BOONSLICK PEDIATRICS NEW PATIENT HISTORY

PLEASE COMPLETE EACH LINE WITH EITHER A RESPONSE OR "NONE"

DATE:_____

PATIENT'S NAME:_____ MALE___FEMALE___DATE OF BIRTH:_____
MOTHER'S NAME:_____ FATHER'S NAME:_____
PATIENT RESIDING WITH:_____

REASON FOR THE VISIT:_____
_____

MEDICAL HISTORY: (Include previous medical problems or illness treated by another physician)
Problem:_____Physician:_____Date:_____
Problem:_____Physician:_____Date:_____
Problem:_____Physician:_____Date:_____

PREVIOUS SURGERIES, SERIOUS ILLNESS, INJURIES, HOSPITALIZATIONS:
Problem:_____Date:_____
Problem:_____Date:_____
Problem:_____Date:_____

CURRENT MEDICATIONS AND DOSAGE: (Include any over the counter medications including Tylenol, vitamins, cold and allergy medications)_____ _____
_____ _____
_____ _____

ALLERGIES: (Include foods, medications, pollen, dust, insect stings, etc. and describe reaction)
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____
Allergen:_____ Reaction:_____

CHILD'S FAMILY INFORMATION: (Your Child's Siblings)
Sibling:_____ Age:_____
Sibling:_____ Age:_____
Sibling:_____ Age:_____
Sibling:_____ Age:_____

FAMILY MEDICAL HISTORY: Please list below any illnesses experienced by parents, grandparents, or siblings such as Allergies, Asthma, Birth Defects, Bleeding Tendencies, Blood Disease, Cancer, Diabetes, Eczema, Emphysema, Epilepsy, Heart, Attack, Heart Defect, Heart Disease, High Blood Pressure, Gastrointestinal Disease, Kidney Disease, Liver Disease, Mental Disorder, Developmental Delay or Learning Disability, Thyroid Disease, Others. Indicate which relative has what type of illness. For example: "Grandmother (indicate if this is Mom's mom or Dad's mom or Mom's grandma or Dad's grandma)-lung Cancer or Sister (child's sister)-asthma.
Relationship:_____ Disease:_____
Relationship:_____ Disease:_____
Relationship:_____ Disease:_____

Patient Demographic Form: revised 10/19

Robert J. Lobonc, M.D.

PATIENT INFORMATION

Patient: Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ AGE:_____ Sex:☐Male ☐ Female Preferred name: _____

Mailing Address:_____ City/State/Zip:_____

Primary Phone: (_____) _____ (Home or Cell) Secondary Phone: (_____) _____ (Home or Cell)

Main Pharmacy Name:_____ Phone:_____

Secondary Pharmacy Name:_____ Phone:_____

Emergency Contact (NOT LIVING WITH PATIENT)

Name:_____ Relationship:_____ Phone:_____

Marital Status of Parents (circle ONE): Married Separated Divorced Widowed Single

MOTHER/GUARDIAN

Name:_____

DOB:_____ Lives with patient? Yes or No

Address:_____

City/State/Zip:_____

Primary Phone: (_____)_____(home or cell)

Email:_____

Employer:_____

Occupation:_____

FATHER/GUARDIAN

Name:_____

DOB:_____ Lives with patient? Yes or No

Address:_____

City/State/Zip:_____

Primary Phone: (_____)_____(home or cell)

Email:_____

Employer:_____

Occupation:_____

Responsible Party- (self, if 18 or older) parent or legal guardian (if under 18)

Last Name:_____ **First Name:**_____ **MI:**_____

DOB:_____ **Social Security #:**_____ **Phone:**_____

Address of Person Responsible:_____

City/State/Zip:_____ **Relationship to Patient:**_____

Insurance Information:

Primary Insurance Co:_____

Policy Holder Name:_____

ID #:_____ Group #:_____

Effective Date:_____

Secondary Insurance Co:_____

Policy holder Name:_____

ID #:_____ Group #:_____

Effective Date:_____

Insurance payment authorization and release: I hereby authorize my insurance benefits to be paid directly to Boonslick Pediatrics, L.L.C. and acknowledge I am financially responsible for any unpaid balance and/or collection fees that may apply. I also authorize the release of any information to my insurance company.

☐Yes, I agree ☐No, I <u>do not</u> agree

E-Prescription Consent for Medication:

With my consent, Boonslick Pediatrics may submit prescription medications utilizing their e-prescription feature.

☐Yes, I consent ☐No, I <u>do not</u> consent

Additional Information:

How did you hear about our practice: _____

Signature of Patient or Legal Guardian:_____ **Date:**_____

BOONSLICK PEDIATRICS, L.L.C.

FINANCIAL POLICY

Thank you for choosing Boonslick Pediatrics as the health care provider for your child. We are committed to providing the best quality care to each of our patients. The following is a statement of our Financial Policy to help you understand your obligations, which we require you to read and sign.

Regarding Insurance

All charges will be submitted to your insurance plan provided that we are a participating contract provider for that plan. Please understand that the agreement of the Insurance Company is a contract between you and your insurance company. We are required, per this agreement, to collect co-payments and balances due at the time of service. Co-pays, coinsurance and deductible amounts are your responsibility. Should we need to send out a statement to collect co-pays, a $10 service charge could be added for each statement sent each month. Please bring your insurance card to each visit.

Separation/Divorce Policy

The parent accompanying the child is responsible for paying the copay or any charges pre-determined to not be covered by the insurance at the time of service. It is your responsibility to keep our office informed of any address, phone number, or insurance changes, as we can only work with the information provided to us. The parent deemed, "responsible/guarantor" will be financially responsible for any account balance unless court ordered otherwise. Please keep the Office Manager made aware of special billing circumstances.

Copays

Copays are a part of your contract between you and the insurance company and by law are due at the time of service. Insurance companies do perform audits and a breach of contract could warrant your loss in coverage. Any copay not paid at the time of service will include a $10 service charge for each month billed out to the patient.

Minor Patients

The adult accompanying a minor patient (parent, guardian, step-parent, other family member or care-giver) will be responsible for payment of copay or any pre-determined charges not covered by the insurance at the time of service. In the event of a true medical emergency, other arrangements may be made with the Office Manager.

Adolescent Unaccompanied Patients

Adolescent patients not accompanied by a parent are responsible for payment of the copay or any charges pre-determined not covered by the insurance at the time of service.

Billing Fees

A $10 to 25 billing charge could be added to any unpaid balances after two unsuccessful attempts have been made. A $35 service fee will be charged to your account for any returned checks.

Account Balances

All coinsurance and deductible amounts are due 30 days after receipt of Statement of Account from Boonslick Pediatrics. Statements are sent monthly to the responsible party provided. We may also try and collect by telephone, mail or email correspondence. If balances are neglected to be paid, and after many attempts, your account will be turned over for collections with inclusion of a service charge at 30% over the account balance. Balance must be paid in full at the time of service unless previous billing arrangements have been established with our office. We accept cash, check, money order, or credit/debit card (Mastercard, Visa, Discover, and American Express).

By signing this agreement, you are stating that you have read the Financial Policy, understand, and agree with the terms. If you have any questions or concerns, please contact the Office Manager at 636-441-4144, Monday through Friday 8:30am-4:30pm.

I, the parent of _____, have read the Financial Policy and I understand and agree to these terms and to assignment of benefits from my insurance company to Boonslick Pediatrics, L.L.C.

_____ _____ _____

Signature of Responsible Party | Printed Name | Date

Boonslick Pediatrics

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Boonslick Pediatrics creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must:
agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and
agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

(PATIENT'S NAME PRINTED)	DATE
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR)	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS (Optional)	DATE

Revised: October 7, 2002

Boonslick Pediatrics, LLC

Patient Policy

Thank you for choosing Boonslick Pediatrics as the health care provider for your child. We are committed to providing the best quality care to each of our patients. The following is a statement of our policy.

Regarding Insurance

All charges will be submitted to your insurance plan provided that we are a participating contract provider for that plan. Please understand that the agreement of the Insurance Company is a contract between you and your insurance company. We are required, per this agreement, to collect copayments and balances due at the time of service. Copays, coinsurance and deductible amounts are your responsibility. Should we need to send out a statement to collect copays, a $10 service charge will be added for each statement sent each month. Please bring your insurance card to each visit.

Separation/Divorce Policy

The parent accompanying the child is responsible for paying the copay or any charges predetermined to not be covered by the insurance at the time of service. It is your responsibility to keep our office informed of any address, phone number or insurance changes, as we can only work with the information provided to us.

Office Hours

We see patients between 9 am and 4:30 pm Monday, Tuesday, Thursday and Friday and between 9 am and 12:30 pm Wednesday and between 9 and 11:30 pm Saturday. Our phones are on Monday through Friday from 8:30 am to 4:30 pm, and off from 12:30 to 1:30 pm for lunch. Our phones are on from 8:30 to 11:30 am on Saturday.

Appointments

Appointments are available during regular office hours and can be scheduled by telephone. When scheduling, please state the nature of your child's visit so that we can deem the appropriate amount of time for the appointment. If you arrive more than 30 minutes after your appointment time, you will be asked to reschedule. If you cannot keep an appointment, we ask for a 2 hour notice of cancellation on a same day sick appointment and 24 hour notice on a well visit, medication recheck or other evaluation. Any missed appointment or cancellation not taken care of in advance is subject to a $25 fee.

Referrals and Paperwork

It is the patient's responsibility to make sure that insurance referrals are requested in a timely fashion. We are also happy to complete any paperwork needed for FMLA, school, and sports or otherwise. We ask that you allow four working days for any non-urgent case. Once you have left our practice, it is our courtesy to hold on to your chart for a given period of time in case any records are ever needed. These records are kept off site so please allow 30 days for completion. Some forms may be subject to a small completion fee (ie: FMLA and a chart retrieval off site.)

After Hours

If your child is ill and our office is closed, the doctor may be reached through the after-hours exchange at 314-388-5353 or 866-582-8060. Please have the details of your child's illness and a pharmacy number available for a prompt response. This service is intended for emergent issues only. Routine matters or minor concerns can be addressed during regular business hours. In the case of a true medical emergency, please go directly to the nearest emergency room.

Medication Refills

For medication refills, please contact your pharmacy. If refill authorization is required, they will contact our office directly. If a refill is needed for a controlled substance, please contact our office. Please allow three business days on all medication prescription refills. Please be aware that the patient may need to be seen by the doctor before a refill is permitted.

BOONSLICK PEDIATRICS, L.L.C.
ROBERT J. LOBONC, M.D.

4704 Mexico Road
Saint Peters, MO 63376
Tele: 636-441-4144
Fax: 636-441-4112

AUTHORIZATION FOR DISLOSURE OF HEALTH INFORMATION

(Complete question #1 with information about who is sending information to us, or if we are sending it to someone else we can stamp it with our data.)

1. I hereby authorize (name of provider)_____,(address)_____
_____,(telephone)_____,(fax)_____
to disclose the following information from the health records of:

Patient Name_____ Date of birth _____
Address_____ Telephone _____
_____

Covering the periods of healthcare

From (date)_____to (date)_____

2. Information to be disclosed: **(Check the boxes to indicate what information needs to be sent.)**
( ) Complete health records ( ) Progress notes
( ) History & physical examination ( ) Laboratory test
( ) Consultation reports ( ) X-ray records
( ) Photographs, videotapes, digital or other images
( ) Other (please specify)_____

(Complete question #3 with the information who the information is being sent to. If we are receiving the information we can stamp it with our data.)

3. This information is to be disclosed to:_____
Address_____City_____State_____Zip_____
Telephone _____ Fax _____

For the purpose of ( ) Changing Physician, ( ) Moving, ( ) Other_____

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

5. I understand that Boonslick Pediatrics, LLC cannot release records of my medical treatment, testing and/or procedure that were done at other healthcare facilities. I must request my records from those facilities separately.

6. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed:_____
(patient) (date)

_____
Or (legal representative) (relationship to patient) (date)

_____
(signature of witness) (date)

NOTICE TO PATIENT:
Information used or disclosed pursuant to an authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA final privacy rule.

Copies that are picked up by a patient are subject to a copy fee to be paid in advance. The copy chart fee is $23.94 plus $0.55 per page. An additional fee up to $22.41 will be charged if records are maintained off-site. These fees are subject to change.