Welcome to Grace Pediatrics
New Patient Consent Forms

Please complete the following questionnaire. This will become part of our office record and will be held in strict confidential manner.

Today's date _____ _____

Information on patient (Child)

Name of Patient _____
Last name First name MI

Patient's Date of Birth _____ **Sex (circle one) M F**

Parent's name _____ Relationship to patient_____
Home address_____
City _____ State _____ ZIP_____
Home phone _____Work phone_____
Cellular phone (Parent's)_____ Contact preference: home or cell # (circle one)
Occupation (Parent's)_____Employer's Name _____
Employer's Address_____
City _____ State _____ ZIP _____
Previous Physician_____
Referred by _____ Relationship to referring person _____

Information on party responsible for PAYMENT (or Insurance Subscriber)

□ Check here if this information is the same as in the box above.

Name _____ Date of Birth _____
Home address _____
City _____ State _____ ZIP _____
Home phone _____ Work phone _____
Employer _____
Relationship to patient_____

Information on emergency contact

Name _____Relationship _____
Address _____
City _____ State _____ ZIP _____
Home phone _____ Work phone _____
Cellular phone_____

Insurance information

Do you have insurance? □ Yes □ No

1st insurance company	Policy #	Group #	Insured's name
2nd insurance company	Policy #	Group #	Insured's name

I agree to be responsible for any charges for services and materials supplied by **Grace Pediatrics** and its doctors for the above patient.

_____
Signature of party responsible for payment Date

Pediatric Patient History(소아 환자 병상 기록)

Name: _____ Date: _____

Date of Birth: _____

- Review of systems

Please circle any of the following that you are experiencing:

Constitutional	Fever(발열), Fatigue(피로), Recent Weight Loss or Gain(최근 체중 변화)
Eyes	Eye discharge(눈 분비물), Recent change in vision(최근 시력 변화)
Ear, Nose, Throat	Ear pain(이통), hearing disturbance(청력 장애), dizziness(어지러움) ear discharge(귀분비물), nasal stuffiness(비폐색), runny nose(콧물), nose bleed(비출혈), sore throat(인후통), hoarseness(쉰소리)
Respiratory	cough(기침), sputum(가래), shortness of breath(호흡 곤란)
Cardiovascular	chest pain(흉통), palpitation(두근거림)
Gastrointestinal	abdominal pain(복통), indigestion(소화 불량), vomiting(구토), heartburn(속쓰림), diarrhea(설사), constipation(변비), bloody stool(혈변), black stool(흑색변)
Genitourinary	difficulty urination(배뇨 곤란), frequent urination(빈뇨), blood in urine(혈뇨) painful urination(배뇨통)
Musculoskeletal	joint pain(관절통), joint swelling(관절 부종)
Skin	rashes(발진), change in pigmentation(색소 변화)
Neurologic	headache(두통), seizure(경련), syncope(실신)
Psychiatric	depression(우울), hallucination(환청)
Hematologic	easy bruising(쉽게 멍듬)

- Illness/Conditions

Please check any of following that you have or have ever had:

Y	N		Y	N	
□	□	Frequent ear infection (잦은 귀감염)	□	□	Frequent sinus infection (잦은 축농증)
□	□	frequent throat infection (잦은 인후 감염)	□	□	Asthma (천식)
□	□	Pneumonia (폐렴)	□	□	Allergic rhinitis(알레르기성 비염)
□	□	Heart disease(심장병)	□	□	Seizure disorder(간질)
□	□	Kidney disease(신장병)	□	□	Liver disease(간질환)
□	□	Thyroid disorder(갑상선 질환)	□	□	Skin disease(피부 질환)
□	□	Tuberculosis(결핵)	□	□	Sexually transmitted disease(성병)
□	□	High blood pressure(고혈압)	□	□	High blood sugar(당뇨)
□	□	High cholesterol(고지혈증)	□	□	Cardiac Disease(심장병)
□	□	Anemia(빈혈)	□	□	Headache (두통)
□	□	Broke Bones(골절)	□	□	Cancer(암) type(종류):

- Surgical Procedures/Hospitalizations(수술/입원 병력) Year

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

- Medical problems that run in your family (e.g., diabetes, heart problems, cancer) 가족력

Medical problem *Family member*

_____
_____
_____
_____
_____

- Known allergies (including medication allergies) 알레르기, 약물 알레르기 포함

□ No known allergies

Allergies *Symptoms(증상)*

_____
_____
_____

- Prescription and over-the-counter medications you are currently taking. 복용약

(continue on reverse if necessary): 공간이 부족하면 뒷장에 쓰세요.

Medications *Dosage(용량)*

_____
_____
_____
_____
_____
_____

- Birth History 출생력

Birth weight (출생 시 몸무게) : _____ Kg/lbs

Birth By(분만 종류): □ NSVD(자연분만) □ C-section(제왕 절개)

Gestation(임신기간): □ preterm, < 38 weeks (조산) □ full term, 38-41 weeks (만삭)
□ post term, > 41 weeks(과숙)

Any complication during the pregnancy(임신중 이상) □ Yes □ No

_____

Any complication during and after delivery (분만 중/후 이상) □ Yes □ No

_____

- Immunization 예방 접종

□ Up to date 필요한 예방 주사를 모두 맞음

□ Behind 필요한 예방 주사를 모두 맞지 못함

- Social history

Who do you live with? 현재 같은 세대에 거주하는 사람은 ?

_____

Does anyone in your household smoke? 현재 동거하는 사람들 중에 흡연하는 사람이 있습니까?

□ Yes □ No

_____

Signature of person completing the form: □ Patient □ Other _____

Grace Pediatrics

Notice of Privacy Practices Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the **Grace Pediatrics** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

1. _____

Patient acknowledgement (Signature) Date

Grace Pediatrics

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from **Grace Pediatrics**, **Grace Pediatrics** may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Grace Pediatrics**. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **Grace Pediatrics** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **Grace Pediatrics** to restrict how my health information is used or disclosed. **Grace Pediatrics** does not have to agree to my request for the restriction, but if **Grace Pediatrics** does agree, **Grace Pediatrics** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **Grace Pediatrics** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment maybe withdrawn if I withdraw my consent.

2._____

Signature Date

Financial Policy

Thank you for choosing **Grace Pediatrics** as your health care provider. We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be noncovered services that are not considered reasonable and necessary by your insurance carrier.

Participating insurance plans

For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

Nonparticipating plans

For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment by cash, check or charge (American Express, Discover, VISA, MasterCard) is expected at the time of service. Your policy is a contract between you and your insurance company.

Minors

A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Authorization to pay benefits to physician/clinic

I hereby assign payment directly to **Grace Pediatrics** for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance.

Authorization to release information

I hereby authorize **Grace Pediatrics** to release any information acquired in the course of my examination or treatment to my referring physician and/or my insurance company.

Acknowledgement

I have read and understand the above Financial Policy and Benefit Authorization and agree to all provisions outlined herein.

_____

Signature of patient or responsible party Date