William Newton PEDIATRICS

1230 E. 6th Avenue, Suite 1A Winfield, KS 67156 Ph: 620-402-6699 Fax: 620-307-2993

Patient Registration Form – WNH Pediatrics

First Name:	**Last Name:**	**Middle Initial:**
DOB: / / SEX:	**Primary Language:**	
Ethnicity: ☐Hispanic/ ☐Non-Hispanic / ☐Unknown	Race: ☐Asian / ☐Black / ☐Hawaiian / ☐White	
CONTACT INFORMATION		
Mailing Address:	City: ZIP: State:	
Who lives at this household:		
Home Phone:	Cell Phone:	
Email Address:		
Primary Contact Name and guarantor:		
Relationship to the Patient:	Lives with patient: ☐Yes/☐No Date of Birth: / /	
Work Phone: ( ) -	Cell Phone: ( ) -	
Email Address:	Employer:	
Secondary Contact Name:		
Relationship to the Patient:	Lives with patient: ☐Yes/☐No Date of Birth: / /	
Work Phone: ( ) -	Cell Phone: ( ) -	
Email Address:	Employer:	
EMERGENCY CONTACT OTHER THAN PARENTS:		
Name: Relationship to child:	Phone: ( ) -	
Insurance Information: MUST BE FILLED OUT	**Secondary Insurance:**	
Insurance Company:	Insurance Company:	
Policy #:	Policy #:	
Subscriber Name:	Subscriber Name:	
Subscriber DOB:	Subscriber DOB:	
Please Check here if NO Insurance: ☐		
Responsible Party:	Relationship to Patient:	DOB:
SSN:	Address:	Phone Number:
Preferred Pharmacy:	City:	

CONSENT TO LEAVE MESSAGE:

In compliance with HIPPA laws and to better protect your family's privacy, William Newton Pediatrics needs consent to leave messages regarding your child/children's test results, appointments, referrals, or billing/insurance information. By signing at the end of this document you give William Newton Pediatrics permission to leave detailed messages at any the phone numbers that you have listed on the Patient Registration. **If there are any numbers that you would not like for us to leave a message on please let our staff know and they will have you fill out a Restricted Consent to Leave Messages form for the primary and secondary contacts.**

Parent Signature:	Parent Name:

William Newton PEDIATRICS

Medical History

Patient Name: _____ **DOB:** _____

Preferred Pharmacy: _____ **City:** _____

Please list ANY allergies: _____

Personal Medical History:

During the pregnancy with this child, was there any concern for the infant that was noted by any ultrasound or any obstetrician providing care? ☐ No ☐ Yes _____

_____

Has your child ever been involved in a serious injury or accident? ☐ No ☐ Yes
If yes, when and why? _____

Has your child ever had surgery? ☐ No ☐ Yes
If yes, when and what procedure? _____
_____

Has your child ever stayed overnight in a hospital? ☐ No ☐ Yes
If yes, when and why? _____
_____

Please check if your child has had any of the following medical problems:

No	Yes		No	Yes	
☐	☐	Chicken Pox	☐	☐	Problems with Ears or Hearing
☐	☐	Frequent Ear or Sinus Infections	☐	☐	Chronic or Recurrent Skin Problems (Acne, Eczema, etc)
☐	☐	Pharyngitis/Tonsillitis	☐	☐	Anemia or Bleeding Problems
☐	☐	Other Infectious Illnesses	☐	☐	Blood Transfusion
☐	☐	Allergic Rhinitis or other Allergy:	☐	☐	Frequent Headaches
☐	☐	Animal Allergens	☐	☐	Seizures
☐	☐	Outdoor Allergens	☐	☐	Developmental Delays
☐	☐	Indoor Allergens	☐	☐	ADD/ADHD
☐	☐	Asthma, Bronchiolitis, Pneumonia, or Croup	☐	☐	Mental Health Concerns
☐	☐	Heart Problems or Heart Murmur	☐	☐	Orthopedic Concerns
☐	☐	Abdominal Pain/ GERD	☐	☐	Diabetes
☐	☐	Constipation requiring doctor visits	☐	☐	Thyroid or other Endocrine Problems
☐	☐	Frequent Urinary Tract Infections	☐	☐	If female and menstrual periods have started, any problems with periods?
☐	☐	Bed-wetting (after 5 yrs of age)			
☐	☐	Eye Conditions/Corrective Lenses			Other: _____

_____

Social History:

Who lives at home? (Including pets) _____
_____

Does anyone in your home smoke? ☐ No ☐ Yes

PLEASE CONTINUE ON BACK

Family Medical History:

*Please mark if **your child has a family history** of any of the following:*

Diagnosis	**Natural Mother**	Natural Father	Sister	Brother	Half-Sister	Half-Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergies										
Asthma/ Lung Disease										
Heart Disease/ Condition										
High Blood Pressure										
High Cholesterol										
Diabetes or Other Endocrine Problems										
Cancer, what type?										
Anemia										
Bleeding Disorders										
Epilepsy or Convulsions										
Developmental Disorders										
Neurological Disorders (including ADD/ ADHD)										
Liver Disease										
Other GI Disease/ Disorder										
Kidney Disease										
Bed-wetting (after 10 yr of age)										
Hearing Impairment										
Vision Impairment or Eye Disorder										
Immune Problems, Recurrent Infections, or HIV/AIDS										
Alcohol Abuse										
Drug Abuse										
Mental Health										
Tuberculosis										
Obesity										
Other										

Parent's Signature: _____ **Date:** _____

POLICY FOR COMMUNICATING WITH NON-INTACT FAMILIES

Patient Name:	Date of birth: / /

We understand that many of our patients come from families with divorced, single, or separated parents, or with other family make-ups that involve multiple caregivers. This helps us communicate with your family appropriately.

1. Are parents legally married? ☐ Yes/☐ No

IF YES, STOP HERE AND SIGN BELOW.

2. If No, who has legal custody of this child?
   - Parent 1 (name): _____
   - Parent 2 (name): _____
   - Joint (Circle both above and provide names): _____
   - Other: _____
3. Are there any legal actions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment?

____Yes ____ No

4. If yes, please provide us with a copy of the legal paperwork which supports this restriction.

By signing at the end of this document I understand that William Newton Pediatrics does not have the authority to restrict access of lawful guardians or parents to their child's medical records unless the proper legal paperwork has been provided to us. I further understand that it is not William Newton Pediatrics' responsibility to play go-between for families that fail to communicate with one another about their child's medical care.

Please be aware families with past due balances may be rescheduled until they can fulfill their financial obligation.

Signature of Parent/Guardian:	Date:

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with William Newton Pediatrics. This is NOT for access to your medical records. This form, when signed, allows William Newton Pediatrics to communicate with the authorized person(s) regarding your personal information concerning insurance, benefits, payments, treatment or other healthcare information regarding your care.

Patient Name: _____ DOB: _____

I hereby give my consent for William Newton Pediatrics to communicate personal information on my behalf to the authorized person(s) named below. This authorization allows William Newton Pediatrics speak with the authorized individual(s) regarding the following: treatment, insurance claims, copays, or other aspects of care. I understand that this is limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named. I understand that it is my responsibility to let William Newton Pediatrics know of any changes or to revoke this authorization. I may revoke this authorization at any time in writing to William Newton Pediatrics. This authorization remains in effect for an unlimited amount of time unless revoked or updated. Any updated signed communication forms will supersede and replace all prior communication forms.

Person(s) authorized to speak with William Newton Pediatrics:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES- PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and/or received a copy of William Newton Pediatrics NOTICE OF PRIVACY PRACTICE.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship of representative (if applicable): _____

William Newton Pediatrics Office Policies

Late Arrivals & Missed Appointments: **We ask you to arrive on time to your appointment. If you are more than 10 minutes late, your appointment will be rescheduled**. You will receive a reminder text 2 business days in advance and we request a 24-hour cancellation notice. Please call our office as soon as possible if you are not able to keep an appointment. We understand that there are family emergencies and difficulties which arise, and we therefore do not charge for missed appointments. **However, if a family has a pattern of repeated missed appointments or last-minute cancellations, they may be asked to leave the practice**.

Fees for Miscellaneous Services: Our clinic reserves the right to charge a nominal fee for printing medical records. You may access your records on the Azalea patient portal free of charge. Ask us how!

Sports Physicals are not covered by insurance. We are happy to complete physicals in our clinic for a fee of $25 due at the time of check in.

For same-day sick visits, please contact us directly at 620-402-6699. **Same-day sick appointments are available on an as-needed basis. We may have a nurse speak with you to assess how urgently your child should be seen, and then we can schedule an appointment according to your needs.**

Can I have more than one child seen at one time? We do not book more than two siblings at a time for well child visits as it usually makes for a chaotic visit for all involved. In addition, in middle school onward, please schedule your children for well visits on different days to give each child the attention and privacy they deserve**. If you arrive with your child for a visit and have brought another sick child whom you would like to be seen, we do our very best to accommodate you at that time. Sometimes we may need to find another time in the day that you return with your other children. Copays are due for each child that is seen by a provider that day.**

Health Assessment Forms and copies of immunization records MUST be requested **at least 3 business days in advance**. Our office will let you know when these documents may be picked up.

Immunizations: William Newton Pediatrics vaccinates all children on the schedule recommended by the Center for Disease Control and Prevention and the American Academy of Pediatrics. This means that we do not split up vaccines or do a slow schedule of vaccinations. By signing below acknowledge that I have read this document and plan to immunize my children accordingly.

Parent Signature:	Patient Name:

Financial Policy

Thank you for choosing William Newton Pediatrics as your healthcare provider. This policy is being provided to you in order to have a clear understanding of our Patient Financial Policy and is important for our professional relationship. **It is your responsibility to provide William Newton Pediatrics with current insurance information. We may ask for your insurance card, so please have it available each time you come to the clinic. If current information is not obtained at the time of service, it will become your responsibility to pay until current information is provided to the clinic. If you fail to provide this information and timely filing expires, you will be responsible for the outstanding balance.**

INSURANCE FILING: Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file the claim for you. However, we will not become involved in disputes between you and your insurance company. If a problem occurs with your claim, you will be asked to contact your insurance company to help resolve the problem. This includes, but is not limited to, questions regarding your deductible, co-insurance, and non-covered charges. William Newton Pediatrics will provide information as needed to assist you with your dispute. Please contact us at 620-222-6261 should you need any documents or information. We want to help you understand your healthcare billing.

CO-PAYMENTS: If your insurance policy calls for a co-pay for office visits, you will be required to pay it at the time of service.

PATIENT FINANCIAL RESPONSIBILITY: William Newton Pediatrics expects payment in full within 30 days from your first billing statement. We accept cash, checks, Mastercard, Visa, and Discover.

Please be aware our returned check fee is $30.00. If you do not have health insurance, we expect payment at the time of the service unless other arrangements have been made in advance. If we anticipate that your insurance company may leave you with a deductible, we may require deposits prior to services being rendered.

PAYMENT OPTIONS: Credit is a form of trust William Newton Pediatrics has placed in you. Prompt payment is your obligation when you are granted credit and is vital to the clinic's continued provision of quality health care service to this community. You are responsible for the timely payment of your account. You will receive a monthly statement for services which is due upon receipt. If a payment arrangement is needed, please contact our billing department at 620-222-6261. Timely payments are expected once this agreement is made. We accept many forms of payment including VISA, MasterCard, American Express, DISCOVER, cash, money orders, or checks.

SELF PAY PATIENTS: You will be required to pay a deposit on services. Any deposit collect will apply towards your total balance due. If you would like to pay in full at the time of service, a discount may be applicable. Please speak with the staff at check in if you wish to take advantage of this discount.

ACCIDENTS AND INJURIES: All medical expenses that result from a vehicle accident or public liability are considered the personal responsibility of the patient.

COLLECTIONS PROCESS: If we do not receive your payment in full within sixty (60) days of your first mailed statement, and you have not made arrangements with our office or billing department, your account will be considered delinquent and may be considered for collection action. If your account is placed in collections, you will be charged collection fees including but not limited to agency fees, attorney fees and court costs.

FINANCIAL ASSISTANCE: For more information concerning financial assistance programs contact the billing office at 620-222-6261.

Please ask if you have any questions regarding our fees, policies, or your responsibilities. Please direct questions to our billing office at 620-222-6261.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to William Newton Pediatrics separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance, co-pays, or amounts more than insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

Signature for Assignment of Benefits and acknowledgment of Financial Policy:

_____ DATE_____

Clinic and Patient Partnership Agreement - Code of Conduct

The WNH Physician Clinics have a strong tradition of excellence in patient care. We are committed to providing patient-centered care along with the patient's participation. These expectations outline our partnership agreement which is intended to provide compassionate care in an environment that promotes comfort, healing, and mutual respect between the patient and the clinic team. The first offense of the behavior listed below will result in a verbal warning, second offense will warrant a written warning of the unacceptable behavior, third offense will result in the termination of the patient-physician/nurse practitioner relationship. Physically threatening behavior will result in immediate termination.

- The patient and the clinic staff (inclusive of the providers, nurses, medical assistants, administrative office staff, etc.) will work together to provide the best possible care for the patient in a respectful environment. This includes communication of the patient's progress during office visits.

- Any rude, threatening, or demeaning comments or behaviors will be addressed by the clinic, whether in person or via alternative communication such as telephone or the patient portal. The clinic will not tolerate any profanity, disruptive behavior, or any behavior that interferes with the care of the patient or another patient. Discrimination towards team members, other patients, and/or their family members based on race, color, religion, gender identity, sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, or political beliefs will not be tolerated.

- Any physically threatening behavior demonstrated by the patient, in person or via alternative communication such as telephone or portal communications, will result in the immediate termination of care by the clinic. Staff will immediately contact security and, if needed, local law enforcement.

- Families are welcome and recognized as an important part of a patient's care. However, the clinic will not tolerate from patient's family members: Profanity, disruptive behavior, or any other behavior that interferes with the care of any patient. Discrimination towards team members, other patients, and/or their family members based on race, color, religion, gender identity, sexual orientation, disability, age, marital status, income derived from a public assistance program, or political beliefs will not be tolerated. Family members that exhibit physically threatening behavior towards any clinic team member will also have security immediately contacted and if needed, local law enforcement. This will also result in termination of the patient-physician/nurse practitioner relationship.

- The clinic does not permit any alcohol or drug use on the facility's property. Anyone, including families, violating this will be asked to leave the facility. Patients who have a pain management contract with us would also be evaluated for violation of that contract and could lead to termination of the patient-physician/nurse practitioner relationship.

Signature: _____ Date: _____

Relationship to patient: _____

William Newton PEDIATRICS

Medical Record Release

Primary Care Physician: TODD PETERS, MD

Patient Name: _____

Birthdate: _____

PERSON OR FACILITY AUTHORIZED TO DISCLOSE RECORD INFORMATION: _____

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

Todd Peters, MD - William Newton Pediatrics

Fax: 620-307-2993 Phone: 620-402-6699

1230 E 6th Ave Ste 1A
Winfield, KS 67156

INFORMATION TO BE DISCLOSED / SHARED:

Copies of my health information within the following dates: _____ to _____

Check only those documents needed:

- ☐ Discharge Summary
- ☐ Emergency Department Reports
- ☐ Immunizations
- ☐ Inpatient Progress Notes
- ☐ Laboratory/Pathology Reports
- ☐ Operative Reports
- ☐ Outpatient Visit (Office) Notes
- ☐ School Physical Forms
- ☐ X-ray reports
- ☐ Other
- ☐ Records from Specific Provider:

I understand that if the person or entity that receives the described record information is not a health care provider or health plan covered by federal privacy regulations, the record information may be re-disclosed and no longer protected by these regulations. I understand that I may revoke this authorization at any time by delivering a written revocation to this facility. I authorize the use or disclosure of the record information described. I have read and understand the form. I am the patient listed or am authorized to act on behalf of the patient as the patient's representative.

Signature: _____ Date: _____ Relationship to patient: _____