name Date of Birth

Address____

City____________________________ State________________ Zip Code________

Home Phone______________________ Cell Phone______________

Parent/Guardian Information (please print)

____

First Name Last Name Middle Name Date of Birth

Address____(if different from patient)

City____________________________ State________________ Zip Code________

Home Phone______________________ Cell Phone______________

Parent/Guardian Information (please print)

____

First Name Last Name Middle Name Date of Birth

Address____(if different from patient)

City____________________________ State________________ Zip Code________

Home Phone______________________ Cell Phone______________

Insurance Information (please print)

Primary Insurance_______________________ Effective Date_____________

Primary Insured Name____________________________ DOB________________

Group #_______________________ Policy #___________________

Secondary Insurance______________________ Effective Date_____________

Secondary Insured Name____________________________ DOB________________

Group #_______________________ Policy #___________________

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY DATE COMPLETED

BIRTH DATE AGE

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. __________

If mother and father are not living together or if child does not live with parents, what is the child's custody status? __________

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? __________

Birth History

Birth weight __________

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? __________

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain __________

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What __________ When __________

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? __________

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain __________

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain __________

General

Do you consider your child to be in good health? ☐ Yes ☐ No Explain __________

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain __________

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain __________

Has your child had any surgery? ☐ Yes ☐ No Explain __________

Has your child ever been hospitalized? ☐ Yes ☐ No Explain __________

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain __________

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain __________

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain __________

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain __________

If your child is in school:

How is his/her behavior in school? __________

Has he/she failed or repeated a grade in school? __________

How is he/she doing in academic subjects? __________

Is he/she in special or resource classes? __________

Family History

Have any family members had the following:

Condition				
Deafness	☐ Yes	☐ No	Who ________	Comments ________
Nasal allergies	☐ Yes	☐ No	Who ________	Comments ________
Asthma	☐ Yes	☐ No	Who ________	Comments ________
Tuberculosis	☐ Yes	☐ No	Who ________	Comments ________
Heart disease (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
High cholesterol	☐ Yes	☐ No	Who ________	Comments ________
Anemia	☐ Yes	☐ No	Who ________	Comments ________
Bleeding disorder	☐ Yes	☐ No	Who ________	Comments ________
Liver disease	☐ Yes	☐ No	Who ________	Comments ________
Kidney disease	☐ Yes	☐ No	Who ________	Comments ________
Diabetes (before 50 years old)	☐ Yes	☐ No	Who ________	Comments ________
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who ________	Comments ________
Epilepsy or convulsions	☐ Yes	☐ No	Who ________	Comments ________
Alcohol abuse	☐ Yes	☐ No	Who ________	Comments ________
Drug abuse	☐ Yes	☐ No	Who ________	Comments ________
Mental illness	☐ Yes	☐ No	Who ________	Comments ________
Mental retardation	☐ Yes	☐ No	Who ________	Comments ________
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who ________	Comments ________

Additional family history ____

Past History

Does your child have, or has he/she ever had:

Condition			
Chickenpox	☐ Yes	☐ No	When ________
Frequent ear infections	☐ Yes	☐ No	Explain ________
Problems with ears or hearing	☐ Yes	☐ No	Explain ________
Nasal allergies	☐ Yes	☐ No	Explain ________
Problems with eyes or vision	☐ Yes	☐ No	Explain ________
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain ________
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ________
Anemia or bleeding problem	☐ Yes	☐ No	Explain ________
Blood transfusion	☐ Yes	☐ No	Explain ________
Frequent abdominal pain	☐ Yes	☐ No	Explain ________
Constipation requiring doctor visits	☐ Yes	☐ No	Explain ________
Bladder or kidney infection	☐ Yes	☐ No	Explain ________
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain ________
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When ________
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ________
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	Explain ________
Frequent headaches	☐ Yes	☐ No	Explain ________
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ________
Diabetes	☐ Yes	☐ No	Explain ________
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ________
Any other significant problem	☐ Yes	☐ No	Explain ________
Use of alcohol or drugs	☐ Yes	☐ No	Explain ________

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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GREEN MOUNTAIN PEDIATRICS

DR. DAN SCHLOEGEL AND DR. FRANCINE PASTON
255 UNION BLVD., SUITE 120
LAKEWOOD, CO 80228
OFFICE 303 936-7415
FAX 303 936-2177

Patient Financial Policy

February 2023

Thank you for choosing Green Mountain Pediatrics as your child's healthcare provider! We are committed to providing your child with the best medical care possible. In order to thoroughly assess your child's growth and development, and to provide quality care with the most current technologies, we must ensure that we are able to meet the expenses necessary to operate and staff this facility.

Your clear understanding of our Patient Financial Policy is important to our professional relationship, which is why we provide this Agreement to outline the policy and clarify your agreement to pay for services provided. Please ask if you have questions about our fees, our policies, or your responsibilities. After reading this document, please sign and date the last page to indicate you accept the terms.

Insurance & Understanding Your Benefits

We provide services to you, not to insurance companies or government agencies. If you provide us with the necessary information, we are happy to file claims with your insurance company on your behalf. We will ask for your insurance card at each visit to verify the information and ensure that we have a copy of the card for our records. You are financially responsible for any balances not covered by your insurance plan.

Depending on your exact benefits, you may be responsible for deductibles, co-payments, co-insurance, and non-covered charges. Many insurance companies cover all services included in a Well-Child Check, but some of these charges may be attributed to your deductible or require coinsurance. Office visits that are not Well-Child Checks often require a copay and some of the services rendered may be attributed to your deductible or require coinsurance.

Please take the time to understand your insurance benefits, including requirements related to referrals and pre-authorization of services. As an outside party in the relationship between you and your insurance carrier, we are generally unable to intervene on your behalf in the event of a dispute. You are ultimately financially responsible for paying for services provided to you by our clinicians. If the patient in question is a child, the responsible party will be the child's parent or legal guardian, insurance guarantor, and/or the authorized assigned representative who brings the child in for medical care.

Co-Payments

Co-payments are due at the time you check in for your appointment, before your child is seen by a provider. If you do not make your co-payment on the date of service, you will have a balance due on your account until it has been paid.

Financial Policy Continues on Back of Page

Understanding Our Charges

Patients will be charged for the services that are performed during the course of their appointment. There is a base charge for the office visit itself, which may include an examination of the patient, discussion of the nature of the patient's health concerns, medical decision making by the provider, and development and discussion of a treatment plan. Other charges will be assigned for services that are performed during the visit which often include, but are not limited to, vision and hearing tests, emotional and behavioral screeners, laboratory tests, and administration of immunizations.

No-Show Fee

Missed appointments cost our practice and prevent our providers from seeing patients who could have used the time dedicated for your appointment. Please call our office as soon as you know you will be unable to make your appointment. If an appointment is missed and we do not hear from you, we will assess a $15 "No Show" fee. Multiple "no shows" per family within a twelve month period may result in dismissal from the practice.

Payment Options

We require that you complete a Card-on-File agreement at our office to easily take care of your balances. Once your insurance carrier has adjudicated the claim for your visit, you will receive an EOB (Explanation of Benefits) letter that tells you exactly what the insurance will pay and how much of the bill is your responsibility. We receive this same letter and will only charge you what your insurance company tells us is your responsibility. With a card on file, you will receive an email from Athena five calendar days with the charge amount before the payment is scheduled. During these five days, you will have the opportunity to call us and make different payment arrangements if necessary. In the event that your total balance due is more than you can pay, we will work with you to create a payment plan.

Green Mountain Pediatrics will also accept cash, checks, and credit card payments. Cash and checks can be accepted at the office, and one-time credit card payments can be made in person, through the Athena Patient Portal, or by calling the office at (303) 936 - 7415.

Thank you for taking the time to read and understand our Financial Policy. We appreciate the opportunity to provide your child with our medical services! Please let us know if you have any questions or concerns.

Patient(s) Name and Date of Birth:

____

____

____

____

I have read and agree with the information contained in this Financial Policy.

____

Responsible Party Printed Name **Responsible Party Signature** **Date**

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Consent for the Use or Disclosure of Protected Health Information

March 2023

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, Green Mountain Pediatrics may not use your personal health information for the purposes of treatment, payment, or healthcare operations without your consent. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. Prior to signing this consent form, you have the right to review the Notice of Information Practices which is available in the office and online. You may request restrictions on the uses and disclosures described in the Notice of Information Practices or revoke this consent at any time by completing a Medical Record Restriction or Revocation Request form, which is available in the office and online.

I, ________________________________, hereby consent to the use and disclosure of the personal health information of my dependent,________________________________, for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given an opportunity to read Green Mountain Pediatrics' Notice of Information Practices and to ask and receive answers to questions before signing.

I understand that I may request restrictions on the uses and disclosures of my dependent's health information at any time by completing and signing the restriction request section of this form. I further understand that Green Mountain Pediatrics is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing a Medical Record Restriction or Revocation Request form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

This authorization will expire when my dependent turns 18 years old, unless revoked or modified prior to that date, at which point their medical records will belong to them.

____

Printed Name Signature Date